HealthLinkNow

PATIENT INTAKE-Adults

Patient ID #:

Demographics

Race/Ethnicity:

Name:

Phone:

Email:

Identified gender:

Mailing Address:

Preferred language:

Location when participating in sessions:

Current living situation:

DOB:/Age

Pronouns:

How did you hear about HLN: _____

Presenting Problem/PSYCHIATRIC HISTORY

Why are you seeking mental health telehealth /telemedicine treatment at this time? Please list all symptoms and behaviors ._____

_____

How long have symptoms been present for?_____

Have you experienced any of the above listed symptoms/behaviors in the past? If so which ones?

_____

Do you have other concerns that you would like addressed?_____

What are your short term goals/expectations for treatment?_____

What are your long term goals/expectations for treatment?_____

Would you like a referral for support services? Yes ☐ No ☐

If so, what kind of support services?_____

Are you currently participating in any mental health treatment? (e.g., psychiatrist, psychologist, therapist, etc).

What mental health services are you seeking from HealthLinkNow? (Check all that apply.) ?

Check all Services you are interested participating in:

- ☐ Psychiatric Medication Management
- ☐ Therapeutic

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- ☐ Couples Therapy
- ☐ Group Therapy
  - ☐ Depression
  - ☐ Anxiety
  - ☐ Stress Management
  - ☐ Occupational problems
  - ☐ Anger Management
  - ☐ Past Traumas
  - ☐ LGBTQ+
  - ☐ Self Esteem
  - ☐ COVID-19
  - ☐ Coping Skills

Have you ever HARMED yourself INTENTIONALLY? Yes ☐ No ☐

If yes, please explain: _____

Have you ever ATTEMPTED SUICIDE? Yes ☐ No ☐

If yes, please explain: _____

How many attempts in the past and most recent

Have you ever HARMED OTHERS? Yes ☐ No ☐

If yes, please explain: _____

Have you ever been the VICTIM OF ABUSE OR NEGLECT, or EXPLOITATION? Yes ☐ No ☐

If yes, what was the nature of the abuse/neglect? _____

Have you experienced a SIGNIFICANT LOSS? Yes ☐ No ☐

If yes, please explain: _____

Have you every perpetrated ABUSE, NEGLECT, OR EXPLOITATION?

Yes ☐ No ☐

If yes, please explain: _____

Are you <u>currently</u> prescribed medications for your mental health? Yes ☐ No ☐
If yes, PLEASE FILL OUT IN MEDICATION LIST SECTION.

Have you been prescribed medications for your mental health in the <u>past</u>? Yes ☐ No ☐
If yes, PLEASE FILL OUT IN MEDICATION LIST SECTION.

Have you ever been psychiatrically hospitalized? Yes ☐ No ☐
If yes,

a. Voluntary or involuntary hospitalization? _____

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b. Length of stay? _____
c. Dates: _____
d. Name of facility: _____

Would you like a referral for support services ? Yes ☐ No ☐ If so, what kind?: _____

Mental Health History

History of Emotional/Behavioral Functioning:
Have you ever been diagnosed with a mental health diagnosis? Yes ☐ No ☐ If so, which one?:
_____

Have you ever participated in mental health treatment (psychotherapy, psychiatric services, counseling, etc) ☐Yes ☐No
If yes, please fill out below

OUTPATIENT TREATMENT for you:

Please fill in the table below if applicable:

Provider Type	Name	Location	When (month/year)?	For how long?
Psychiatrist				
Therapist				
Any other provider				

PSYCHIATRIC PROGRAMS for you: (residential or day treatment programs, including any alcohol and drug treatment programs):

Where	When (month/year)?	Length of Stay	Type of Treatment	Diagnosis

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SUBSTANCE ABUSE HISTORY: *If applicable*

Have you ever smoked cigarettes? Yes☐ No☐

Currently? Yes☐ No☐

How many packs per day? _____ For how many years?_____

In the past, if quit?_____ For how many years? _____

Do you currently use street drugs or use any prescription drugs not as prescribed? Yes ☐ No ☐

Currently? Yes☐ No☐

How many per day? _____ For how many years?_____

In the past, if quit?_____ For how many years? _____

How often have you had a drink containing alcohol in the past year? Consider a drink a bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor (like scotch, gin or vodka).

☐Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4-5 times/week ☐ 6+ days/week

Medical History

Patient has executed an Advanced Directive ☐ Yes ☐ No

NUTRITION:

Do you have any food/medication allergies? ☐ Yes ☐ No

If so, please describe: _____

Have you lost or gained ten pounds or more in the last 3 months? ☐ Yes ☐ No

What is your current weight? _____

What is your current height? _____

Have you had a decrease in appetite or amount of food they are eating? ☐ Yes ☐ No

If so, please describe: _____

Do you have any dental problems? ☐ Yes ☐ No

If so, please describe: _____

Do you have disordered eating habits (example: bingeing, self-induced vomiting)? ☐ Yes ☐ No

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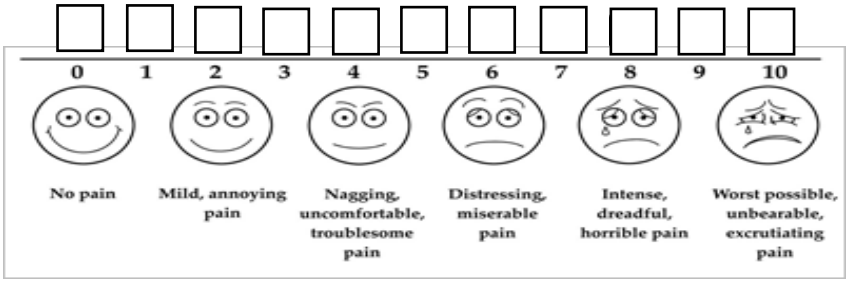
If so, please describe: _____

CURRENT PAIN LEVEL:

Are you in any pain at this time? ☐ Yes ☐ No



Please rate their pain on a scale of 1 through 10, where 10 is the most severe.

Where is your pain? _____

Current medical problems:

_____

_____

Past medical problems, non-psychiatric hospitalizations or surgeries:

_____

_____

For women only: Are you currently pregnant or do you think you may be pregnant?

☐ Yes ☐ No

Do you have any concerns about your physical health that you would like to discuss with us?

☐ Yes ☐ No

Date and place of last physical exam:

_____

Are currently prescribed any medical medications (eg., cholesterol, hypertension, etc) ?

☐ Yes ☐ No

If yes, please list below:

Medical Medication/Supplements/OTC	**Reason**	**Dosage**	**X's/Day (Ie., 2x a day)**	**Adverse Reaction/Side**

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				Effect

CURRENT & **Past PSYCHOTROPIC** medications: If you have ever taken any of the following medications, please, indicate the dates and any response (e.g. positive, did not work, etc)/side effects.

PSYCHOTROPIC Medications	Reason	Dosage	X's/Day (Ie., 2x a day)	Response/Side Effect

Do you have any concerns or have any difficulties paying for your prescriptions/medical bills?

☐ Yes ☐ No If yes, please explain:

_____

_____

Family Mental Health History

Are you currently: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

How long have you been married or partnered? _____

How long have you been divorced or widowed? _____

How would you identify your sexual orientation?

☐ Straight/Heterosexual ☐ Unsure/ Questioning ☐ Lesbian/ Gay/ Homosexual ☐ Asexual ☐ Bisexual

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☐ Other, _____

Do you have children? ☐ Yes ☐ No

If yes, How many? _____

Do you feel you have a sufficient social support system? ☐ Yes ☐ No

Do you confide in them about your problems? ☐ Yes ☐ No

If applicable, what are your family's preferences or perceptions of your treatment, services, or care?

_____

Where do you live?

☐ alone, without paid supports ☐ prefer not to answer ☐ alone, with paid supports ☐ supported housing/living ☐ with family/ significant other/ natural supports ☐ Other, _____

Do you believe that your basic needs are being met? (i.e. clothing, shelter, food, etc.)? ☐ Yes ☐ No

If so, describe: _____

Do you feel safe in your home? ☐ Yes ☐ No

Do you have any concern in paying for your living? ☐ Yes ☐ No

If so, describe: _____

Do you have difficulty accessing transportation? ☐ Yes ☐ No

If so, describe: _____

Have any of your biological relatives (e.g. parents, grandparents, brothers or sisters, children) had problems with depression, attempted suicide, anxiety, hearing voices, drugs, alcohol, or other mental health problems? And have they been treated by a mental health professional? If yes, list below: ☐ Yes ☐ No

1. Relationship of family member: _____

   Diagnosis or reason for treatment: _____

2. Relationship of family member: _____

   Diagnosis or reason for treatment: _____

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3. Relationship of family member: _____

Diagnosis or reason for treatment: _____

4. Relationship of family member: _____

Diagnosis or reason for treatment: _____

EDUCATIONAL HISTORY

Highest grade completed? _____

Where?_____

Did you participate in Special Education? ☐ Yes ☐ No

Describe. _____

How would you describe your academic performance?_____

How confident do/did you feel in your ability to succeed in your classes?_____

What was/is your preferred area(s) of study?_____

Do you plan or wish to further your education?_____

Do you have any current literacy / reading issues ☐ Yes ☐ No

Reading Level: ☐ Cannot read ☐ Can read some ☐ Can read very well

Writing Level: ☐ Cannot write ☐ Can write some ☐ Can write very well

Do you need assistive technology? ☐ Yes ☐ No

Describe.

_____

OCCUPATIONAL HISTORY

Are you currently: ☐ Working ☐ Unemployed, looking for work ☐ Unemployed, not looking for work

☐ Disabled ☐ Retired ☐ Student

Where do you work? _____

For how long? _____

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Have you ever served in the military? ☐ Yes ☐ No Describe. _____

Have you ever received or do you currently receive financial assistance? ☐ Yes ☐ No If so, please describe: _____

Finances

How do you support yourself financially? (ie.,SSI, Family support, etc):

_____

Are you currently having serious financial problems? ☐ Yes ☐ No

Do you have any concern or difficulty in obtaining food? ☐ Yes ☐ No

Do you have any concern or difficulty with transportation? ☐ Yes ☐ No

Do you access community resources (for example Food Stamps, HUD housing, etc.) ☐ Yes ☐ No

If yes, which community resources:_____

Legal

Have you ever been arrested? ☐ Yes ☐ No Describe. _____

Do you have any pending legal problems? ☐ Yes ☐ No Describe. _____

If yes to either, will this be a topic of discussion/influence treatment being sought?

_____

Please indicate if you are currently involved with and/or have the following.

Powers of attorney: ☐ Yes ☐ No

Are you under civil or criminal court ordered mental health treatment: ☐ Yes ☐ No

Are you under civil or criminal court ordered substance use disorder treatment: ☐ Yes ☐ No

Letters of guardianship/ parenting plans / court order for custody: ☐ Yes ☐ No

Supervision by the department of corrections: ☐ Yes ☐ No

*If answered yes to any of the questions above, please provide all relevant legal documents/paperwork

Wellness/Leisure

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What do you like about yourself? What are your personal strengths?

_____

What are your interests and hobbies?

_____

What is your ability to self care?

_____

What is important to you?

_____

What helps you to feel calm?

_____

What would you consider to be your personal areas which need improvement?

_____

Cultural/Spiritual

How would you describe your cultural background or ethnicity?

_____

Where were you born and raised?

_____

Do you speak any other languages? ☐ Yes ☐ No

_____

Do you consider yourself a religious or spiritual person? ☐ Yes ☐ No

_____

What is your faith or tradition?

_____

How important is your religious or spiritual beliefs in your daily life?

_____

Are you a member of a church or faith community? ☐ Yes ☐ No

How do your spiritual or religious beliefs apply to your health, if at all?

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Leave this section blank, for HLN office use only:

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INSURANCE INFORMATION

Primary Insurance Name: Member/Subscriber ID:

Name of Policy Holder (first, last):

Relation to Patient (if someone other than patient): Complete below if information is other than patient:
Policy Holder's DOB:

Policy Holder's SSN:

Policy Holder's Email Address:

Policy Holder's Address:

Do you have a secondary insurance? ☐ Yes ☐ No

Complete below if applicable:

Secondary Insurance Name: Member/Subscriber ID:

Name of Policy Holder (first, last):

Relation to Patient (if someone other than patient):

Complete below if information is other than patient

Policy Holder's DOB:

Policy Holder's SSN:

Policy Holder's Email Address:

Policy Holder's Address:

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ADMISSION/INTAKE ASSESSMENT (Part 2)

Columbia- Suicide Severity Rating Scale		
Ask questions that are bolded and underlined. Ask Questions 1 and 2.	**Yes**	**No**
1) Wish to be Dead: **Have you wished you were dead or wished you could go to sleep and not wake up?**	☐	☐
2) Suicidal Thoughts: **Have you actually had any thoughts of killing yourself?**	☐	☐
IF YES to question #2, ask questions 3-6. **If no to question #2,** go directly to question #6.		
3) Suicidal Thoughts with Method: **Have you been thinking about how you might kill yourself?** E.g. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it… and I would never go through with it."	☐	☐
4) Suicidal Intent (without specific plan): **Have you had these thoughts and had some intention of acting on them?** As opposed to "I have these thoughts but I definitely will not do anything about them."	☐	☐
5) Suicide Intent with Specific Plan: **Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?**	☐	☐

6) Suicide Behavior Question: **Have you ever done anything, started to do anything, or prepared to do anything to end your life?** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **IF YES, ask: How long ago did you do any of these?**	**Yes: within the past 30 days**	**Yes: over 30 days ago**	**No**
	☐	☐	☐

Low Risk: Schedule initial appointment as soon as possible, notify assigned provider of severity, provider will administer PHQ-9 at initial appointment and document safety planning in session note.

Moderate Risk: Schedule initial appointment as soon as possible, notify assigned provider of severity, provider will administer CSSRS at initial appointment and document safety planning in session note.

High Risk: Evaluate patient for higher level of care. If patient does not meet criteria for higher level of care, complete **Columbia Lifetime Assessment** and designate patient as Moderate Risk and complete moderate risk process.If patient meets criteria for higher level of care, initiate welfare check.

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11249 Gold Country Blvd #130 Gold River, Ca 95670

Patient Identification #:

Patient Health Questionnaire
(PHQ - 9)

Date Completed (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

Time of Administration:

☐ Admission

☐ During Treatment..... { ☐ Days ☐ Weeks ☐ Months } since Admission ☐☐

☐ Discharge

Be sure to fill in all choices with ☒ **not** ☑

Over the last week, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Please place an X in the box below your answer.	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
For office coding:	0 +	+	+	

= TOTAL SCORE: ☐☐

(add up each item)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficulty

☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐101

Patient Account Number

■

SAMHSA's 8 dimensions of wellness

Date:

YOUR WELLNESS WHEEL

Score your current level of happiness in each of the sections on this wheel. The scale is 1-5. 1 is your lowest level of happiness and 5 is your highest level of happiness. You can either fill the corresponding section in or you can write some reasons for your score in that section – either way works. Then you can draw lines connecting each section like the example provided by the dotted lines. This is your wheel and it can show you quickly what is working and what still needs improvement. Good luck on your wellness journey.

Key

1. I am very unhappy with this part of my life.

2. I am unhappy with this part of my life, but I haven't hit rock-bottom.

3. This part of my life is pretty good but could still use some improvement.

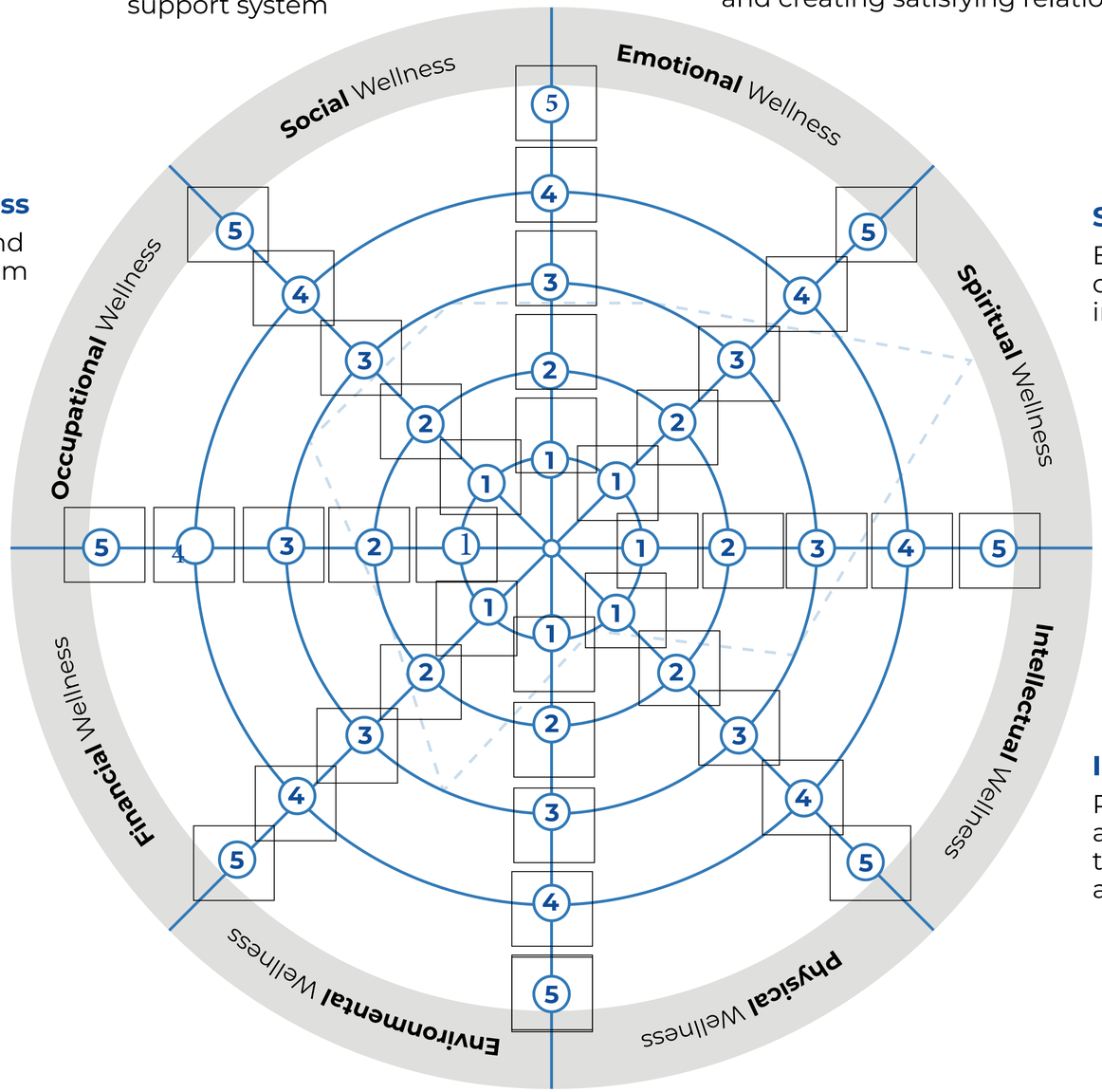
4. I am content with this part of my life, but I can see a few tweaks that would make it even better.

5. I am completely happy and fulfilled in this part of my life – there is no room for improvement.

Social Wellness
Developing a sense of connection, belonging, and a well-developed support system

Emotional Wellness
Coping effectively with life and creating satisfying relationships

Occupational Wellness
Personal satisfaction and enrichment derived from one's work



Spiritual Wellness
Expanding our sense of purpose and meaning in life

Financial Wellness
Satisfaction with current and future financial situations

Intellectual Wellness
Recognizing creative abilities and finding ways to expand knowledge and skills

Environmental Wellness
Good health by occupying pleasant, stimulating environments that support well-being

Physical Wellness
Recognizing the need for physical activity, diet, sleep, and nutrition

*Total will be calculated by administrative team

Total:

HealthLinkNow

Mental Health Resources

If you or someone you know is in need of urgent or in-person mental health services please utilize the following resources:

Emergency Services:

Dial 911 or go to your nearest **Emergency Room**

If the situation is potentially life-threatening, get immediate emergency assistance by calling 911, available 24 hours a day.

National Suicide Prevention Lifeline:

Dial : 988

Trained crisis workers are available to talk **24 hours a day, 7 days a week**. Your confidential and toll-free call goes to the nearest crisis center in the Lifeline national network. These centers provide crisis counseling and mental health referrals.

Find in-person mental health services by visiting:

https://www.findbhhelp.com/