ARISE BEHAVIORAL AND WELLNESS HEALTH

Psychiatric Medication Management

I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: ____
(Last) (First) (Middle Initial)

Birth Date: _______ /_______ /_______ Age: ________ Gender: □ **Male** □ **Female**

Ethnicity/national origin: __________________ Race: __________________
Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: ____
____

Address:____
(Street and Number)
____
(City) (State) (Zip)

Home Ph: ( ) ____
May we leave a message? □ Yes □ No

Cell/Other Ph: ( )____
May we leave a message? □ Yes □ No

E-mail: ____
May we email you? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

*How did you hear about us?____

Permission to thank this person for the referral? ❑ Yes ❑ No

Emergency Contact:____
Ph. #___________________________Relationship:_____________________
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:
____

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Previous/Current Diagnosis:___________________________________

Are you currently or have you ever taken any psychotropic medications? If yes, please list:

PAST MEDICATIONS	Dosage/Times	Prescribed By	Taken as Prescribed?
CURRENT MEDICATIONS	**Dosage/Times**	**Prescribed By**	**Taken as Prescribed?**

GENERAL HEALTH AND MENTAL HEALTH INFORMATION 1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
____
____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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Please list any specific sleep problems you are currently experiencing:
____
____

3. How many times per week do you generally exercise? ______________

What types of exercise to you participate in?______________________
____

4. Please list any difficulties you experience with your appetite or eating patterns:
____
____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No □
Yes
If yes, for approximately how long?
____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No □
Yes
If yes, when did you begin experiencing this?
____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe:
____

8. Do you drink alcohol more than once a week? □ No □ Yes
If yes, how often?_______________ Do you binge drink?_________

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

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10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? ___________________________

    On a scale of 1-10, how would you rate your relationship? __________

11. What significant life changes or stressful events have you experienced recently: ____
____
____
____

FAMILY MENTAL HEALTH HISTORY:
In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle and List Family Member(s)

Alcohol/Substance Abuse yes/no __________________________________

Anxiety yes/no ____

Abuse or Neglect yes/no____ Bipolar Disorder yes/no____ Depression yes/no ____

Domestic Violence yes/no _______________________________________

Eating Disorders yes/no____ Schizophrenia yes/no ____

Suicide Attempts yes/no ____

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ADDITIONAL INFORMATION:

1. Status: □ **F/T Employed** □ **P/T Employed** □ **F/T Student** □**P/T Student**
(check one)

Employer:____
School:____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:
____
____

3. What do you consider to be some of your strengths?
____
____
____
____

4. What do you consider to be some of your weaknesses?
____
____
____
____

5. What would you like to accomplish out of your time in therapy?
____
____
____
____

6. Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms?
____
____
____
____

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Insurance Information

Patient Name: _____________________________ Date: _______________
S.S. #: ________________________ D.O.B:___________________

Name of Insurance Company:________________________________

Policy ID #_____________________________ Group ID:_______________

Subscriber Name:______________________Subscriber DOB:____________

Relationship to Patient:_________________________________

Name of Secondary Insurance? (if applicable) _________________________

Policy ID #_____________________________ Group ID:_________________

Subscriber Name:_________________________ Subscriber DOB:____________

Relationship to Patient:_________________________________

Workers' Comp Insurance:____

Claim #: ___________________________Date of Injury__________________

Adjustor :__________________________ Adjustor Ph. #_________________

Address to send claims:____

____

Assignment Of Benefits

I authorize the release of any medical or other information necessary to process this claim to my insurance company. I also authorize payment of medical benefits to Arise Behavioral and Wellness Health, for services rendered to me.

Client Signature____________________________ Date:______________
___ ____________________