Office: Date Received: \_\_\_\_\_\_\_\_\_\_ □ Portal Link Sent □ Welcome Email Sent □ Ins Card & ID □ Golden

Patient Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Secondary Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Minor: Parent Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coparent Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Copy of Court Agreement (any custody arrangement) Additional Contact Info.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Mental Health: □ Yes □ No Current Medications with dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cultural and/or Gender Expressions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| REASON FOR SEEKING MENTAL HEALTH SERVICES(check all that apply) | |
| □ Behavior Problems/School Adjustments | □ Trauma/PTSD |
| □ Attention Deficit/Hyperactivity Disorder | □ Family Therapy/Couples Counseling |
| □ Mood D/O | □ Custody/Court/Legal Issues |
| □ Anxiety | □ Suicidal Ideation/Homicidal Ideation |
| □ Substance Use Disorder/Substance Abuse  □ Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Individual Therapy  □ Youth 8-10: \_\_\_ No SI in the last two weeks. \_\_\_ Appropriate for Telehealth. |
|  |  |

Appointment Availability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only

Authorization Approval: \_\_\_\_\_\_\_\_\_\_ Reached/1st scheduled appointment for intake: \_\_\_\_\_\_\_\_\_