Mental Health Association in Indian River County Walk-In Center Intake Form: Adult

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

How did you hear about us? ☐ 211 ☐ Behavioral Health Center ☐ Childcare Resources
☐ Connections Center ☐ CORE/Probation ☐ Clerk of the Court ☐ DCF ☐ Healthy Start
☐ Doctor:______________________ ☐ Family ☐ Friend ☐ Google ☐ Health Department
☐ Hospital/Emergency Room ☐ Insurance Company:__________________ ☐ Mental Health Court
☐ Social Media ☐ Newspaper/Magazine ☐ Radio ☐ Return Client ☐ School:___________________
☐ Self ☐ Victims Advocacy ☐ Vocational Rehabilitation ☐ Website ☐ Other: _____________________

SS#: _______________________ DOB: ____________ Age: _________ Gender: _________________

Address: ____
(Street) (Apt.) (City) (Zip code)

County: ☐ Indian River ☐ St. Lucie ☐ Martin ☐ Brevard ☐ Other: ______________________________

Home phone: _______________________________ Work phone: ______________________________

Mobile phone: ______________________________ Preferred contact #: ☐ Home ☐ Mobile ☐ Work

Can we leave a message? ☐ Yes ☐ No Email: ____

Emergency contact name: _________________________________ Phone: _________________________

Relationship of emergency contact to me: ____

Would you a like to register to vote or update your current voter registration? Y N (circle)

Highest Grade/Education completed: __________________

Race: ☐ Asian ☐ Black/African American ☐ Haitian ☐ Hispanic/Latino ☐ White ☐ Other:_____________

Marital status: ☐ Married ☐ Single ☐ Living with committed partner ☐ Divorced ☐ Separated ☐ Widowed

Estimated Gross Annual Household Income: __________________ Occupation: _____________________

Employment: ☐ Full time ☐ Part time ☐ Homemaker ☐ On Disability ☐ Retired ☐ Unemployed

Do you have health insurance coverage? ☐ Yes ☐ No

Name of Plan: ☐ None ☐ Aetna ☐ AVMed ☐ Blue Cross Blue Shield ☐ Care Plus ☐ Cenpatico ☐ Cigna
☐ Clear Health Alliance ☐ Conventry ☐ Freedom ☐ Humana ☐ Magellan ☐ Medicare ☐ Molina
☐ Optimum ☐ Prestige ☐ PsychCare ☐ Sunshine ☐ Tricare ☐ United Behavioral Health ☐ Wellcare
☐ Other: ____

Are you a veteran? ☐ Yes ☐ No Are you a US citizen? ☐ Yes ☐ No

Who lives with you? ____

Ages of minor ages children in home: ☐ N/A ____

Are you seeking care due to an accident (auto, home, work, slip/fall) or symptoms due to an accident? ☐Yes ☐No

What are you looking for? ☐ Community resources ☐ Counseling/Individual Therapy ☐ Group counseling

☐ Medication management ☐ Parenting assistance ☐ Psychiatric evaluation ☐ Support groups

☐ Other: ____

Have you ever received our services? ☐ Yes ☐ No When? ____________________________________

Signature:		Date:	

TURN IN THIS PAGE ONCE COMPLETED THEN COMPLETE NEXT DOCUMENTS.

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

Briefly describe your need for mental health services: ______________________________
____
____

Have you ever been diagnosed? ☐ Yes ☐ No If yes, Diagnosis: ______________________

Do you have a therapist? ☐ Yes ☐ No Provider: ______________________________

Do you have a prescriber for mental health meds? ☐ Yes ☐ No If yes, provider:______________

Please list all medications taken including over the counter medications

Current Medication Taken	Dosage & Times per Day	Why Taken?	Who prescribes?

Have you ever been Baker Acted or Psychiatrically Hospitalized? ☐ Yes ☐ No

Dates and reason: ____

Have you had other inpatient care (residential, detoxification or substance abuse treatment)? ☐ Yes ☐ No

Dates and reason: ____

Have you had individual therapy or counseling? ☐ Yes ☐ No

Dates and reason: ____

Have you had group therapy? ☐ Yes ☐ No

Dates and reason: ____

Have you been in the care of a psychiatrist? ☐ Yes ☐ No

Dates and reason: ____

Do you own or have access to any weapons? ☐ Yes ☐ No Describe: ______________________

Our office is a weapon free environment. No weapons of any kind can be brought on site.

Have you ever threatened/attempted suicide? ☐ Yes ☐ No (If yes, # of attempts:_____ # of threats: ______)

Dates/details:____

Do you have current thoughts about not living? ☐ Yes ☐ No Describe: ______________________
____

Do you have current thoughts to physically harm anyone else? ☐ Yes ☐ No Describe: ______________

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(Last) (First) (Middle Initial)

____

Alcohol use: ☐ none ☐ past ☐ current Tobacco use: ☐ none ☐ past ☐ current

Marijuana use: ☐ none ☐ past ☐ current Cocaine use: ☐ none ☐ past ☐ current

Street pill use: ☐ none ☐ past ☐ current If yes, what pills? ____________________

Hallucinogen use: ☐ none ☐ past ☐ current If yes, what? ____________________

Other substance use: ☐ none ☐ past ☐ current If yes, what? ____________________

Last substance(s) used & when: ☐ N/A ____________________

Do you have medical problems affecting your mental health? ☐ Yes ☐ No

Describe: ____________________

Do you currently have a primary care physician? ☐ Yes ☐ No If yes, provider: ____________________

Do you have pending/current legal issues (charges, court, custody, DCF, parole, probation)? ☐ Yes ☐ No

If yes, check all that apply: ☐ pending charges ☐ court ☐ custody ☐ DCF ☐ parole ☐ probation

Describe:____________________

Do you have current stressors affecting your mental health? ☐ Yes ☐ No

Describe: ____________________

Height: ___________ Weight: ___________

Appetite: ☐ high for me ☐ normal for me ☐ fair for me ☐ low for me

Current eating habits: (Check all that apply): ☐ Healthy food choices ☐ Poor food choices ☐ 3 meals a day ☐ 2 meals a day ☐ 1 meal a day ☐ Skipping meals ☐ Decreased appetite ☐ Overeating ☐ Purging

Sleep: ☐ high for me ☐ normal for me ☐ fair for me ☐ low for me

Current sleeping habits: (Check all that apply): ☐ Restful ☐ 8 hrs. ☐ 6-8 hrs. ☐ 4-6 hrs. ☐ less than 4 hrs. ☐ Can't sleep ☐ Trouble falling asleep ☐ Toss and turn ☐ Distressing dreams/nightmares ☐ Wake up too early; can't go back to sleep ☐ Oversleeping

What helps you with the concerns you described (or what has helped you in the past)?

____

____

____

Signature:		Date:	