Behavioral Health Affiliates, LLC

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Patient Intake Information

Today's Date: ____/____/____

1. Patient Name: *First* _____ *MI* _____ *Last* _____

2. Address: _____

3. City: _____ State: _____ Zip: _____

4. Telephone Number(s) (*Please indicate whether messages can be left at each number)*

Home: _____ Can message be left? ❑Yes ❑No

Work: _____ Can message be left? ❑Yes ❑No

Mobile: _____ Can message be left? ❑Yes ❑No

5. SS#: _____-_____-_____ **6.** Date of Birth: ____/____/____ **7.** ❑Female ❑Male

8. Marital Status: *(please check and specify date where indicated)*

❑Single ❑Married Date of Marriage: ____/____/____

❑Significant Other ❑Separated Date of Separation: ____/____/____

❑Divorced Date of Divorce: ____/____/____

❑Widow(er) Date Widowed: ____/____/____

9. ❑Employed ❑Unemployed ❑Full-Time Student ❑Part-Time Student Employer: _____

Insurance Intake Information

10. Insurance ID#: _____

11. Insurance Company:_____

12. Subscriber's Name:_____ **13.** Relationship to Patient: _____

14. Subscriber's Address (if different from patient): _____

15. Group #: _____ **16.** Subscriber's DOB: ____/____/____ **17.** ❑Female ❑Male

18. Subscriber's SS#: _____-____-_____ **19.** Co-Pay Due: _____

20. Auth Number: _____ **21.** # Auth. Visits: _____

22. Referred By: _____

23. Name of Spouse/Significant Other: _____ **24.** DOB: ____/____/____
(if different from patient):

Address:_____ City/State/Zip: _____

Telephone Number: *Home:* _____ *Work:* _____ *Mobile:* _____

25. Emergency Contact Person & Telephone #: _____

26. Name(s) & Date(s) of Birth of Children:

_____ _____ _____

_____ _____ _____

27. Patients' Rights Form Received? *(please initial, if yes)* _____

******** OFFICE USE ONLY ********

DX Code: _____.____ **Assigned Therapist:** _____

***** OFFICE USE ONLY *****

Clinical Intake Information

Psychiatric HX: _____

_____

_____

_____

_____

_____

_____

Suicide Potential: ❑*At risk* ❑ *Not at risk* ❑*Passive SI*

History of Violence*:* ❑*YES* ❑*NO*

Substance Abuse: ❑*YES* ❑ *NO* *Length of Recovery* _____

History & Current Medications: _____

_____

Prescriber of Meds: _____

Medical Problems: _____

_____

Allergies/Drug Sensitivities: _____

PCP: _____