Holistic Mental Health, PLLC Brief Intake Sheet

1. Patient Demographic Information:

Name of Patient: _____ Preferred Name: _____

Street Address: _____ City: _____ State: ____ Zip:_____

Phone Number: _____ Birthday: _____ SS#:_____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

2. Referral Information:

Name of Referring Provider (if any): _____ Phone Number: _____

If Self-Referred, please list how you learned of this practice: _____

3. Important Medical Information and Medication Information:

Primary Care Physician: _____ Phone Number: _____ Fax Number: _____

Pharmacy Name: _____ Phone Number: _____ Fax Number: _____

Do you currently have or plan to get within the next 2 years any type of Medicare insurance, including secondary or supplemental policies? Please check one of these choices: 1) □ No 2) □ Yes 3) □ Unsure

Current Medications with doses (Including Supplements):_____

_____

_____

_____

Any Allergies to Medications (Include Reaction): _____

4. Treatment Questions:

1. What life events, stresses, or mental health issues have led you to seek treatment at this time?

_____

_____

2. What would you like to accomplish out of your time in treatment? _____

_____