Intake Information Form

OFFICE USE ONLY

Name: ____________________________________ **Date of Birth** ____/____/____ **Gender:**___________________

Reason for assessment (What is the reason for coming in today?)

☐ Anger/Aggression ☐ Suicidal thoughts ☐ Homicidal thoughts ☐ Depression ☐ Anxiety

☐ Detour program ☐ Eating Disorder ☐ Detox ☐ Substance use

When applicable, please indicate substance(s) used:______________________________________

____

Other/Additional Info:____

____

____

Current safety concerns:

Are you able to keep yourself safe while waiting in the lobby? ☐ Yes ☐ No

Suicidal thoughts in last 24 hours? ☐ Yes ☐ No Current suicide plan(s)? ☐ Yes ☐ No

Homicidal thoughts in last 24 hours? ☐ Yes ☐ No Current homicidal plan(s)? ☐ Yes ☐ No

Currently at risk for alcohol withdrawal? ☐ Yes ☐ No

Expected level of care recommendation:

☐ Inpatient Admission ☐ Partial Hospitalization (PHP)/ Intensive Outpatient (IOP)

☐ Outpatient Referrals ☐ Detour/Alternative to suspension

☐ Other (indicate services desired):____

Within the ***past 7 days***, have you experienced any of the following (check all that apply):

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Chills ☐ Fever ☐ Sweating ☐ Cough

☐ Rash ☐ None ☐ Other: ____

Have you recently been exposed to any of the following diseases (check all that apply):

☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella ☐ None

Do you have a ***history*** of any of the following diseases (check all that apply)?

☐ MRSA ☐ C-diff ☐ VRE ☐ ESBL ☐Chicken Pox ☐ Measles ☐ Mumps

☐ Rubella ☐ None

Do you have a ***history*** of a positive TB test? ☐ Yes ☐ No

Have you traveled outside of the U.S. in the past <u>six months</u>? ☐ Yes ☐ No

Have you traveled to or from Africa in the last 30 days? ☐ Yes ☐ No

Have you had physical contact with an individual who has the Ebola Virus Disease in the last 30 days?

☐ Yes ☐ No

Linden Oaks
BEHAVIORAL HEALTH

TURN OVER →

PATIENT LABEL

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Current Providers	Name	Name of Practice/Location (City)	Phone#
Primary Care Physician			
Psychiatrist			
Therapist			
Other Provider			
School			

Please indicate all *current* medical conditions:____

____

____

Current Medications	
Name Of Medication	**Dosage & Frequency**

Hospitals are required to record a patient's race and ethnicity following the current federal standards. These standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity.

Ethnicity: Are you Hispanic, Latino, or of Spanish origin? ☐ **Yes** ☐ **No**

Race Identification (check all that apply):

☐ **White** ☐ **Asian** ☐ **Black/African American** ☐ **American Indian or Alaskan Native**

☐ **Native Hawaiian or Other Pacific Islander** ☐ **Other**

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