INTEGRATED BEHAVIORAL HEALTH, LLC (IBH)

Intake Form

Intake Date: _____ Form Completed By: _____ Patient Chart ID _____

Sections 1-3 must be complete prior to scheduling intake appointment

1. Patient Demographics

Full Name: _____ Date of Birth: _____

SSN: _____ Gender: __M __F __Other

Address: _____

_____

Phone Number(s): _____ Email: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact Relationship to Patient: _____

2. Insurance Information

Insurance Provider: [ ] Medicaid [ ]Medicare [ ] United [ ]CareFirst [ ]Cigna [ ] Aetna [ ] Tricare [ ] Veteran's Administration (VA) [ ] Other _____

Member ID / Group Number: _____

Policyholder Relationship to Patient: [ ] Self [ ] Spouse [ ] Parent [ ] Other _____

Policyholder Name (if not self): _____ For minors, upload copy of Parents' ID

Upload Insurance Card (front and back): [ ] completed by _____(staff name)

3. Reason for Visit

Service(s) Requested: [ ] Therapy [ ] Medication Management [ ] IOP [ ] PRP [ ] PHP/PDTP

Presenting Problem(s): _____

Duration and Severity of Symptoms: _____

Referral Source (e.g., ZocDoc, PCP, agency): _____

Is this a court-ordered visit/service? __Yes __No

If yes, ask patient to email or bring a hard copy of their court order

Current Medications: _____

Ask to bring their pill bottles with them to the first appointment if they can

Past Psychiatric Diagnoses: _____

Hospitalizations (Mental/Medical): _____

Previous Mental Health Programs: _____

Reminder: Patients Should Bring the Following Items to their First Appointment

- *Photo ID (if not already on file)*
- *Insurance card (if not already on file)*
- *Bottles of all their current medications or their medication list*

INTEGRATED BEHAVIORAL HEALTH, LLC (IBH)

Sections 4-7 must be completed in-office at the intake appointment (or prior to 1st appt if no intake appt)

4. Health Care Team & Pharmacy Information

Current Psychiatrist's Name: _____ Phone: _____

Current Therapist's Name: _____ Phone: _____

Primary Care Provider's Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____ Fax: _____

Pharmacy Address: _____

_____

5. Mental Health History

Substance Use History: _____

Trauma History (if applicable): _____

Suicidal Ideation or Self-Harm History: _____

6. Demographic Information

Marital Status: [ ] Single (Never Married) [ ]Married [ ] Divorced [ ] Widowed [ ] Other: _____

Race: [ ] Prefer Not to Disclose [ ] Black/African American [ ]Asian [ ]Hispanic/Latino [ ] White

[ ] American Indian/Alaska Native [ ] Native Hawaiian/Other Pacific Islander [ ] Other_____

7. Consent Forms

[ ] HIPAA Acknowledgment (Notice of Privacy Practices)

[ ] Informed Consent

[ ] Telehealth Consent (if applicable)

[ ] Authorization to Bill

[ ] Release of Information

Section 8 to be completed during intake appt by clinician (or by patient prior to 1st appt if no intake appt)

8. Social History

Living Situation: [ ] Rental (apartment etc.) [ ] With parents [ ] With spouse [ ] Own house [ ]

Homeless [ ] Other please explain: _____

Education Level: [ ] High school [ ] College degree [ ] Professional [ ] Other

Relationship Status: [ ] Married [ ] Single [ ] Divorced [ ] Other _____

Support System (family, friends, children and/or others: _____

Employment Status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Other: _____