Intake Prescreen

Member Info

Member's Name: _____

Assessment Date: _____

Date of Birth: _____

Age: _____

Insurance type and number: _____

Employment: _____

Identified gender: _____

Race: _____

SSN: _____

Marital status: _____

Phone: _____Best time to call: _____

Address: _____

Email: _____

Parent/Guardian: _____

Emergency Contact:_____

Diagnosis (Past and/or Present): _____

Member could not provide a diagnosis or provider that might have one: _____

Presenting Information

Diagnosis (past and/or present):_____

Briefly Describe the Reasons Member is Seeking Treatment: _____

Current Mental Health Treatment (include agency and provider names): _____

_____

Past Mental Health Treatment (include agency and provider names): _____

_____

History of Psychiatric Hospitalizations:

_____

_____

Description of any Legal Issues (include when, where, why):

_____

_____

Risk Assessment

Current suicidal or homicidal ideations: _____

Risk
No Risk
Low
Moderate
High

History of suicidal and homicidal ideations or attempts: _____

_____

_____

Medical Information

Primary Care Provider: _____

Date of Last Health and Physical/Doctor that completed: _____

_____

Medical Specialists for Major Medical issues: _____

_____

Current Pharmacy: _____

List of current medications: _____

_____

_____

List of Any Known Allergies (medication, seasonal, food): _____

_____

_____