Second Wind Mental Health, LLC

11 SW Brantley Dr. Winston, OR 97496
www.secondwindmentalhealth.com

Phone: 541-679-0366 Fax: 541-679-4821

| Tamara Lee, PMHNP, BC | Jenny Tausch, PMHNP, BC | Michael Fernandez, MSW, CSWA |
| Diane Rose, LCSW, LLC | Tom Pugel, LMFT, LLC | McKenzie Smith, PMHNP, BC, LLC |

Patient Information-Adolescent

Patient Name:_____ DOB: _____

SSN: _____ Gender: □ Male □ Female □ Transgender

Physical Address: _____

Phone Number: _____ Is this a cell phone? □ **Yes** □ **No**

Guarantor Name: _____

Relationship to patient: _____

Is your phone number the same as the patients? □ **Yes** □ **No/Other:** _____

Is this a cell phone? □ **Yes** □ **No**

Are you responsible for bringing the patient to appointments? □ **Yes** □ **No**

If NO, please list responsible person: _____ **Phone #** _____

Is your address the same as the patients? □ **Yes** □ **No/Other Address:** _____

_____

Second Guarantor Name: _____

Is your phone number the same as the patients? □ **Yes** □ **No/Other:** _____

Is this a cell phone? □ **Yes** □ **No**

Are you responsible for bringing the patient to appointments? □ **Yes** □ **No**

If NO, please list responsible person: _____ **Phone #** _____

Is your address the same as the patients? □ **Yes** □ **No/Other Address:** _____

_____

Email: _____

Would you like to sign up for our patient portal? □ **Yes** □ **No**

Emergency Contact:

Name:_____ Number:_____ Relationship:_____

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Insurance

Primary Insurance: _____

□ Self □ Parent □ Stepparent □ Legal Guardian □ Power of Attorney □ Other:_____

Policy/Member Number:_____ Group Number:_____

Policy holders name if different from patient:_____

Policy holder SSN: _____ Policy holder DOB: _____

Secondary Insurance: _____

□ Self □ Parent □ Stepparent □ Legal Guardian □ Power of Attorney □ Other:_____

Policy/Member Number:_____ Group Number:_____

Policy holders name if different from patient:_____

Policy holder SSN: _____ Policy holder DOB: _____

What services are you seeking?

□ Medication Management □ Individual Therapy □ Family/Couples Therapy □ Hypnotherapy

Where you referred to us? □ **Yes** □ **No** By Whom:_____

Are you changing mental health providers? □ **Yes** □ **No** Reasoning:_____

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Patient Intake Form

Patient Intake Form-Adolescent

Name:_____ DOB:_____

Current PCP:_____ Other specialist:_____

Last visit date:_____ Weight:_____ Height:_____

Reason for seeking treatment:_____

Please answer the following questions regarding the patient.

□ Antibiotics in the last year? □ **Yes** □ **No**

□ Labs within the last 6 months?
Where: _____

□ Childhood Immunizations up to date? _____

□ Allergies □ **Yes** □ **No** **(Please list)** _____

□ Chronic Illness □ **Yes** □ **No** **(Please explain)** _____

□ Serious Illness □ **Yes** □ **No** **(Please explain)** _____

□ Trauma to the head □ **Yes** □ **No** **(Please explain)**_____

□ Operations □ **Yes** □ **No** **(Please list)** _____

□ Injuries □ **Yes** □ **No** **(Please explain)** _____

Medications:

Current medications with dosage		Past medications (also reason no longer taking)	

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Patient Intake Form

Is the patient experiencing any of the following behaviors or symptom?
If the patient can fill this area out, please have them do so.
(Check all that apply.)

□ Anxiety/worry	□ Distractibility	□ Obsessive thoughts	□ Wide mood swings
□ Suspicion/paranoia	□ Guilt/shame	□ Social discomfort	□ Excessive happiness
□ Excessive energy	□ School issues	□ Change in appetite	□ Low self-esteem
□ Sleep problems	□ Impulsivity	□ Fear away from home	□ Hopelessness
□ Self-harm behaviors	□ Panic Attacks	□ Visual hallucinations	□ Compulsive behavior
□ Thoughts of death	□ Loneliness	□ Hyperactivity	□ Frequent arguments
□ Boredom	□ Eating problems	□ Lack of motivation	□ Tantrums
□ Depression	□ Confusion	□ Withdrawal from others	□ Flashbacks
□ Irritability/anger	□ Crying spells	□ Nightmares	□ Aggression/fights
□ Sadness	□ Bedwetting	□ Running away	□ Refusing no as an answer
□ Rejection sensitivity	□ Refusal to mind	□ Physical complaints of pain	□ Thoughts of killing self
□ Truancy	□ Acting violently	□ Perfectionism	□ Thoughts of killing others
□ Stuttering	□ Fatigue	□ Social problems with Friends	□ Problems with family

Psychiatric History:

Has the patient ever been diagnosed with a mental health related disorder?_____

Has the patient ever been admitted to a psychiatric hospital? Where?_____

Has the patient been to any outpatient counseling in the past? With who? _____

Does the patient have a history of experimenting or abusing illicit substances, including marijuana and alcohol? Which substances and for how long?_____

Have you, as the guardian, worked with the child's teacher or school counselor? □ **Yes** □ **No**
Dates/Grades? _____

Describe: _____

Has the child had any psychological testing □ **Yes** □ **No**

If so when? _____

What Kind: _____

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Patient Intake Form

Is the patient currently or has ever been a victim of a violent crime? (please explain)_____

_____

Has the patient experienced any of the following traumas or loss?

□ Emotional abuse	□ Physical abuse	□ Sexual abuse	□ Lived in a foster home
□ Parent illness	□ Parent substance abuse	□ Violence in the home	□ Teen pregnancy
□ Loss of a loved one	□ Neglect	□ Homelessness	

□ Other Information we need to know about:_____

_____

Home Life

Who is currently living in the household other than patient? (Including pets)

Is the patient in foster care? □ **No** □ **Yes** (please explain)_____
Has the patient ever been in foster care? □ **No** □ **Yes -How long?**

Was the patient adopted? □ **No** □ **Yes** (please explain)_____

Were there any problems with pregnancy or delivery of the child? □ **No** □ **Yes** □ **Unknown**: (please explain)

_____

Did the patient's mom receive prenatal care at time of pregnancy?_____

Was the mom under the influence of alcohol, drugs, or cigarettes during pregnancy?_____

Terms: Months:_____ Birth Weight:_____ Place of Birth: _____

Infant's Temperament: Easy, fussing, average, colicky: _____

Feeding (How long): Breast fed: □ **Yes** □ **No** _____ Bottle fed: □ **Yes** □ **No** _____ □ **Both**

Comments: _____

Milestones were: Early: ____ On time: _____ Late: _____ Additional Comments: _____

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Patient Intake Form

FAMILY PSYCHIATRIC HISTORY- including substance abuse:

Mother: _____

Father: _____

Siblings: _____

Other: _____

_____

SOCIAL/ EDUCATIONAL HISTORY:

Current grade level: _____ School: _____

Free time activities. What does the patient do for fun? Please share any hobbies, special interest, talents, and/ or strengths:

_____

_____

_____

Please share the patient's spiritual beliefs: _____

Any other information we should know about?

_____

_____

_____

_____

_____

_____

Please feel free to attach medication lists, health records, or any other information you feel we may need.