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, LCSW | Lisa Jennings, LCSW, MAC, CADCIII |
| Tom Pugel, LMFT, LLC | McKenzie Smith, PMHNP, BC, LLC |

Patient Information

Patient Name:_____ DOB: _____

SSN: _____ Gender: □ Male □ Female □ Transgender

Relationship Status: □ Single □ Married □ Divorced □ Widowed □ Other:_____

Physical Address: _____

Mailing Address: (check if same as above □):_____

Preferred phone number:_____Is this a cell phone? □ **Yes** □ **No**
Alternate phone number:_____

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

Emergency Contact :

Name:_____ Number:_____ Relationship:_____

Employment information: Employment status: □ Employed □ Unemployed □ Student □ Retired

Employer:_____ Job Tittle:_____

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 □ EMDR

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

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

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Patient Name: _____

Patient Medical Information

Current PCP:_____ Other specialist:_____

Last visit date:_____ Weight:_____ Height:_____

Reason for seeking treatment:_____

Are you currently or have you ever been in the armed forces, law enforcement, or a first responder?
□ **No** □ **Yes,** _____

Have you ever experienced or been diagnosed with the following? (Check all that apply)

□ Headaches	□ Asthma	□ Abortion	□ Diabetes
□ STD	□ High fevers	□ Chronic pain	□ Meningitis
□ Seizures	□ Hearing problems	□ Accident	□ Vision problems
□ Stomach aches	□ Head injury	□ Surgery	□ Dizziness/fainting
□ Sleep disorder	□ Miscarriage		

Are you experiencing any of the following behaviors or symptoms? (Check all that apply.)

□ Anxiety/worry	□ Distractibility	□ Obsessive thoughts	□ Wide mood swings
□ Eating problems	□ Guilt/shame	□ Social discomfort	□ Change in appetite
□ Excessive energy	□ Sexual problems	□ Work/school	□ Gambling problems
□ Sleep problems	□ Homicidal thoughts	□ Fear away from home	□ Loneliness
□ Self-harm behaviors	□ Panic Attacks	□ Hearing voices	□ Pornography issues
□ Thoughts of death	□ Visual hallucinations	□ Fatigue	□ Low self-worth
□ Boredom	□ Suspicion/paranoia	□ Hyperactivity	□ Computer addiction
□ Frequent arguments	□ Impulsivity	□ Parenting problems	□ Hopelessness
□ Irritability/anger	□ Crying spells	□ Racing thoughts	□ Depression
□ Aggression/fights	□ Nightmares	□ Lack of motivation	□ Compulsive behavior
□ Flashbacks	□ Sadness	□ Confusion	□ Withdrawal from others

Allergies:_____

Medications:

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

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Patient Name: _____

Mental Health

Have you had any outpatient counseling in the past? With who? _____

Have you ever been admitted to a psychiatric hospital? Where?_____

Have you had ideas, made statements, or attempted to hurt yourself? (please explain)_____

Have you had ideas, made statements, or attempted to hurt someone else? (please explain)_____

Alcohol and Other Drugs, Gambling Addiction, and Treatments

Do you have a history of alcohol abuse? How long ago and did you seek treatment? If so where?_____

Do you have a history of gambling? How long ago and did you seek treatment? If so where? _____

Do you have a history of drug and substance abuse? Which drug and how long?_____

How often do you use or consume the following?
□ Tobacco _____ □ Caffeine _____ □ Alcohol _____ □ Marijuana _____
Have you used any of the following?
□ Cocaine/Crack □ Ecstasy □ Heroin □ Methamphetamines
□ Others (explain)_____
Last day used:_____
Are you currently going through any withdrawals? (please explain)_____

Have any of the above issues been a problem within the last 30 days? (please explain)_____

Legal Issues

Are you currently or have you ever been the victim of a violent crime? (please explain)_____

Have you ever been convicted of a misdemeanor or felony?_____

_____

Do you have a restraining order in place against someone? □ No □ Yes | Do you have a restraining order again YOU? □ No □ Yes Please explain:

_____

Are you a registered sex offender? □ **No** □ **Yes**

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Patient Name: _____

Family and Social History

Have you experienced any of the following traumas or loss?

□ Emotional abuse □ Financial problems □ Sexual abuse □ Lived in a foster home
□ Parent illness □ Parent substance abuse □ Violence in the home □ Teen pregnancy
□ Loss of a loved one □ Neglect □ Placed a child for adoption □ Homelessness
□ Physical abuse

Do you have children? □ **No** □ **Yes** How many? _____
Are they currently living with you? _____
Is DHS involved? □ **No** □ **Yes:** (please explain) _____

How is your relationship with them? _____

Who is currently living in your household other than children? _____

Are there any issues with other family members? _____

Please describe your support system. _____

Do you currently go to a support group? _____
Are you interested in receiving information on support groups? □ **No** □ **Yes**

Highest level of education completed? _____

Please share any hobbies, special interests, talents, skills, and strengths: _____

Your sexual orientation and gender identity is important to us please select any that apply:

□ Male □ Bisexual □ Heterosexual □ Pansexual □ Transgender- Male to Female
□ Female □ Homosexual □ Transsexual □ Non-binary/gender fluid □ Transgender- Female to Male

Please explain your spiritual beliefs and any affiliations: _____

Is there any history of substance abuse or mental illness in your family? If so, please explain. _____

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.