Hamilton Davis Mental Health, Inc.

CLIENT INTAKE FORM

INTAKE DATE:_____ INTAKE COORDINATOR: _____

CLIENT'S NAME: _____ ☐ MALE ☐ FEMALE CLIENT'S PHONE#: _____

ADDRESS:_____ CITY:_____ ZIP:_____

COUNTY OF RESIDENCE:_____ D.O.B. _____

CLIENT IS AT: ☐HOME ☐HOSPITAL ☐OTHER MEDICAID #- _____

MEDICARE #_____ SOCIAL SECURITY # _____

OTHER INSURANCE NAME & POILCY#: _____

CONTACT PERSON#- _____ RELATIONSHIP TO CLIENT: _____

CONTACT PHONE#-_____

REFERRAL SOURCE: HamltonDavis Mental Health, Inc.

Office #: (601) 932-8991; Fax #: (601) 932-1007

REQUIRED: Please email all intakes to: christina@hamiltondavismentalhealth.com

PHYSICIAN:_____ PHONE #- _____

ADDRESS:_____ CITY:_____ ZIP: _____

DIAGNOSIS: _____

DIET/FOOD ALLERGIES:_____

SERVICES NEEDED:

- ☐ Psychosocial Rehabilitation Services (PSR)
- ☐ Day Treatment Services
- ☐ Day Treatment Services Pre-K

ADDITIONAL PERTINENT INFORMATION/SPECIAL NEEDS: _____

_____

_____

FOR OFFICE USE ONLY: _____

VERIFICATION OF MEDICAID, AND/OR MEDICARE, AND/OR OTHER INSURANCE STATUS: ☐ YES ☐ NO

DATE INSURANCE VERIFIED: _____ DATE REFERRAL RECEIVED: _____ DATE CLIENT CONTACTED: _____

BY WHOM: _____

Hamilton Davis Mental Health, Inc.

Functional Outcomes

In the last 30 days, have you/your child had problems with sleeping or feeling sad?
Yes ( ) No ( ) Required Field

In the last 30 days, have you/your child had problems with fears and anxiety?
Yes ( ) No ( ) Required Field

Do you/your child currently take mental health medicines as prescribed by your doctor?
Yes ( ) No ( ) Required Field

In the last 30 days, has alcohol or drug use caused problems for you or your child?
Yes ( ) No ( ) Required Field

In the last 30 days, have you/your child gotten in trouble with the law?
Yes ( ) No ( ) Required Field

In the last 30 days, have you/your child actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?
Yes ( ) No ( ) Required Field

In the last 30 days, have you/your child had trouble getting along with other people including family and people outside the home?
Yes ( ) No ( ) Required Field

Do you/your child feel optimistic about the future? Yes ( ) No ( ) Required Field

Children Only: In the last 30 days, has your child had trouble following rules at home or school?
Yes ( ) No ( )

Children Only: In the last 30 days, has your child been placed in state custody (DCF criminal justice)?
Yes ( ) No ( )

Adults Only: Are you currently employed or attending school? Yes ( ) No ( )

Adults Only: In the last 30 days, have you been at risk of losing your living situation?
Yes ( ) No ( )

Therapeutic approach/evidence based treatment used? (explain) _____

_____

Level of Improvement to Date

Level of improvement to date: Minor Moderate Major No Progress to Date

Maintenance Treatment of Chronic Condition Required Field

Barriers to discharge (explain): _____

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Symptoms

If present, check degree to which it impacts daily functioning.

Anxiety/panic attacks:	**N/A**	Mild	Moderate	Severe	Required Field
Decreased energy:	**N/A**	Mild	Moderate	Severe	Required Field
Delusions:	**N/A**	Mild	Moderate	Severe	Required Field
Depressed mood:	**N/A**	Mild	Moderate	Severe	Required Field
Hallucinations:	**N/A**	Mild	Moderate	Severe	Required Field
Angry outbursts:	**N/A**	Mild	Moderate	Severe	Required Field
Hyperactivity inattention:	**N/A**	Mild	Moderate	Severe	Required Field
Irritability/mood instability:	**N/A**	Mild	Moderate	Severe	Required Field
Impulsivity:	**N/A**	Mild	Moderate	Severe	Required Field
Hopelessness:	**N/A**	Mild	Moderate	Severe	Required Field
Other psychotic symptoms:	**N/A**	Mild	Moderate	Severe	Required Field

Other (include severity)(explain): _____

Functional Impairment Related Symptoms

If present, check degree to which it impacts daily functioning.

ADLs: N/A Mild Moderate Severe Required Field

Relationships: N/A Mild Moderate Severe Required Field

Substance use disorder: N/A Mild Moderate Severe Required Field

Last date of substance use: MM/DD/YYYY

Physical health: N/A Mild Moderate Severe Required Field

Work/school: N/A Mild Moderate Severe Required Field

Drug(s) of choice: _____

Risk Assessment

Suicidal: None Ideation Planned Imminent Intent Hx of Self-Harming Behavior

Required Field

Homicidal: None Ideation Planned Imminent Intent Hx of Self-Harming Behavior

Required Field

Safety plan in place? (if plan or intent indicated):Yes ( ) No ( )

If prescribed medication, is enrollee compliant?: Yes ( ) No ( )

Current Measurable Treatment Goals

Current Measurable Treatment Goals (explain): Required Field

_____

_____

_____

Have traditional behavioral health services been attempted (e.g. individual/family/group therapy, medication management, etc.)? Yes ( ) No ( )

Additional information?

_____

_____

_____

_____

_____