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: ______________________________

## 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): ____________________________________________________

Hamilton Davis Mental Health, Inc.

## 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?

______________________________________________________________________

______________________________________________________________________

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