BK BEHAVIORAL HEALTH CENTER

MENTAL HEALTH SERVICES APPLICATION

Restore. Rebuild. Reclaim Lives.

Confidential Patient Application — Please print legibly. Complete ALL sections.

Date Received __/__/____ **Client ID #** _____ **Assigned Clinician** _____

■ RESTORE ■ REBUILD ■ RECLAIM LIVES

1. CLIENT DEMOGRAPHICS

Personal Identification

Last Name _____ **First Name** _____ **Middle Name** _____

Preferred Name / Nickname _____ **Date of Birth** __/__/____ **Age** _____ **SSN (Last 4 Only)** XXX-XX-____

Legal Sex _____ **Gender Identity** _____ **Pronouns** _____

■ ■ Male ■ Female ■ Intersex ■ Unknown

■ ■ Male ■ Female ■ Non-Binary ■ Transgender ■ Other:___

■ ■ He/Him ■ She/Her ■ They/Them ■ Other:___

Race / Ethnicity ■ Am. Indian/Alaska Native ■ Asian ■ Black/African Am. ■ Hispanic/Latino ■ Native Hawaiian/Pacific Islander ■ White ■ Multiracial ■ Other ■ Prefer Not to Say

Contact Information

Home Address (Street / Apt #) _____

City _____ **State** __ **ZIP Code** _____ **County** _____

Cell Phone (___) ___-_____ **Home Phone** (___) ___-_____ **Work Phone** (___) ___-_____

Email Address _____ **OK to Voicemail?** ■ Yes ■ No **OK to Text?** ■ Yes ■ No

Background Information

Marital Status _____ **Employment Status** _____ **Highest Education Level** _____

■ ■ Single ■ ■ Married ■ ■ Dom. Partner ■ ■ Divorced ■ ■ Separated ■ ■ Widowed

■ ■ FT Employed ■ ■ PT Employed ■ ■ Self-Employed ■ ■ Unemployed ■ ■ Student ■ ■ Retired/Disabled

■ ■ <8th Grade ■ ■ Some HS ■ ■ GED/HS Diploma ■ ■ Some College ■ ■ Assoc. Degree ■ ■ Bachelor's Degree

Housing Status _____ **Primary Language** _____ **Interpreter?** _____ **U.S. Military Veteran?** _____

■ ■ Own ■ Rent ■ Family/Friends ■ Shelter ■ Transitional ■ Homeless ■ Other:___

■ ■ Yes ■ No

■ ■ Yes ■ No

Employer / School Name _____ **Occupation / Grade / Position** _____ **# of Dependents** _____

2. EMERGENCY CONTACT INFORMATION

Emergency Contact #1

Full Name _____ **Relationship to Patient** _____ **Primary Phone** (___) ___-_____

Alternate Phone (___) ___-_____ **Email (optional)** _____ **OK to Contact?** ■ Yes ■ No

Emergency Contact #2

Full Name	_____	**Relationship to Patient**	_____	**Primary Phone**	(___) ___-_____
Alternate Phone	(___) ___-_____	**Email (optional)**	_____	**OK to Contact?**	■ Yes ■ No

3. GUARDIAN INFORMATION FOR MINORS

Complete ONLY if patient is under 18 or requires a legal guardian. Write N/A if not applicable.

Guardian Last Name	_____	**Guardian First Name**	_____	**Relationship to Patient**	_____
Guardian Date of Birth	__/__/____	**Phone Number**	(___) ___-_____	**Email**	_____
SSN Last 4	____				

Guardian Address (if different from patient) _____

Legal Custody Type	**Court Order on File?**
■ ■ Full Custody ■ Joint Custody ■ Legal Guardian (Non-Parent) ■ No Formal Order	■ ■ Yes ■ No ■ Pending

4. INSURANCE & MEDICAID INFORMATION

Primary Insurance

Insurance Company Name	_____	**Plan Name / Type**	_____	**Effective Date**	__/__/____
Member ID #	_____	**Group #**	_____	**Insurance Phone**	(___) ___-_____
Policy Holder Name	_____	**Holder Date of Birth**	__/__/____	**Relationship to Patient**	■ ■ Self ■ Spouse ■ Parent ■ Child ■ Other

Secondary Insurance (if applicable)

Insurance Company	_____	**Member ID #**	_____	**Group #**	_____

Medicaid / Medicare

Medicaid / Medicare Status		**Medicaid ID #**	_____	**Medicare ID #**	_____

■ ■ Medicaid Only ■ Medicare Only ■ Both (Dual)
■ Neither ■ Pending

Referral / Auth #	_____	**Referring Physician**	_____	**PCP NPI #**	_____

5. FINANCIAL RESPONSIBILITY

Self-Pay Patient? ■ Yes ■ No

Sliding Scale Requested? ■ Yes ■ No

Household Size _____

Estimated Copay $_____

Household Annual Income

■ ■ Under $15K ■ $15–30K ■ $30–50K ■ $50–75K ■ $75–100K ■ Over $100K ■ Prefer not to say

Preferred Payment Method

■ ■ Cash ■ Check ■ Credit/Debit ■ HSA/FSA ■ Payment Plan ■ Other:___

Other Funding Source (EAP, Grant, FQHC, etc.) _____

By submitting this application, I accept financial responsibility for all charges not covered by insurance, including co-payments, deductibles, co-insurance, and non-covered services. A signed Financial Responsibility Agreement will be required prior to the first appointment.

6. REFERRAL INFORMATION

How did you hear about us?

■ ■ Physician/Provider ■ Hospital/ER ■ Court/Legal ■ Insurance ■ Online ■ Social Media ■ Friend/Family ■ Self-Referral ■ School/Employer ■ Other:___

Referring Provider / Organization _____

Referral Date __/__/____

Referring Provider Phone (___) ___-_____

Referring Provider NPI # _____

Auth / Referral # _____

Urgency of Need

■ ■ Routine ■ Soon ■ Urgent ■ Crisis/Same Day

Reason for Referral / Primary Reason for Seeking Services

7. PRESENTING PROBLEMS & SYMPTOMS

Check ALL presenting concerns that apply:

■ Depression / Low Mood	■ Anxiety / Panic	■ Grief / Loss	■ Trauma / PTSD
■ Anger Management	■ Relationship Problems	■ Family Conflict	■ Domestic Violence
■ Substance Use / Addiction	■ Alcohol Use	■ Bipolar / Mood Swings	■ Psychosis / Hallucinations
■ ADHD / Focus Problems	■ Eating Disorder	■ Self-Harm	■ Suicidal Thoughts
■ OCD	■ Personality Issues	■ Sleep Disorders	■ Work / Life Stress
■ Co-Occurring Disorders	■ Medication Management	■ Child / Adolescent Issues	■ Social Isolation
■ Adjustment Difficulty	■ Sexual / Gender Identity	■ Caregiver Stress	■ Other: _____

PHQ-2 & GAD-2 Quick Screening — Last 2 Weeks

Question	Not at All (0)	Several Days (1)	>Half Days (2)	Nearly Every Day (3)
PHQ-2: Little interest or pleasure in doing things	■	■	■	■
PHQ-2: Feeling down, depressed, or hopeless	■	■	■	■
GAD-2: Feeling nervous, anxious, or on edge	■	■	■	■
GAD-2: Not being able to stop or control worrying	■	■	■	■

Symptom Onset (when did this begin?) _____

Severity _____

Frequency of Symptoms _____

■ ■ Mild – Manageable ■ Moderate – Interfering ■ Severe – Disabling ■ Crisis ■ ■ Daily ■ Weekly ■ Monthly ■ Situational

Describe your primary concern in your own words

8. MEDICAL HISTORY

Primary Care Physician	_____	**PCP Phone**	(___) ___-_____	**Date of Last Physical**	__/__/____
Height	_____	**Weight**	_____	**Blood Type**	_____

Current Medical Conditions — Check all that apply:

■ Hypertension	■ Diabetes (Type 1)	■ Diabetes (Type 2)	■ Heart Disease / Arrhythmia
■ Stroke / TIA	■ Asthma / COPD	■ Epilepsy / Seizure Disorder	■ Traumatic Brain Injury
■ Chronic Pain	■ HIV / AIDS	■ Hepatitis B	■ Hepatitis C
■ Liver Disease / Cirrhosis	■ Kidney Disease	■ Thyroid Disorder	■ Cancer (current/recent)
■ Autoimmune Disorder	■ Sleep Disorder	■ Pregnancy	■ Obesity (BMI ≥ 30)
■ Neurological Condition	■ Fibromyalgia	■ Migraines	■ None Known

Allergies:

Allergen	Type (Drug / Food / Environmental)	Reaction	Severity
			■ Mild ■ Moderate ■ Severe
			■ Mild ■ Moderate ■ Severe
			■ Mild ■ Moderate ■ Severe
			■ Mild ■ Moderate ■ Severe

Surgical History / Previous Medical Hospitalizations

9. PSYCHIATRIC HISTORY

Previous MH Treatment? ■ Yes ■ No **Currently in Treatment?** ■ Yes ■ No **Previous Psych. Hospitalization?** ■ Yes ■ No **# of Hospitalizations** _____

Previous Therapist / Clinician _____ **Approx. Years in Treatment** _____ **Reason Treatment Ended** _____

Prior Psychiatric Diagnoses — Check all that apply:

■ Major Depressive Disorder	■ Persistent Depressive Disorder	■ Bipolar I	■ Bipolar II
■ Cyclothymia	■ GAD	■ Panic Disorder	■ Social Anxiety Disorder
■ PTSD	■ Acute Stress Disorder	■ OCD	■ Body Dysmorphic Disorder
■ Schizophrenia	■ Schizoaffective Disorder	■ ADHD	■ Autism Spectrum Disorder
■ Borderline Personality Disorder	■ Antisocial Personality Disorder	■ Other Personality Disorder	■ Anorexia Nervosa
■ Bulimia Nervosa	■ Binge Eating Disorder	■ Alcohol Use Disorder	■ Opioid Use Disorder
■ Stimulant Use Disorder	■ Cannabis Use Disorder	■ Dissociative Disorder	■ Adjustment Disorder
■ No Known Psychiatric Diagnosis	■ Other: _____		

Psychiatric Hospitalization History:

Facility Name	Year	Duration	Reason for Admission	Voluntary?
				■ Yes ■ No
				■ Yes ■ No
				■ Yes ■ No
				■ Yes ■ No

10. MEDICATION HISTORY

Current Medications, Vitamins & Supplements — List ALL

Medication / Supplement Name	Dose	Frequency	Prescribing Provider	Reason

Previous Psychiatric Medications

Previous Psychiatric Medications Tried? ■ Yes ■ No **Any Adverse Reactions?** ■ Yes ■ No

List previous psychiatric medications — name, dose, helpful?, reason discontinued

Describe any adverse medication reactions

Current Prescribing Physician / Psychiatrist	_____	**Pharmacy Name & Phone**	_____

11. SUBSTANCE USE ASSESSMENT

Current Use?	■ Yes ■ No	**Past Use?**	■ Yes ■ No	**In Recovery?**	■ Yes ■ No	**Prior SUD Treatment?**	■ Yes ■ No
Withdrawal Hx?	■ Yes ■ No	**Overdose Hx?**	■ Yes ■ No	**Narcan Prescribed?**	■ Yes ■ No	**Sobriety Date**	__/__/____

Substance Use Detail — Complete for each substance used

Substance	Status	Age 1st Use	Frequency of Use	Amount/Route	Last Use
Alcohol	■ Current ■ Past ■ Never				
Cannabis / Marijuana	■ Current ■ Past ■ Never				
Cocaine / Crack	■ Current ■ Past ■ Never				
Methamphetamine	■ Current ■ Past ■ Never				
Heroin	■ Current ■ Past ■ Never				
Prescription Opioids	■ Current ■ Past ■ Never				
Benzodiazepines	■ Current ■ Past ■ Never				
Stimulants (non-Rx)	■ Current ■ Past ■ Never				
Hallucinogens	■ Current ■ Past ■ Never				
Inhalants	■ Current ■ Past ■ Never				
Other: _____	■ Current ■ Past ■ Never				

12. TRAUMA & ABUSE HISTORY

This information is collected to provide trauma-informed care. You may leave any item blank that you are not comfortable answering at this time.

History of Trauma / Adverse Experiences — Check all that apply:

■ Physical Abuse	■ Sexual Abuse / Assault	■ Emotional / Psychological Abuse	■ Neglect (Physical)
■ Neglect (Emotional)	■ Domestic Violence (as victim)	■ Domestic Violence (as witness)	■ Community / Gang Violence
■ Combat / War Trauma	■ Natural Disaster	■ Serious Accident / Injury	■ Sudden Loss / Grief
■ Childhood Abuse	■ Human Trafficking	■ Racial / Ethnic Trauma	■ Medical Trauma
■ Incarceration	■ Refugee / Displacement Trauma	■ Witnessing Death or Violence	■ No Traumatic History Reported
■ Other: _____			

Age(s) at Time of Trauma _____ **Duration** _____ **Perpetrator Relationship** _____ **Previously Disclosed?** _____

■ ■ Single Event ■ Repeated ■ Ongoing

■ ■ Parent ■ Partner ■ Family ■ Acquaintance ■ Stranger ■ Authority ■ N/A

■ ■ Yes ■ No ■ Partial

Currently Safe from Harm? _____ **Receiving Trauma-Focused Treatment?** _____

■ ■ Yes – Safe Now ■ No – Ongoing Concern ■ Unsure

■ ■ Yes ■ No

Additional trauma information (optional — share only what you are comfortable with)

13. FAMILY HISTORY

Family MH / Substance Use History — Check all that apply:

■ Depression	■ Bipolar Disorder	■ Schizophrenia	■ Anxiety Disorders
■ Substance Abuse / Addiction	■ Alcohol Use Disorder	■ Suicide Attempts	■ Completed Suicide
■ ADHD / Learning Disabilities	■ Autism Spectrum	■ Dementia / Alzheimer's	■ Personality Disorder
■ Eating Disorder	■ PTSD	■ OCD	■ No Known Family History

Specify family member(s) and diagnosis (e.g., Mother – Depression, Brother – AUD)

Raised By _____ **Quality of Childhood Family Relationships** _____ **Number of Siblings** _____

■ ■ Both Bio. Parents ■ Single Mother ■ Single Father ■ Stepparent(s) ■ Grandparent(s) ■ Foster Care ■ Adoptive ■ Other

■ ■ Very Close ■ Somewhat Close ■ Distant ■ Conflicted ■ Abusive ■ Variable

Current family relationships and support systems

14. SOCIAL & EDUCATIONAL HISTORY

Current Living Situation _____ **Quality of Social Support** _____ **Romantic Relationship Status** _____

■ ■ Alone ■ Spouse/Partner ■ Children ■ Parents ■ Family ■ Roommates ■ Group Home ■ Other

■ ■ Strong ■ Moderate ■ Limited ■ Isolated

■ ■ Single ■ Dating ■ Engaged ■ Married ■ Separated ■ Divorced ■ Widowed

Do You Have Children? ■ Yes ■ No **Ages of Children** _____ **Legal Involvement** _____

■ ■ None ■ Probation ■ Parole ■ Drug Court ■ Pending Charges ■ CPS ■ Other

Learning Disabilities Diagnosed? ■ Yes ■ No ■ Unknown

Special Education Services? ■ Yes ■ No

School Disciplinary Issues? ■ Yes ■ No

Work history / vocational concerns / hobbies and interests

15. RISK ASSESSMENT

■■ SAFETY & RISK — Information collected to ensure your safety. All responses are confidential except as required by law (imminent risk of harm, mandated reporting).

Suicidality & Self-Harm

Current Suicidal Ideation

■ ■ None ■ Passive ■ Active/No Plan ■ Active with Plan ■ Active Intent

Past Suicidal Ideation

■ ■ None ■ Passive ■ Active/No Plan ■ Active with Plan

Suicide Attempt History

■ ■ None ■ 1 Attempt ■ 2–3 Attempts ■ 4+ Attempts

Most Recent Attempt (date and method) _____

Medical Treatment Required? ■ Yes ■ No

Hospitalized for Attempt? ■ Yes ■ No

Current Self-Harm?

■ ■ Current ■ Past ■ None

Self-Harm Method _____

Homicidal Ideation?

■ ■ None ■ Passive ■ Active / Target Identified

Access to Firearms / Weapons?

■ ■ None ■ Yes – Secured ■ Yes – Unsecured ■ Unknown

Current Risk Factors — Check all that apply:

■ Social isolation	■ Recent major loss	■ Financial crisis	■ Relationship breakup
■ Recent hospital discharge	■ Access to lethal means	■ Substance intoxication	■ History of impulsivity
■ Command hallucinations	■ Hopelessness	■ Recent legal problems	■ Domestic violence (ongoing)
■ Terminal illness	■ Chronic pain	■ Lack of support network	■ None identified

Protective factors / reasons for living

16. FUNCTIONAL IMPAIRMENT ASSESSMENT

Rate your current level of difficulty in each area:

Domain	0 — None	1–2 Mild	3–4 Moderate	5–6 Significant	7–8 Severe	9–10 Unable to Function
Work / School Performance	■	■	■	■	■	■
Social Relationships	■	■	■	■	■	■
Family / Home Life	■	■	■	■	■	■
Self-Care / Daily Tasks	■	■	■	■	■	■
Sleep Quality	■	■	■	■	■	■
Appetite / Eating	■	■	■	■	■	■
Concentration / Memory	■	■	■	■	■	■
Motivation / Energy	■	■	■	■	■	■

Financial / Independent Living	■	■	■	■	■	■
Overall Life Satisfaction	■	■	■	■	■	■

Describe how symptoms affect your daily functioning

17. STRENGTHS & SUPPORT SYSTEMS

Personal Strengths — Check all that apply:

■ Problem-solving skills	■ Communication skills	■ Empathy / compassion	■ Resilience / adaptability
■ Creativity	■ Sense of humor	■ Intelligence	■ Strong work ethic
■ Spiritual / religious faith	■ Optimism / hope	■ Physical health	■ Financial stability
■ Insight into problems	■ Willingness to change	■ Positive family support	■ Other: _____

Primary Support Systems — Check all that apply:

■ Spouse / Partner	■ Children	■ Parents	■ Siblings
■ Extended family	■ Friends	■ Coworkers	■ Religious / faith community
■ Therapist / Counselor	■ Support group (AA/NA/other)	■ Case manager	■ Pet(s)
■ Online community	■ Sponsor / Mentor	■ Community organization	■ None currently

Describe your strengths, coping strategies, and support systems in your own words

18. TREATMENT GOALS

Goal 1 — Primary treatment goal (what do you most want to achieve?)

Goal 2 — Secondary goal

Goal 3 — Additional goal (optional)

What would success in treatment look like for you? Describe your desired outcome.

Preferred Service Type	Preferred Modality	Preferred Appointment Days
■ ■ Individual ■ Group ■ Family ■ Couples ■ Psychiatry/Meds ■ IOP ■ PHP ■ Case Mgmt ■ Peer Support	■ ■ In-Person ■ Telehealth ■ Either	■ ■ Mon ■ Tue ■ Wed ■ Thu ■ Fri ■ Sat ■ Flexible

Barriers to treatment — Check all that apply:

■ Transportation	■ Childcare	■ Work schedule	■ Cost / finances
■ Stigma / shame	■ Prior negative treatment experience	■ Lack of motivation	■ Language barrier
■ No perceived need	■ Other: _____		

19. CLINICAL SUMMARY — FOR STAFF / CLINICIAN USE ONLY

STAFF SECTION ONLY — Do not complete if you are the patient or guardian completing this form.

Intake Completed By _____ **Credential / Title** _____ **Date of Intake** __/__/____ **Client ID #** _____

Level of Care / Disposition _____

■ ■ Outpatient (OP) ■ IOP ■ PHP ■ Residential ■ Detox ■ Referred Out ■ No Services ■ Crisis/Emergency

Risk Level Assessed _____

■ ■ None ■ Low ■ Moderate ■ High ■ Imminent – Action Taken

Assigned Clinician _____

Provisional Diagnosis (ICD-10) _____ **Secondary Diagnosis** _____ **Specifier / Severity** _____

Presenting Problem Summary — clinical observations, mental status, key findings

Clinician Notes / Observations / Safety Plan Summary / Recommendations

Supervising Clinician Name & Credential _____ **Supervisor NPI #** _____ **Supervision Date** __/__/____

Supervising Clinician Signature _____ **Date** _____

20. CONSENT & SIGNATURE PAGES

CONSENT FOR TREATMENT	I voluntarily consent to receive behavioral health services at BK Behavioral Health Center (BKBHC). Treatment may include psychological evaluation, individual, group, and family therapy, medication management, and other evidence-based interventions. I understand I have the right to withdraw consent at any time without affecting future care.
HIPAA NOTICE OF PRIVACY PRACTICES	I acknowledge receipt of BKBHC's Notice of Privacy Practices. My protected health information (PHI) is protected under HIPAA and will only be used or disclosed as permitted by law or with my written authorization. BKBHC may use my PHI for treatment, payment, and healthcare operations.
FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS	I authorize BKBHC to bill my insurance on my behalf and assign benefits directly to BKBHC. I agree to pay all co-pays, deductibles, and non-covered charges at time of service. I am ultimately responsible for all charges incurred regardless of insurance coverage.
RELEASE OF INFORMATION AUTHORIZATION	I authorize BKBHC to exchange treatment-relevant information with my PCP, referring provider, insurance carrier, pharmacy, and other treating providers as necessary for coordinated care. Specially protected information (substance use, HIV/AIDS) requires separate written consent. I may revoke this authorization in writing at any time.
EMERGENCY / CRISIS PROTOCOL & MANDATORY REPORTING	BKBHC clinicians are mandated reporters required by law to break confidentiality when there is imminent risk of harm to myself or others, or in cases of suspected child or elder abuse/neglect. In a psychiatric emergency, 911 may be contacted. BKBHC follows established crisis protocols for patient safety.
TELEHEALTH CONSENT	I consent to receiving services via BKBHC-approved telehealth platforms and acknowledge the inherent privacy risks of electronic communication. I may request in-person services at any time. I agree to participate from a private, confidential location and will not record sessions without prior written consent.
RECORDS & PHOTOGRAPHS	I authorize BKBHC to maintain electronic health records and photograph identification documents as required. Records are maintained according to applicable state and federal law and HIPAA guidelines.
PATIENT RIGHTS & GRIEVANCE PROCEDURES	I acknowledge that I have been informed of my rights as a patient: respectful and dignified care, record access, confidentiality, informed consent, treatment planning participation, and the right to file a grievance without retaliation. A complete Patient Rights document is available upon request.

By signing below, I confirm that I have read (or had read to me), understood, and agree to all consents, authorizations, and acknowledgments above. I certify that all information in this application is accurate and complete to the best of my knowledge.

Patient / Legal Guardian Signature		**Date**	
Printed Name of Patient / Guardian		**Date of Birth**	
Relationship to Patient (if signing on behalf)		**Today's Date**	
Witness / Staff Signature		**Date**	
Supervising Clinician Signature / NPI #		**Date**	

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