BK BEHAVIORAL HEALTH CENTER

CONFIDENTIAL PATIENT INTAKE FORM

Complete all sections legibly. All information is strictly protected under HIPAA.

FOR OFFICE USE ONLY	Date Received: _____	Client ID #: _____	Assigned Clinician: _____	Program: _____

1 — PATIENT DEMOGRAPHICS

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

Date of Birth __/__/____ **Age** ____ **SSN Last 4** XXX-XX-____ **Legal Sex** ■ Male ■ Female ■ Intersex **Veteran?** ■ Yes ■ No

Gender Identity ■ Male ■ Female ■ Non-Binary ■ Transgender ■ Other:___ **Pronouns** ■ He/Him ■ She/Her ■ They/Them ■ Other:___

Race/Ethnicity ■ Am.Indian ■ Asian ■ Black/African Am. ■ Hispanic/Latino ■ Native Hawaiian ■ White ■ Multiracial ■ Other **Primary Language** _____ **Interpreter?** ■ Yes ■ No

Address _____ **City** _____ **State** __ **ZIP** _____ **County** _____

Cell (____)____-_____ **Home** (____)____-_____ **Work** (____)____-_____ **Email** _____ **VM?** ■Y ■N **Text?** ■Y ■N

Employment ■ FT ■ PT ■ Self-Emp ■ Unemployed ■ Student ■ Retired ■ Disabled **Marital** ■ Single ■ Married ■ Divorced ■ Widowed ■ Sep. ■ Dom.Partner

Housing ■ Own ■ Rent ■ Family ■ Shelter ■ Transitional ■ Homeless ■ Other:___ **Education** ■ <8th ■ Some HS ■ GED/HS ■ Some College ■ Assoc. ■ Bach. ■ Grad+

2 — EMERGENCY CONTACTS & NEXT OF KIN

Contact 1 Name _____ **Relationship** _____ **Phone** (____)____-_____ **OK to contact?** ■ Yes ■ No

Contact 2 Name _____ **Relationship** _____ **Phone** (____)____-_____ **OK to contact?** ■ Yes ■ No

Legal Guardian (minor) _____ **Relationship** _____ **Phone** (____)____-_____

3 — INSURANCE & FINANCIAL INFORMATION

Primary Insurance

Company _____ **Plan Name** _____ **Member ID #** _____ **Group #** _____

Policy Holder _____ **Holder DOB** __/__/____ **Relationship** _____ **Eff. Date** __/__/____

Secondary Insurance (if applicable)

Company _____ **Member ID #** _____ **Group #** _____ **Self-Pay?** ■ Yes ■ No **Sliding Scale?** ■ Yes ■ No

Medicaid/Medicare ■ Medicaid ■ Medicare ■ Both ■ Neither **Referral / Auth #** _____ **Copay $** _____

** Please present insurance card(s) at front desk upon arrival.*

4 — REFERRAL SOURCE & REASON FOR SERVICES

Referred By ■ Physician ■ Hospital/ER ■ Court/Legal ■ Insurance ■ Online ■ Social Media ■ Friend/Family ■ Self ■ Other:____ **Referring Provider** _____

Primary Concerns (check all that apply):

■ Depression/Low Mood	■ Anxiety/Panic	■ Trauma/PTSD	■ Grief/Loss	■ Anger Management	■ Relationship/Family
■ Substance Use	■ Alcohol Use	■ Bipolar/Mood Swings	■ Psychosis	■ ADHD/Focus	■ Eating Disorder
■ Self-Harm/Suicidal Thoughts	■ OCD	■ Personality Disorder	■ Work/Life Stress	■ Co-Occurring Disorder	■ Medication Mgmt

Describe your primary concern in your own words:

_____

_____

5 — PSYCHIATRIC & MENTAL HEALTH HISTORY

Prior MH Treatment? ■ Yes ■ No **Currently in Treatment?** ■ Yes ■ No **Prior Hospitalization?** ■ Yes ■ No **Current Ideation?** ■ Yes ■ No

Prior Diagnoses (check all that apply):

■ Major Depression	■ Persistent Dep.	■ Bipolar I	■ Bipolar II	■ GAD	■ Panic Disorder
■ Social Anxiety	■ PTSD	■ Acute Stress	■ OCD	■ Schizophrenia	■ Schizoaffective
■ ADHD	■ Autism Spectrum	■ Borderline PD	■ Antisocial PD	■ Eating Disorder	■ Alcohol Use Disorder
■ Opioid Use Disorder	■ Stimulant Use Disorder	■ Cannabis Use Disorder	■ TBI	■ No Known Dx	■ Other:_____

Suicidal Ideation (past) ■ Yes ■ No **Suicide Attempt?** ■ Yes ■ No **Self-Harm?** ■ Yes ■ No **Homicidal Ideation?** ■ Yes ■ No **Explain:** _____

Hospitalization History (complete if applicable):

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

6 — SUBSTANCE USE HISTORY

Current Use? ■ Yes ■ No **Past Use?** ■ Yes ■ No **Prior SUD Tx?** ■ Yes ■ No **In Recovery?** ■ Yes ■ No **Withdrawal Hx?** ■ Yes ■ No **Overdose Hx?** ■ Yes ■ No **Narcan Rx?** ■ Yes ■ No

Substance	Age 1st Use	Freq. of Use	Amt/Route	Last Use	Currently?
Alcohol					■ Yes ■ No
Cannabis					■ Yes ■ No
Cocaine/Crack					■ Yes ■ No
Methamphetamine					■ Yes ■ No
Heroin					■ Yes ■ No
Prescription Opioids					■ Yes ■ No
Benzodiazepines					■ Yes ■ No
Stimulants (non-Rx)					■ Yes ■ No
Hallucinogens					■ Yes ■ No
Other:_____					■ Yes ■ No

7 — MEDICAL HISTORY & CURRENT HEALTH

Primary Care Physician _____ **Phone** (____)____-_____ **Last Physical** _____ **Height** ____ **Weight** ____

Current Medical Conditions (check all that apply):

■ Hypertension	■ Diabetes (I/II)	■ Heart Disease	■ Stroke/TIA	■ Asthma/COPD	■ Epilepsy/Seizure
■ Traumatic Brain Inj.	■ Chronic Pain	■ HIV/AIDS	■ Hepatitis B/C	■ Liver Disease	■ Kidney Disease
■ Thyroid Disorder	■ Cancer (current)	■ Autoimmune	■ Sleep Disorder	■ Pregnancy (EDD:___)	■ None Known

Allergies (medication, food, environmental):

Allergen	Type	Reaction	Severity
			■ Mild ■ Mod ■ Severe
			■ Mild ■ Mod ■ Severe
			■ Mild ■ Mod ■ Severe

8 — CURRENT MEDICATIONS & SUPPLEMENTS

List ALL medications, vitamins, supplements, and herbal remedies:

Medication / Supplement	Dose	Frequency	Prescriber	Reason

Previous Psych Medications? ■ Yes ■ No **Which were helpful?** _____ **Any adverse reactions?** _____

9 — FAMILY, SOCIAL & LEGAL HISTORY

Family MH/SUD History (check all that apply):

■ Depression ■ Bipolar Disorder ■ Schizophrenia ■ Anxiety ■ Substance Abuse ■ Alcohol Use Disorder

■ Suicide/Attempts ■ Personality Disorder ■ ADHD/Learning Disability ■ Autism Spectrum ■ Dementia/Alzheimer's ■ No Known History

Trauma/Abuse Hx ■ Physical ■ Sexual ■ Emotional ■ Neglect ■ Domestic Violence ■ Community Violence ■ None **# Dependents** ____

Legal Involvement ■ Probation ■ Parole ■ Drug Court ■ Pending Charges ■ None **DUI/DWI Hx?** ■ Yes ■ No **Living With** ■ Alone ■ Spouse ■ Children ■ Parents ■ Roommates ■ Other

10 — CLINICAL SCREENING & FUNCTIONAL ASSESSMENT

Last 2 Weeks:	Not at All (0)	Several Days (1)	More than Half (2)	Nearly Every Day (3)
PHQ-2: Little interest/pleasure in doing things	■	■	■	■
PHQ-2: Feeling down, depressed, or hopeless	■	■	■	■
GAD-2: Feeling nervous, anxious, or on edge	■	■	■	■
GAD-2: Can't stop or control worrying	■	■	■	■

Current Functioning Rate difficulty: 1 = None → 5 = Extreme

Work/School ■1 ■2 ■3 ■4 ■5 **Social Relationships** ■1 ■2 ■3 ■4 ■5 **Family/Home** ■1 ■2 ■3 ■4 ■5 **Self-Care** ■1 ■2 ■3 ■4 ■5

Sleep Quality ■1 ■2 ■3 ■4 ■5 **Appetite/Eating** ■1 ■2 ■3 ■4 ■5 **Concentration** ■1 ■2 ■3 ■4 ■5 **Life Satisfaction** ■1 ■2 ■3 ■4 ■5

Treatment Goals (briefly list below):

Goal 1: _____ **Goal 2:** _____

Goal 3: _____ **Strengths/Supports:** _____

Service Preference ■ Individual Therapy ■ Group Therapy ■ Family Therapy ■ Psychiatry/Medication ■ IOP ■ PHP ■ Case Management ■ Peer Support **Modality** ■ In-Person ■ Telehealth ■ Either

11 — CONSENTS, AUTHORIZATIONS & PATIENT RIGHTS

CONSENT FOR TREATMENT	I voluntarily consent to behavioral health services at BK Behavioral Health Center including evaluation, therapy, medication management, and evidence-based interventions. I understand I may withdraw consent at any time without affecting future care.
HIPAA / NOTICE OF PRIVACY PRACTICES	I acknowledge receipt of BKBHC's Notice of Privacy Practices. I understand my health information is protected under HIPAA and will only be shared as permitted by law or with my written authorization, for treatment, payment, and healthcare operations.
FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS	I authorize BKBHC to bill my insurance on my behalf and assign payment directly to BKBHC. I agree to pay all co-pays, deductibles, and non-covered charges at time of service and accept responsibility for all charges incurred.
RELEASE OF INFORMATION	I authorize exchange of treatment-relevant information with my PCP, referring provider, insurance, pharmacy, and treating providers for coordinated care. This authorization may be revoked in writing at any time.
EMERGENCY, CRISIS & MANDATORY REPORTING	I understand clinicians are mandated reporters required by law to break confidentiality when there is imminent risk of harm to self or others, or in suspected abuse/neglect cases. In a psychiatric emergency, 911 may be contacted.
TELEHEALTH CONSENT	I understand telehealth sessions involve electronic communication and carry some privacy risks. I consent to telehealth services and may request in-person services at any time. I will participate from a private, confidential location.
PATIENT RIGHTS & GRIEVANCES	I have been informed of my rights including respectful care, record access, confidentiality, informed consent, participation in treatment planning, and the right to file a grievance without retaliation. A full Patient Rights document is available upon request.

By signing below I confirm I have read, understood, and agree to all consents and authorizations above.

Patient / Legal Guardian Signature _____ **Date** _____

Printed Name of Patient / Guardian _____ **Date of Birth** _____

Witness / Staff Signature _____ **Date** _____

12 — FOR CLINICIAN / STAFF USE ONLY

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

Level of Care ■ Outpatient ■ IOP ■ PHP ■ Residential ■ Detox ■ Referred Out ■ No Services **Risk Level** ■ None ■ Low ■ Moderate ■ High ■ Imminent

Clinician Notes / Observations:

_____

_____

_____

Supervising Clinician Signature / NPI # _____ **Date** _____

BK Behavioral Health Center Restore. Rebuild. Reclaim Lives.

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