

Intake Information

PERSONAL INFORMATION

Full Name

Address

Phone(s)

Voicemail OK? Yes No

Date of Birth

Email

EMERGENCY CONTACT & PROVIDERS

Emergency Contact Name

Phone

Primary Care Provider

Address / Phone / Fax

Medication Provider

Address / Phone / Fax

MEDICAL INFORMATION

Current Behavioral Medications

Medication Allergies

Other Medical Issues

HOSPITALIZATION, SUICIDE & SELF-HARM HISTORY

Suicide Attempts

Inpatient – Behavioral Health (how many / where)

Inpatient – Chemical Dependency (how many / where)

Intensive Outpatient (MH / DBT / CD) (how many / where)

Self-Harm – cutting / burning (how many years)
