	New Client
	Previous Client
	Apt. Date:
	Apt with:

Capstone Behavioral Healthcare - Adult Intake Form

Reminder: If client has a legal guardian he/she must sign paperwork

Last Name:_____ **First Name**:_____**MI**____
Date of Birth ___/___/___ Age: ____ Gender ☐ Male ☐ Female SS #_____
Street Address:_____Apt or Box #:_____
City_____State_____ZIP_____County_____
Email address:_____ May we send you information at this email? ☐ Yes ☐ No
Home Phone (_____) _____ May we text, call, or leave a message at this #? ☐ Yes ☐ No
Cell Phone (_____) _____ May we text, call, or leave a message at this #? ☐ Yes ☐ No
Work Phone (_____) _____May we text, call, or leave a message at this #? ☐ Yes ☐ No
Do you currently reside in a: ☐ Private Residence ☐ Residential program ☐ Correctional Facility ☐ Nursing Home

Current Legal Status, Restrictions, or Requirements: (**documentation required if other than none**): ☐
None ☐ CINA ☐ Guardianship ☐ Power of Attorney ☐ Conservatorship ☐ Substance Abuse Commitment
☐ Mental Health Commitment ☐ Other relevant Court Orders requiring treatment or evaluation:_____
Guardian/Cons./POA Name: _____ **Phone:**_____
Guardian/Cons./POA Address: _____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other_____
Ethnicity: ☐ White/Caucasian ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian/Pacific Islander ☐ Other: _____
Employment:
☐ Full time ☐ Part time ☐ Unemployed/looking for work ☐ Student ☐ Retired ☐ Disabled ☐ Other: _____
Employer: _____ Occupation:_____ Address:_____

Referral for: ☐ Mental Health ☐ Substance Abuse ☐ OWI/Zero Tolerance ☐ Domestic Abuse
Referred by: ☐ Self ☐ Hospital ☐ Family/Friend ☐ School ☐ Court ☐ Physician ☐ DHS ☐ Probation Officer ☐ Other: _____
Name of referral (If applicable, DHS contact, probation officer, doctor):_____

Briefly describe what brings you to Capstone:

_____
_____
_____
_____

Insurance:
Primary Insurance: _____ Insured's Name:_____
Insured's Date of Birth:_____
Secondary Insurance:_____ Insured's Name:_____
Secondary Insured's Date of Birth: _____

Emergency Contact: _____ Relationship to Client:_____ Phone: _____
I give consent to contact the above listed person in the event of an emergency ☐ Yes ☐ No
I give consent to contact the above listed person to coordinate my care ☐ Yes ☐ No

Name_____ DOB_____

FAMILY/HOME INFORMATION

How many people live in your home? (Include yourself)_____

Name	Age	Relationship

MEDICAL/HEALTH INFORMATION

Have you received mental health treatment before? ☐ Yes ☐ No
If so, Where_____ When: _____

Do you use: ☐ Tobacco? ☐ Alcohol? ☐ Drugs?

Have you been treated for alcohol/drug problems before? ☐ Yes ☐ No
If so, Where_____ When: _____

It is very important for your therapy and medication management at Capstone Behavioral Healthcare that we are able to have contact with your primary care provider (PCP). Do you give your permission for us to contact your PCP? ☐ Yes ☐ No If you decline, please provide specific reason for your denial: _____

Who is your primary doctor/medical provider?_____ _____ _____
Name City Phone Number

Which pharmacy do you use? _____ City: _____ Phone: _____

Please list any current or ongoing medical problems:

_____

_____

What medications do you take? (Include non-prescription, herbal medicines and supplements)

Medicine	Dose	Frequency	Who prescribes

Please list any allergies, including medication allergies/sensitivities:

_____

Name_____ DOB_____

Client/Legal Guardian Signature_____ Completed on: ___/___/___

Witnessed By: _____

SUBMIT