Faith & Hope LLC

A Mental Health Practice

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. Thank you!

Name_____Date_____

Sex Male Female Transgender

Date of Birth _____ Social Security #_____

Race_____ Hispanic or Latino Yes No

Marital Status Single Married Divorced Widowed Separated

Home Phone_____ Cell Phone_____ Work Phone_____

Address_____
Street City State Zip

Email Address_____Preferred communication Text Phone Email

Employer_____ Occupation_____

Emergency Contact_____ Phone _____

Relationship to Patient_____ Email_____

Primary Care Physician_____

Primary Language English Other

Pharmacy of choice: _____ In which city: _____

Patient Signature_____
Patient Name _____ DOB _____Today's Date_____

Effective Date 01/01/2019

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Allergies_____

Current Medication	Dose	When do you take it

Prior Psychiatric Hospitalization/ Year	Diagnosis/Condition

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances?_____

If yes, where were you treated and when?_____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

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Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones?

_____

Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long?

_____

_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other			_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:
How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____
In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No
What kind? _____ How often per day on average? _____ How many years?_____

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For Women: Last menstrual period_____

Do you think you may be pregnant_____

If post-menopausal, how many years since your last period_____

At what age did your complete menopause_____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom:

_____
_____
_____
_____

How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

Legal History:

Have you ever been arrested? _____
Do you have any pending legal problems? _____

Current Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?
1._____

2._____

3._____

Patient Signature_____

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What are your treatment goals?

_____

_____

_____

_____

_____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

Patient Signature_____

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CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY AGREEMENT

I hereby grant Faith & Hope, LLC permission to treat myself for any Psychiatric illness. Additionally, I authorize Faith & Hope LLC to furnish all information regarding my Psychiatric history, diagnosis and treatment as well as subsequent follow up to any other parties as needed. We apologize currently Faith & Hope LLC **DOES NOT accept** any private or public insurances. Payment for all services is due at the time of service. Faith & Hope LLC reserves the right to make payment arrangements on a case by case basis. Your first service with Faith & Hope LLC will be $350.00 and every appointment there after will be $150.00 until further notice. I also acknowledge that reasonable and customary attempts will be made toward any void checks or charge backs will be charged an additional $35.00 fee. If such attempts fail, my account will be turned over to collections for further processing. * Faith & Hope LLC has a no refund policy for services rendered.

Patient Name Print_____

Patient Name Sign_____

Date Signed_____

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"No-Show" Policy

We at Faith & Hope LLC understand whole heartedly there are times when you cannot keep a scheduled appointment, due to work or family obligations. However, when you do not call and cancel/reschedule those appointments, you deprive another patient of access to much needed care. Conversely, there may be a time that you are told there are no available appointments. Then a patient does not show up we could have addressed your concern had he/she simply contacted us.

It is our desire here at Faith & Hope LLC to provide care whenever there is a need. We do work by schedule; the number of available appointments is limited. As such if you are the "Owner" of one of those slots and are unable to keep your appointment please call us (813)551-0637 to reschedule.

You have up to 24 hours prior to your scheduled appointment to call off and avoid this penalty. If you do have a no call **NO_SHOW**, you will be charged and additional $50.00 on your next appointment.

Again, we understand that life-happens and you may be unable to be on time for an appointment. Frankly, it has happened to me. If this be the case, you may be asked to reschedule, or dependent upon availability, simply, worked in to patient flow of the morning/afternoon.

Please sign below acknowledging you have read, understand and accept the "NO-SHOW" policy. Although we wish we didn't have one, we understand the necessity.

Respectfully,
Faith & Hope LLC

Patient Print_____

Patient Signature_____
Patient Name_____ Todays Date_____

Privacy Notification and Release of information

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I understand that my healthcare information will be exchanged among my healthcare providers through a healthcare provider exchange (HIE). Faith & Hope LLC will follow state and federal laws including HIPPA, when protecting the release of information which includes but is not limited to behavioral health drug/ alcohol/substance abuse/ abuse treatment/ sexual abuse/genetic testing. Participating in the (HIE) is not a condition to receive healthcare and I may decline participating in the exchange. I also authorize Faith & Hope LLC and Jacqueline Ustache APRN PHMNP-BC and/or any provider treating me to release any information and record concerning diagnostic and treatment.

Consent to Contact

By providing a cell phone/ home phone/ email address I expressly consent to receiving live auto dial ort pre-recorded message call, text messages and/or emails from Faith & Hope LLC its affiliate, agents, contractors, or business associates including but not limited to third party debt collectors at any phone number or email address provided or is associated with my account for any purpose.

I have received notice of Faith & Hope LLC notice of privacy practices and understand that I may obtain a copy of this notice upon request.

My signature below represents that I have read the above and give my agreement and authorization to all the above.

Patient Print_____DOB_____

Patient Signature_____Date/Time_____

Reviewed by _____Date _____

Reviewed by _____Date _____