Renewed Hope Counseling and Wellness

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Intake Form

Today's Date: _______________

What kind of services are you requesting?

☐ Medication Management ☐ Counseling Services ☐ Case Management ☐ CBRS Services

Who referred you to our clinic? ____

Patient Information

Legal First Name | Initial | Last Name

Address | City, State, Zip

Primary Phone | Email Address

Date of Birth | Age | Gender | Social Security Number

Parent/Guardian/Spouse Name | Phone

Address (if different from above) | City, State, Zip

In Case of Emergency

Name of local friend/relative (not living at same address)	Relationship	Primary Phone	Alt Phone

Insurance Information

	Primary Insurance	Secondary Insurance
Subscriber Name		
Relationship to Patient		
Subscriber DOB		
Subscriber ID#		
Group#		
Phone# from back of card		

Medical History

____
Primary Care Physician

____
Clinic/Location Phone

____
Psychiatrist/Other Physician

____
Clinic/Location Phone

Are you under the care of any other providers not listed above? ☐ Yes ☐ No

If yes, please provide name and phone:

____
Provider Name Phone

____
Previous Diagnoses/Mental Health Treatment

Medical Conditions: ____

____

____

Current Medications		
Name of Medication	Dose	Frequency

Preferred Pharmacy: ____

Allergies, including Medication: ____

____

____

What else would you like us to know about you? ___________________________________

____

____