Wake Forest Health Network – Behavioral Health Emerywood

320 Boulevard St., High Point, NC 27265
P: 336-878-6226 / F: 336-878-6272

Mental Health Intake Form (Pleas complete all information)

Name:

Date of Birth:

Primary Care Physician:

Current Therapist/Counselor:

Therapist's Phone:

What are the problem(s) for which you are seeing help?
1._____
2._____
3._____

What are your treatment goals?
_____
_____
_____

Current Symptoms Checklist: (check for any symptoms present)
( ) Depressed mood ( ) Racing Thoughts ( ) Excessive worry ( ) Unable to enjoy activities ( ) Impulsivity

( ) Anxiety attacks ( ) Sleep pattern disturbance ( ) Increased risky behavior ( ) Avoidance

( ) Loss of interest ( ) Increased libido ( ) Hallucinations ( ) Concentration/forgetfulness

( ) Decreased sleep ( ) Suspiciousness ( ) Change in appetite ( ) Excessive energy ( ) Excessive guilt

( ) Increased irritability ( ) Fatigue ( ) Crying spells ( ) Decreased libido

Do you have access to guns? If yes, please explain.
_____
_____

Patient Name: _____
Medical Record Number: _____
CSN: _____
Today's Date: _____

Behavioral Health Emerywood
Appointment Notification Notice

We understand that situations may arise which prevent you from keeping your appointment. However, we do request that you provide us with 24 hour notice if you realize that you will be unable to keep the appointment. This will allow the providers to serve another patient during that time. If you arrive more than 15 minutes late for an appointment you may be asked to reschedule. **Patients who have more than three no-showed appointments can be dismissed from our practice. A no-show is defined as missing your appointment without informing Wake Forest Health Network Behavioral Health Emerywood**. It is important to note that if we are unable to confirm your appointment, it may be cancelled to allow another patient to be scheduled.

Please fill in the bottom section of this form with every number you would like us to call to remind you of your appointments.

Patient's Name: _____ **Patient Date of Birth:** _____

Parent or Guardian Name *(if patient is child)*: _____

Home #: _____ **Cell #:** _____

Work #: _____ **Other:** _____

What number is best to reach you at during the day (M-F, 8:00 a.m. to 5:00 p.m.)? _____

Special Requests: _____
_____

Signature of Patient/Legally Responsible Person _____

Staff Witness's Signature _____

Please do not hesitate to call our office at (336) 878-6226 if you have any questions or concerns.
We consider you to be a valued patient, and look forward to seeing you.

Patient Name: _____
Medical Record Number: _____
CSN: _____
Today's Date: _____

Atrium Health Wake Forest Baptist

Behavioral Health Emerywood

Informed Consent

EMERGENCY CARE FACTS: If you have a mental health emergency, please call the office at 336-878-6226 during normal office hours and tell the staff member you are having a mental health crisis.

Statement of Patient Rights

Patients have the right to:

- Be treated with dignity and respect.
- Fair health care; no matter what race, religion, gender, ethnicity, age, handicap, or source of payment.
- Ask for what they want in a provider.
- Turn down or drop out of care at any time.
- Have their health care and other patient records kept private.
    - By law, records can only be released without patient permission when there is fear of harm to self or others, suspected child or elder abuse, court order, or when information needs to be given to someone to process a payment
- Easy access to timely care.
- To not have money influence the choices about their care. Talk with the provider in a way they can understand about:
    - diagnosis and treatment choices
    - type of therapy/testing
    - clinical guidelines used when making choices about their care
    - anticipated expected course, risks, and choices of treatment
- Have a copy of the treatment plan if asked.
- Have facts about health insurance coverage and, if it applies, its role in the health care process.
- Know what to expect for the cost of their care before appointments.
- Ask their provider about their work history and training.
- Give input on the *Wake Forest Health Network Patient Rights and Responsibilities* policy.
- Freely file a complaint or appeal.
    - This is done by calling either the *Office Manager of this office* or *Wake Forest Baptist Patient Relations/Complaints* at 336-713-2273 (CARE) or *email* patientrelations@wakehealth.edu
- **Know the name of the provider's clinical supervisor if this applies. NAME:_____**
- Be told of his/her right to call Disability Rights NC, the office named under federal and State law to protect and argue for the rights of persons with disabilities.
- Be told that anything sent through email is at risk of privacy breach.
    - You have the right to have emails sent with extra protection by writing the word "SECURE" in the subject line.

Statement of Patient Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers true information so they can give the best possible care.
- Ask questions about their care and fees following the treatment plan the patient and provider agree to.
- Tell all providers about medication changes, even if it was prescribed to them by someone else.
- Be willing to follow their doctor's care plan.
- Keep their appointments.
    - Patients should call the office as soon as they know they need to cancel visits. More than 24 hour notice is needed.
    - Missed appointments may cause you to be dismissed.
- Let their provider know when the treatment plan is not working.
- Let someone know if they have any concerns about the quality of care they are given.
- Report abuse and fraud.
- **Not make any voice or video recordings, or take any pictures in any Wake Forest office. INITIAL _____**

I agree to take part in behavioral health care services at Wake Forest Health Network Behavioral Health Emerywood. I know that I am agreeing only to the services that the provider is trained to give.

If the patient is under the age of eighteen or not able to agree to care, I confirm that I have the legal right to agree to treatment for this person.

I know that information about my behavioral health care may be discussed with other providers involved in my care. This is to best plan my care. I will talk about any concerns I have about information I would not like to be shared with my providers.

I have read the emergency care facts and patient rights and responsibilities. A copy of this form has been given to me.

_____ _____

Signature of Patient/Legally Responsible Person **Date**

_____ _____

Provider Signature **Date/Time (Required)**

Chart Copy

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MRN:

Wake Forest
Baptist Health
Wake Forest Health Network

Behavioral Health Emerywood
320 Boulevard St., High Point, NC 27265
P: 336-878-6226 / F: 336-878-6272

Mental Health Intake Form (Please complete all information)

Name:

Date of Birth:

Primary Care Physician:

Current Therapist/Counselor:

Therapist's Phone:

Are you currently seeking Medication Management, Therapy, or both?

What are the problem(s) for which you are seeing help?
1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check for any symptoms present)
( ) Depressed mood ( ) Racing Thoughts ( ) Excessive worry ( ) Unable to enjoy activities ( ) Impulsivity

( ) Anxiety attacks ( ) Sleep pattern disturbance ( ) Increased risky behavior ( ) Avoidance

( ) Loss of interest ( ) Increased libido ( ) Hallucinations ( ) Concentration/forgetfulness

( ) Decreased sleep ( ) Suspiciousness ( ) Change in appetite ( ) Excessive energy ( ) Excessive guilt

( ) Increased irritability ( ) Fatigue ( ) Crying spells ( ) Decreased libido

Do you have access to guns? If yes, please explain.

_____
_____

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PATIENT INFORMATION

Full Name:	Address:
Birth Date:	City:
Age:	State: Zip:
Sex: ❑ Male ❑ Female	Primary Phone:
SSN#:	Work Phone:
Employment Status:	Mobile Phone:
Employer:	Secondary Phone:
Retirement Date *(if applicable)*:	Email:
Marital Status: ***Please Check One*** ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Domestic Partner	Race: ***Please Check One*** ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Other Pacific Islander ❑ Unknown/Other Race ❑ White or Caucasian
Ethnicity: ***Please Check One*** ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown	Emergency Contact:
	Emergency Number:
Preferred Language:	Relationship of Emergency Contact:
If Patient is a MINOR: ***Please Complete this Section***	
Mother's Name:	Father's Name
Mother's Birthdate:	Father's Birthdate:
Mother's Phone:	Father's Phone:
Is Mother the Guarantor? Y N	Is Father the Guarantor? Y N

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INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Member Number/ID for Patient:	Member Number/ID for Patient:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name *(name on card)*:	Subscriber Name *(name on card)*:
Subscriber Birthdate:	Subscriber Birthdate:
Relationship to Patient:	Relationship to Patient:

NEW PATIENT
MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:

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Last Zoster Vaccine *(Shingles)*:	

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			

Patient Name: _____ DOB: _____

High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	*Past:* Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:

Patient Name: _____ DOB: _____

Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N
Have you ever taken someone else's drugs? Y N	

FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✓ CHECK ALL THAT APPLY	Alcohol/DrugAbuse	Asthma	Cancer (type:_____)	Emphysema(COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	HeartDisease	HighCholesterol	HighBlood Pressure	KidneyDisease	Stroke	ThyroidDisease	Migraines	Other_____	Other_____	Other_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*
Sexual partner(s) is/are/have been: ❑ Male ❑ Female	
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy	

Patient Name: _____ DOB: _____

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EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?		***Duration:*** How long (min.): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLY

	CONSTITUTION		CARDIOVASCULAR		SKIN
	Activity change		Chest pain		Color change
	Appetite change		Leg swelling		Pallor
	Chills		Palpitations		Rash
	Diaphoresis		**Gastrointestinal**		Wound
	Fatigue		Abdominal distention		**ALLERGY/IMMUNO**
	Fever		Abdominal pain		Environmental allergies

Patient Name: _____ DOB: _____

	Unexpected weight change		Anal bleeding		Food allergies
	HEAD, EAR, NOSE & THROAT		Blood in stool		Immunocompromised
	Congestion		Constipation		**NEUROLOGICAL**
	Dental problem		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal pain		Headaches
	Ear pain		Vomiting		Light-headedness
	Facial swelling		**ENDOCRINE**		Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Polydipsia		Syncope
	Postnasal drip		Polyphagia		Tremors
	Rhinorrhea		Polyuria		Weakness
	Sinus pressure		**Genitourinary**		**HEMATOLOGIC**
	Sneezing		Difficulty urinating		Adenopathy
	Sore throat		Dysuria		Bruises/bleeds easily
	Tinnitus		Enuresis		**PSYCHIATRIC**
	Trouble swallowing		Flank pain		Agitation
	Voice change		Frequency		Behavior problem
	EYES		Genital sore		Confusion
	Eye discharge		Hematuria		Decreased concentration
	Eye itching		Penile discharge		Dysphoric mood
	Eye pain		Penile pain		Hallucinations
	Eye redness		Penile swelling		Hyperactive
	Photophobia		Scrotal swelling		Nervous/anxious
	Visual disturbance		Testicular pain		Self-injury
	RESPIRATORY		Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness		**MUSCULAR**		
	Choking		Arthralgias		
	Cough		Back pain		
	Shortness of breath		Gait problems		
	Stridor		Joint swelling		
	Wheezing		Myalgias		
			Neck pain		
			Neck stiffness		

Patient Name: _____ DOB: _____