Office Use Only: PC / BH

PRISM HEALTH

PLEASE READ: Prism Health recognizes all genders and identities; however, many insurance companies and legal entities unfortunately do not. Please be aware that the legal name and sex you have listed with your insurance must be used on documents pertaining to insurance and billing. When addressing you, we will always use the name and pronouns that you request to assure that we are using the most respectful language.

Please let us know if there is anything we can do to make your time with us more comfortable. Thank you.

PATIENT REGISTRATION **TODAY'S DATE:**

Name on file with your insurance
Last: First: Middle:

Date of Birth:

Name You Go By: Social Security Number:

Sex Assigned at Birth:
☐Male ☐Female ☐Intersex

Pronouns You Use: ☐ He/His ☐ She/Hers ☐ They/Theirs ☐ Other_____

Gender Identity: ☐ Woman ☐ Man ☐ Transgender ☐ Cisgender ☐ Two-Spirit
☐ Gender Non-Conforming ☐ Non-Binary☐ Questioning ☐ Decline
☐ Another _____

Sexual Orientation: ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Queer ☐ Asexual ☐ Pansexual ☐ Straight
☐ Questioning ☐ Decline ☐ Another _____

Relationship Structure: ☐ Single ☐ Monogamous ☐ Polyamorous ☐ Open/Non-Monogamous ☐ Aromantic
☐ Kink/BDSM ☐ Questioning ☐ Decline ☐ Another _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Choose not to say ☐ Don't know

Race: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Pacific Islander
☐ White ☐ Choose not to say ☐ Don't know ☐ Another _____

Physical Address:
City: State:

Main Phone:
OK to leave voicemail? ☐ Y ☐ N

Work Phone: _____
OK to leave voicemail? ☐ Y ☐ N

Other Phone: _____
OK to leave voicemail? ☐ Y ☐ N

Email address:

☐ N

Employer:
Occupation: Full-time ☐ Part-time ☐

Preferred Written / Spoken Language:
☐English ☐Spanish ☐Mandarin ☐Russian ☐ASL
☐Other_____

Do you need interpretation services?
☐ N ☐ Y, language:_____
Do you have a visual impairment? ☐Y ☐N

How did you hear about Prism Health? ☐ Online/Internet ☐ Facebook ☐ Yelp ☐ A current patient
☐ Pivot/testing ☐ Friend/Partner/Family ☐ Outreach event ☐ Other: _____

(OVER)

PRISM HEALTH

Please note: All patients are asked to provide the below information in order to determine if you might be eligible for discounted fees or services.

What is your current annual income? $_____ ☐ Decline to Answer

How many people are in your household? _____ ☐ Decline to Answer

Are you a US Veteran? ☐Y ☐N

EMERGENCY INFORMATION

Emergency Contact Name:_____Relationship:_____

Phone: _____

INSURANCE INFORMATION (Note: Co-pays are due at the time of service)

Insurance Name and ID Number:	Who is the insurance subscriber? ☐ Yourself ☐ Someone else	When did your insurance start? Month: Year:

PRISM HEALTH

Please note, all of the following sections can be discussed in more depth with your therapist.

PRESENTING CONCERNS

Briefly describe the reasons that brought you here today: _____

_____

_____

When did you notice the concern? _____

Are you experiencing any symptoms related to your mental health? If yes, please check to indicate frequency.

Sadness	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Feeling worthless	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Insomnia	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Difficulty concentrating	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Feeling bad about yourself	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Feeling guilty	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Thinking about death and/or suicide	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Decreased performance at work or school	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Intentionally hurting yourself (e.g. cutting)	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Feeling tired/not having energy	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Loss of interest in things you used to enjoy	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Isolating yourself/withdrawing from relationships	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Increased irritability and/or anger	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Forgetfulness	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Restlessness	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Muscle tension	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Nervousness	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Feeling excessively worried	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Seeing or hearing things that other people don't hear	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Racing thoughts	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Having unwelcome thoughts or memories	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Avoiding certain thoughts/situations	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Feeling on guard or easily startled	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Nightmares	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Flashbacks	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Checking, touching, or counting things a lot	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Repeating specific behaviors over and over	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Restricting your food intake	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Worrying about your weight/appearance	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Other: _____	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Other: _____	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Other: _____	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
If you checked any of the above problems, how difficult have these problems made it for to do your work, take care of your home, or get along with other people?	☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

PRISM HEALTH

MENTAL HEALTH HISTORY

Type	When (Beginning - End)	Where	Why
Outpatient Therapy			
Mental Health Medication Prescription			
Psychiatric Hospitalization			

PREVIOUS MENTAL HEALTH PROVIDER INFORMATION

Are you transferring your care from another mental health provider? ☐ Y ☐ N

If so, please list the name and phone number of your previous provider.
Please complete a **Release of Information** if you would like us to obtain copies of your records.
Name of Provider: _____
Phone Number: _____

MEDICAL INFORMATION

Is your current primary care provider Prism Health? ☐ Y ☐ N If yes, please skip to next section. If no, please complete.
Do you currently have a primary care provider? ☐ Y ☐ N If yes, who? _____
Please list CURRENT medical concerns: _____
_____
Please list allergies: _____

Please list your current medications and dosage, including over-the-counter supplements:

Medication Name	Dose	Frequency

Do you take your medications as prescribed? ☐ Y ☐ N

FAMILY HISTORY

Please list mental health conditions that any of your immediate family members have had:

Family Member	Condition

SOCIAL/CULTURAL INFORMATION

Who are your closest social supports? _____

Are you experiencing difficulties or concerns due to oppression, discrimination, or culture? ☐ Y ☐ N If so, please describe:
_____
_____

Please describe your spirituality, religion, or worldview: _____

PRISM HEALTH

Highest level of education completed: _____
Are you currently enrolled in a school or training program? ☐ Y ☐ N If yes, please list: _____
_____
Have you ever been convicted of a misdemeanor or felony? ☐ Y ☐ N If yes, please explain: _____
_____
Are you currently involved in any legal proceedings? ☐ Y ☐ N If yes, please explain: _____
_____

SUBSTANCE USE AND GAMBLING

Do you drink **caffeinated** beverages? ☐ Y ☐ N
How often and how many caffeinated beverages do you drink? _____

Do you use **tobacco** products? ☐ Y ☐ N
What products do you use? ☐ Cigarettes/cigars ☐ Vaporizers ☐ Chewing tobacco
How often and how much do you use? _____

Do you drink **alcohol**? ☐ Y ☐ N
How often and how much do you drink? _____

Do you use **marijuana** products? ☐ Y ☐ N
What products do you use? ☐ Smoking implements ☐ Vaporizers ☐ Edibles
How often and how much do you use? _____

Do you use **prescription medications** that are not prescribed to you? ☐ Y ☐ N
What do you use? _____
How often and how much do you use? _____

Do you use **any other substances**? ☐ Y ☐ N
What do you use? _____
How often and how much do you use? _____

Do you **gamble**? ☐ Y ☐ N
How and where do you gamble? _____
How often and how much do you gamble? _____

In your life, has someone ever expressed concern about your alcohol or drug use? ☐ Y ☐ N
In your life, has your alcohol or drug use led to social, financial, or employment problems? ☐ Y ☐ N
In your life, has someone ever expressed concern about your gambling? ☐ Y ☐ N
In your life, has your gambling led to social, financial, or employment problems? ☐ Y ☐ N

OTHER

Is there anything else you would like your therapist to know about you?

PRISM HEALTH

Please read the following carefully and sign below:

I certify that the information I have given on my patient intake form is correct and complete to the best of my knowledge. I acknowledge that keeping any health information from my provider may hinder them from being able to give me adequate patient care. It is my responsibility to keep my provider informed of any new health issues that may arise.

Patient Signature	Date
Parent/Guardian Signature (If applicable)	Date