Adult Mental Health Pre-screen form

Name:

Date of Birth:

Address:

Phone #

Pharmacy Used:

Primary Care Provider:

Primary Insurance information: **Phone #:**

Insurance #:

Secondary Insurance:

Insurance #: **Phone #:**

Social Security #:

Is the provider covered under your insurance plan?

What issue(s) have led you to seek a medication evaluation? What is your psychiatric diagnosis (if known)?

Are you currently seeing a therapist? If so, for how long and how often do you see your therapist?

Are you currently taking any psychiatric medication(s)? If so, please list them.

Have you taken any psychiatric medications in the past that you are no longer taking? Please list them.

Does you have a history of self-harming behaviors or suicidal thoughts? If so, please describe.

Have you ever been to an emergency room for a psychiatric evaluation? If so, what was the outcome of this/these evaluation(s)?

Have you ever been in a psychiatric hospital?

Have you ever had a problem with drug or alcohol use?

Have you ever engaged in disordered eating (binging/purging/restricting)?

Are you currently being treated for a mental health condition?

What non-psychiatric medications, if any, are you currently taking?

Have you ever seen a psychiatrist specialist? If so, what diagnosis was given and what treatment was required?

How soon you do want an appointment?

Thank you very much for completing the form. Once I receive it I will contact you shortly.