GLOBAL HEALTHCARE SERVICES, LLC.

Joint Commission Accredited

INTAKE FORM □ ADULT □ CHILD

DATE _____

CLIENT'S NAME _____ DOB _____

CLIENT'S PHONE NUMBER: _____SOC. SEC. # _____
☐ CHECK TO PROVIDE CONSENT TO LEAVE A MESSAGE ☐ CHECK TO PROVIDE CONSENT TO TEXT
GENDER _____ AGE _____ RACE _____ MA# _____

CLIENT'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE _____

GRADE LEVEL IF IN SCHOOL: _____ NAME OF SCHOOL: _____

SCHOOL ADDRESS: _____ CITY: _____

STATE_____ ZIP CODE: _____ TELEPHONE NUMBER: _____

PLACEMENT NAME IF IN PLACEMENT: _____
PLACE ADDRESS: _____ CITY: _____
STATE: _____ ZIPCODE: _____

ANY HISTORY OF HOSPITALIZATIONS , SUBSTANCE USE DISORDER, HOMELESSNESS, RUN AWAY,etc_
□ YES □ NO

IF YES, PLEASE EXPLAIN

HAS CLIENT BEEN ARRESTED? □ **YES** □ **NO**
IF YES/ DATE OF ARREST_____ AND REASON FOR ARREST_____

PLEASE PROVIDE HEALTH INSURANCE INFORMATION (Insurance Name, Member ID, and Group Number) if not Medicaid _____

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)
□ INDIVIDUAL THERAPY □ FAMILY THERAPY □ GROUP THERAPY □ PSYCHIATRIC REHABILITAION PROGRAM □ MEDICATION ASSESSMENT □ MEDICATION MANAGEMENT

REFERAL SOURCE □ BCDSS □ DHMH □ SCHOOL □ FAMILY
□ HOSPITAL _____ □ PHYSICIAN _____
□ OTHERS _____

NAME OF REFERRING PERSON: _____ CREDENTIALS: _____
RELATIONSHIP TO CLIENT _____
ADRESSS: _____CITY_____STATE_____ ZIPCODE_____
ARE YOU CURRENTLY ENROLLED IN OMHC OR PRP? □ **YES** □ **NO**
IF YES, NAME OF PROGRAM: _____
THERPAIST'S NAME: _____
CURRENT DSM-V DIAGNOSIS: _____
NAME OF PHYSICIAN OR PROVIDER WHO DIAGNOSED: _____
PRIMARY CARE PHYSICIAN'S NAME: _____
PRIMARY CARE PHYSICIAN'S ADDRESS: _____
DATE OF LAST PHYSICAL EXAM: _____
MEDICATION(S): ☐ Check if not prescribed medication:

MEDICATIONS	DOSAGE	FREQUENCY	REASON PRESCRIBED	**Any Allergies?**

COLLABORATION AGREEMENT:

I agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

Print Therapist Name: _____Title: _____Signature:_ _____

Please Attach Copies of the Following:

1. **Current Psychosocial, Psychiatric or Psychological Evaluation**
2. **Court Order (If child is committed to DSS or DJS)**
3. **Current Therapist Treatment Plan**

NAME OF STAFF COMPLETING INTAKE FORM: _____