Mind Body
WELLNESS CENTER

2808 S. 80TH AVENUE
SUITE 160
OMAHA, NE 68124
P (402) 203-5269
F (402) 502-3112

PERSONAL INFORMATION (* Required field)

If you have any questions about the patient intake form, our staff is available during regular business hours to assist at 402-203-5269.

NAME* First _____ Last _____ Date of Birth _____

ADDRESS* Street _____ City _____ State _____

Zip/Postal Code _____ Phone (h) _____ Phone (c) _____

RESPONSIBLE PARTY

Responsible Party's SSN: _____

Name (if different):

First_____ Last _____

Street _____ City _____ State _____

Zip/Postal Code _____ Phone (h) _____ Phone (c) _____

Do you give our staff permission to leave a voicemail regarding your inquiry into Mind & Body Wellness Center in the event we cannot reach you?* ☐ Yes ☐ No

Do you give our staff permission to send you text alerts regarding your appointments and reminders from Mind & Body Wellness Center in the event we cannot reach you?* ☐ Yes ☐ No

How did you find us?* _____

Emergency Contact Name* _____ Emergency Contact Phone* _____

What condition(s) are you seeking treatment for at our clinic?* ***Please check all that apply.***

- ☐ Depression
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Suicidal
- ☐ Addiction
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Anxiety
- ☐ Addiction Withdrawal
- ☐ Other: _____

Please list any or all anesthesia problems you or your family members have. If none, please enter "N/A" or "None"

_____

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PAST SURGICAL HISTORY ☐ None

_____

_____

_____

ALLERGIES

Medication/supplement | Reaction

_____ _____

_____ _____

MEDICATIONS ☐ None

I am currently compliant with all medications prescribed by my mental health provider. ☐ Yes ☐ No

Name/Dose | Reason for use

_____ _____

_____ _____

_____ _____

_____ _____

If no, please explain:_____

_____

List any non-prescribed and or illicit drug use* If non, Type “n/A” or “None”

_____

_____

PAST MENTAL HEALTH HISTORY

Do you have any of these conditions? Check appropriate box and provide date of onset: ☐ Past Condition ☐ Current Condition

☐ ☐ Depression _____
☐ ☐ Anxiety _____
☐ ☐ PTSD _____
☐ ☐ Insomnia _____
☐ ☐ Schizophrenia _____
☐ ☐ Hallucinations _____
☐ ☐ ADD/ADHD _____
☐ ☐ Suicidal _____

☐ ☐ History of Mental Health Crisis _____
_____
☐ ☐ Seizures _____
☐ ☐ Stroke _____
☐ ☐ Neuromuscular Disease _____
☐ ☐ History of Psychiatric Admission _____
_____
☐ ☐ Other _____

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PAST MEDICAL HISTORY

Do you have any of these conditions? Check appropriate box and provide date of onset

☐ Past Condition ☐ Current Condition

METABOLIC/ENDOCRINE

- ☐ ☐ Hypothyroid (under-active) _____
- ☐ ☐ Hyperthyroidism (overactive thyroid) _____
- ☐ ☐ Other _____

GU/GI

- ☐ ☐ Kidney Disease _____
- ☐ ☐ Liver Disease _____
- ☐ ☐ Other _____

CARDIOVASCULAR

- ☐ ☐ High Blood Pressure _____
- ☐ ☐ Controlled/Uncontrolled _____
- ☐ ☐ Chest Pain _____
- ☐ ☐ Heart Murmur _____
- ☐ ☐ Heart Attack _____
- ☐ ☐ Valve Disease _____
- ☐ ☐ Heart Failure _____
- ☐ ☐ Abnormal Heart Rhythm _____
- ☐ ☐ Bleeding Disorder _____
- ☐ ☐ Other _____

_____

PAIN

- ☐ ☐ Acute Pain _____
- ☐ ☐ Chronic Pain _____
- ☐ ☐ Fibromyalgia _____
- ☐ ☐ Other _____

_____

INFECTIOUS

- ☐ ☐ HIV _____
- ☐ ☐ Tuberculosis _____
- ☐ ☐ Hepatitis _____
- ☐ ☐ Other _____

_____

RESPIRATORY

- ☐ ☐ Shortness of breath _____
- ☐ ☐ Asthma _____
- ☐ ☐ Obstructive Sleep Apnea _____
- ☐ ☐ Pulmonary Hypertension _____
- ☐ ☐ Other Lung Disorders _____

HEMATOLOGY/ONCOLOGY

- ☐ ☐ Bleeding Disorder _____
- ☐ ☐ Cancer (explain _____

_____

- ☐ ☐ Other _____

_____

OTHER

- ☐ ☐ Substance abuse (Please check) _____
  - ☐ ☐ Marijuana ☐ ☐ Cocaine ☐ ☐ Methamphetamine
  - ☐ ☐ Heroine ☐ ☐ Ketamine
- ☐ ☐ Other Recreational Drugs _____
- ☐ ☐ Last Use _____
- ☐ ☐ History Assault _____
- ☐ ☐ History of Violent Behavior _____
- ☐ ☐ Other _____

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Do you exercise regularly?* ☐ Yes ☐ No How many meals to you eat per day?* _____ Are you happy with your weight? ☐ Yes ☐ No

When was the last time you drank alcohol, what type and how much?* _____

Are you concerned about your alcoholic intake?* ☐ Yes ☐ No

In the last year have you drank alcohol or used drugs more than you meant to?* ☐ Yes ☐ No

Have you wanted/needed to cut down on your drinking or drug use in the last year?* ☐ Yes ☐ No

In the last year have you used alcohol or non-prescription drugs to deal with feelings of frustration or stress?* ☐ Yes ☐ No

As a result of drinking or drug use has anything happened in the last year that you wished hadn't happened? ☐ Yes ☐ No

Describe the stress in your life* _____

_____

_____

I am not happy with*

☐ Myself ☐ My Partner ☐ My Health ☐ My Work ☐ My Life History ☐ My Suicide Attempt ☐ Not Applicable

Please check boxes related to the following conditions for Depression*

☐ Self ☐ Mother ☐ Father ☐ Siblings ☐ Significant Other ☐ Not Applicable

Please check boxes related to the following conditions for PTSD*

☐ Self ☐ Mother ☐ Father ☐ Siblings ☐ Significant Other ☐ Not Applicable

Please check boxes related to the following conditions for Schizophrenia*

☐ Self ☐ Mother ☐ Father ☐ Siblings ☐ Significant Other ☐ Not Applicable

Please check boxes related to the following conditions for Suicidality*

☐ Self ☐ Mother ☐ Father ☐ Siblings ☐ Significant Other ☐ Not Applicable

Please check boxes related to the following conditions for Drug Abuse*

☐ Self ☐ Mother ☐ Father ☐ Siblings ☐ Significant Other ☐ Not Applicable

Please check boxes related to the following conditions for Alcohol Abuse*

☐ Self ☐ Mother ☐ Father ☐ Siblings ☐ Significant Other ☐ Not Applicable

Please add any other pertinent health information below_____

_____

_____

Please provide a signature below*

_____

I confirm that, to the best of my knowledge, this document accurately reflects my personal health information