

PATIENT 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 _____
EMAIL* _____
ADDRESS* Street _____ City _____ State _____
 Zip/Postal Code _____ Phone (h) _____ Phone (c) _____
 Emergency Contact Name* _____ Emergency Contact Phone* _____

PERMISSIONS

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?* _____

RESPONSIBLE PARTY (if minor is the patient)

Name (if different from the patient)

First _____ Last _____
 Street _____ City _____ State _____
 Zip/Postal Code _____ Phone (h) _____ Phone (c) _____

PROVIDERS

Primary Care Provider _____

Psychiatric Provider _____

YOUR CURRENT STATE

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

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Post Traumatic Stress Disorder (PTSD) |
| <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Addiction Withdrawal |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Other: _____ |

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

PAST SURGICAL HISTORY None

ALLERGIES

Medication/supplement

Reaction

<hr/>	<hr/>
<hr/>	<hr/>

MEDICATIONS None

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

Name/Dose

Reason for use

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

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

<input type="checkbox"/> <input type="checkbox"/> Depression _____	<input type="checkbox"/> <input type="checkbox"/> History of Mental Health Crisis _____
<input type="checkbox"/> <input type="checkbox"/> Anxiety _____	<input type="checkbox"/> <input type="checkbox"/> Seizures _____
<input type="checkbox"/> <input type="checkbox"/> PTSD _____	<input type="checkbox"/> <input type="checkbox"/> Stroke _____
<input type="checkbox"/> <input type="checkbox"/> Insomnia _____	<input type="checkbox"/> <input type="checkbox"/> Neuromuscular Disease _____
<input type="checkbox"/> <input type="checkbox"/> Schizophrenia _____	<input type="checkbox"/> <input type="checkbox"/> History of Psychiatric Admission _____
<input type="checkbox"/> <input type="checkbox"/> Hallucinations _____	<input type="checkbox"/> <input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> ADD/ADHD _____	
<input type="checkbox"/> <input type="checkbox"/> Suicidal _____	

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
 - Heroin Ketamine
- Other Recreational Drugs _____
- Last Use _____
- History Assault _____
- History of Violent Behavior _____
- Other _____

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