Insurance ID: _____ MR#: _____ Today's Date ___ / ___ / _____

Wilmington Mental Health
3955 Market St Suite B, Wilmington, NC 28403
P: 910-777-5575 | F: 910-777-5273

Type of service: ☐ Individual ☐ Marital/Couple ☐ Group ☐ Child/Teen

Referral Source: ☐ Walk-In ☐ Internet ☐ PT ☐ Ins Co ☐ Other

Demographic Information

Welcome! Thank you for trusting us with your care. Please take a few minutes to fill out this form and notify us if any detail changes during your treatment. This information is important for your treatment and will help us better understand your situation.

PATIENT INFORMATION

SSN: _____ - ____ - _____

Last Name: _____ First Name: _____ Middle ____ DOB: ____/____/_____

Address: _____ City: _____ State: _____ Zip Code: _____

Contact Number: _____ - _____ - _____ ☐ Cell ☐ Home Work Phone: : _____ - _____ - _____ Email: _____

Fill out the following if Patient is a minor or if you are here for marital/premarital counseling (e.g, Spouse/Partner/Boyfriend/Girlfriend/Significant Other):

Last Name: _____ First Name: _____ Middle ____ DOB: ____/____/_____

Address: _____ City: _____ State: _____ Zip Code: _____

Contact Number: _____ - _____ - _____ ☐ Cell ☐ Home Work Phone: : _____ - _____ - _____ Email: _____

Relationship to patient: _____

Please check the item that best describes you:

Gender:
☐ Male
☐ Female
☐ Unknown

Marital Status:
☐ Single ☐ Separated
☐ Married ☐ Divorced
☐ Engaged ☐ Widow

Living Situation:
☐ Living alone
☐ Living with roommates or relatives
☐ Living with spouse/partner/children

Race / Ethnicity
☐ American Indian ☐ African American ☐ Not Hispanic
☐ Alaska Native ☐ Pacific Islander ☐ Hispanic or Latino
☐ Asian ☐ White

EDUCATION

Please list the highest grade you have completed: ☐ Less than High School ☐ HS/GED ☐ Some college ☐ College degree ☐ Master's degree ☐ Phd

Do you have a learning problem? ☐ No ☐ Yes What type? ☐ Speech ☐ Hearing ☐ Reading ☐ Writing ☐ Concentration ☐ Attention ☐ None

If you have problem areas or a preferred way to learn, please describe: _____

EMPLOYMENT

☐ Unemployed ☐ Seeking employment ☐ Working Part Time ☐ Working Full Time ☐ Full time student ☐ Part time student ☐ Per diem

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip Code: _____

PRESENTING PROBLEM

What is/are the reason(s) you are seeking therapy today? How does it affect your everyday life?

_____

_____

How long has the problem been present?

_____

_____

What you want to accomplish during therapy? Please share what you hope will be different in your life as a result of attending therapy.

_____

_____

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What have you tried to make yourself feel better?

_____

_____

Please list the people who currently play a supportive role in your life:

_____

_____

What makes you happy?

_____

_____

Do you have any spiritual beliefs or practices that are important to you? ☐ Yes (If yes, please explain) ☐ No

_____

_____

Is there anything else (e.g., your culture or heritage, etc) that you want your therapist to know? ☐ Yes ☐ No

_____

_____

FAMILY INFORMATION *(Please list members of your immediate family and/or your current household next):*

Name	Age	Relationship	Living in the same house?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

MEDICAL INFORMATION:

Primary Care Provider: _____ Phone #: : _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip Code: _____

How is your physical health, in general? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Do you exercise? ☐ Yes ☐ No ☐ How often? _____

Have you experienced any significant weight loss or gain in the past month? ☐ Yes ☐ No Do you eat at least three healthy meals per day? ☐ Yes ☐ No

How many hours of uninterrupted sleep do you get each night?_____ How many hours do spend using digital material (e.g., cellphone, TV) per day? _____

Date of last physical examination: _____ Are you allergic to any medication? ☐ Yes (specify) _____ ☐ No

Current medication	Dose (mg)	Frequency	What is it for?	Name of Prescribing doctor

EMERGENCY CONTACT: *Name and address of next of kin or relative living with you*

Full Name: _____ Contact Number: _____ - _____ - _____ [Cell / Home]

Relationship to Patient: _____ Do we have permission to contact this person in your behalf? ☐ Yes ☐ No

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Mental Health Information

Are you, or another family member, currently seeing a psychiatrist, psychologist, or therapist? ☐ Yes ☐ No

Counselor's Name: _____ Do you have any previous experience with counseling? ☐ Yes ☐ No

When? _____ Length: _____ Reason? _____

SYMPTOMS

Please circle the number that best illustrates how these symptoms have bothered you recently.	Not at all	Midly	Moderately	Severely
Grief/Loss	0	1 2 3	4 5 6 7	8 9 10
Depressed, sad, or crying	0	1 2 3	4 5 6 7	8 9 10
Past hurts	0	1 2 3	4 5 6 7	8 9 10
Mood swings	0	1 2 3	4 5 6 7	8 9 10
Guilty feelings	0	1 2 3	4 5 6 7	8 9 10
Self-esteem ___ Decreased ___ Increased	0	1 2 3	4 5 6 7	8 9 10
Suicidal thoughts, plans, attempts Thought about ☐ Y ☐ N Planned ☐ Y ☐ N Attempted ☐ Y ☐ N If yes to any of these, when was this? _____ / ____ / _____	0	1 2 3	4 5 6 7	8 9 10
Changed sleep patterns ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Can't get up in the morning ☐ Nightmares	0	1 2 3	4 5 6 7	8 9 10
Change in weight or eating habits ☐ Increase ☐ Decrease	0	1 2 3	4 5 6 7	8 9 10
History of restrictive eating, dieting or purging	0	1 2 3	4 5 6 7	8 9 10
Insecurity or inferiority	0	1 2 3	4 5 6 7	8 9 10
Communication issues				
Loss of interest or energy in pleasurable activities	0	1 2 3	4 5 6 7	8 9 10
Stress	0	1 2 3	4 5 6 7	8 9 10
Work/Career changes	0	1 2 3	4 5 6 7	8 9 10
Disability	0	1 2 3	4 5 6 7	8 9 10
Aging/Dependency	0	1 2 3	4 5 6 7	8 9 10
Marriage-related issues	0	1 2 3	4 5 6 7	8 9 10
Divorce/Separation	0	1 2 3	4 5 6 7	8 9 10
Anxious, nervous, or panicky feelings	0	1 2 3	4 5 6 7	8 9 10
Avoiding places or situations	0	1 2 3	4 5 6 7	8 9 10
Repetitive thoughts or behaviors	0	1 2 3	4 5 6 7	8 9 10
Change in work habits	0	1 2 3	4 5 6 7	8 9 10
Anger or temper problems	0	1 2 3	4 5 6 7	8 9 10
Flashbacks or intrusive memories	0	1 2 3	4 5 6 7	8 9 10
Physical problems, pain, or illness	0	1 2 3	4 5 6 7	8 9 10
Sexual worries or problems	0	1 2 3	4 5 6 7	8 9 10
Addiction to pornography	0	1 2 3	4 5 6 7	8 9 10
Intimacy	0	1 2 3	4 5 6 7	8 9 10
Brain fog, fuzzy thinking, or dissociation	0	1 2 3	4 5 6 7	8 9 10
Memory problems	0	1 2 3	4 5 6 7	8 9 10
Confused or disorganized thoughts	0	1 2 3	4 5 6 7	8 9 10
Periods of high energy/activity with less need for sleep	0	1 2 3	4 5 6 7	8 9 10
God, faith, church/ministry related issues	0	1 2 3	4 5 6 7	8 9 10
School-related issues				
Substance use	0	1 2 3	4 5 6 7	8 9 10
Other (Please explain):	0	1 2 3	4 5 6 7	8 9 10
Scores				

How serious are these matters to you at this time?

1	2	3	4
Very serious	Serious	Not too serious	Not at all serious

How long have you had these problems?

0 to 3 months	3 to 12 months	1 to 5 years	More than 5 years

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Insurance Information

If you are not using any insurance, please skip this section and fill out the "Self-Pay" portion located at the bottom.

PRIMARY INSURANCE: *A copy of your insurance card will be needed.*

Insurance Company: _____

Policy #: _____ Phone # *(for providers):* _____

Primary Holder's Name: _____

DOB: ___/___/_____ SSN: _____ - ____ - _____

Employer Name: _____

Relationship to Patient (Skip the next section if you are the primary holder):

_____ Contact Number _____

SECONDARY INSURANCE: *A copy of your insurance card will be needed.*

Insurance Company: _____

Policy #: _____ Phone # *(for providers):* _____

Primary Holder's Name: _____

DOB: ___/___/_____ SSN: _____ - ____ - _____

Employer Name: _____

Relationship to Patient (Skip the next section if you are the primary holder):

_____ Contact Number _____

INSURANCE AUTHORIZATION:

I give Wilmington Mental Health permission to file my insurance and/or request payment from parties other than insurance companies including attorneys, family or other responsible parties, and authorize the release of any medical records necessary to process claims or requests in my behalf. This is a permanent authorization and I may revoke it at any time by written notice.

X _____ _____

Signature of patient or person acting on patient's behalf Date

FINANCIAL RESPONSIBILITY

I certify that the above information is correct. My signature below indicates that I am the responsible party for payment of all services not paid by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

X _____ _____

Signature of patient or person acting on patient's behalf Date

ATTESTATION

I certify that all information provided on this form is accurate.

X _____ _____

Signature of patient or person acting on patient's behalf Date

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. This *Notice* describes your rights in regard to the protection of your health information and how you may exercise those rights. This *Notice* also gives you the names of contacts should you have questions or comments about the policies and procedures **Wilmington Mental Health** uses to protect the privacy of your health information. Please review this document carefully and ask for clarification if you do not understand any portion of it.

This *Notice* is subject to change. The most recent version can always be found at *www.wilmingtonmentalhealth.com* in the *Forms* section. If we change this *Notice*, you may obtain a copy of the revised document by contacting us 910-777-5575.

By checking the box below and signing, you acknowledge that you have been informed about how your privacy and confidentiality will be maintained by **Wilmington Mental Health.** And that you have received a copy of this *Notice*.

- ☐ I have been informed about how my privacy and confidentiality will be maintained by Wilmington Mental Health.
- ☐ I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing treatment; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessments and accreditation.
- ☐ I have reviewed and received a copy of the Notice of Privacy Practices.

X _____ _____

Patient or Authorized Representative Date

Note: Wilmington Mental Health retains this signed page. Patient retains the Notice of Privacy Practices document.

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Specify)_____