MOFDAPS

Behavioral Health and Comprehensive

Compassionate Care • Professional Support • Your Journey to Wellness

PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name

First Name

M.I.

Preferred Name

Date of Birth

Age

Gender

Social Security Number

Marital Status

Street Address

City

State

ZIP Code

Phone Number

Alt. Phone

Email Address

Race/Ethnicity

Preferred Language

Interpreter Needed?

EMERGENCY CONTACT

Emergency Contact Name

Relationship

Emergency Phone

Secondary Emergency Contact

Relationship

Phone

REFERRAL SOURCE

How did you hear about us?

Referred by (Name)

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PROVIDER & INSURANCE INFORMATION

PRIMARY CARE PROVIDER (PCP)

PCP Name

PCP Practice / Clinic

PCP Phone

PCP Fax

Last Visit Date

PCP Address

INSURANCE INFORMATION — PRIMARY

Insurance Company

Policy / Member ID

Group #

Policyholder Name

Policyholder DOB

Relation to Patient

INSURANCE INFORMATION — SECONDARY

Secondary Insurance Company

Policy / Member ID

Group #

Policyholder Name

Policyholder DOB

Relation to Patient

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Phone

Pharmacy Address

Preferred Mail-Order Pharmacy

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CURRENT MEDICATIONS

MEDICATIONS

List all current medications, dosages, and frequency:

Medication — Name	Dosage	Frequency	Prescriber
Medication 1 — Name			
Medication 2 — Name			
Medication 3 — Name			
Medication 4 — Name			
Medication 5 — Name			
Medication 6 — Name			
Medication 7 — Name			
Medication 8 — Name			

OVER-THE-COUNTER MEDICATIONS & SUPPLEMENTS

List any OTC medications, vitamins, or supplements you take regularly:

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ALLERGIES & MEDICAL HISTORY

ALLERGIES

Medication Allergies (list reactions)

Food Allergies

Other Allergies (latex, environmental, etc.)

MEDICAL CONDITIONS

List any current or past medical conditions / diagnoses:

SURGICAL HISTORY & HOSPITALIZATIONS

List any past surgeries or hospitalizations (include dates and reasons):

WOMEN'S HEALTH (IF APPLICABLE)

Currently Pregnant?

Due Date

Number of Pregnancies

Nursing?

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MENTAL HEALTH HISTORY

PREVIOUS MENTAL HEALTH TREATMENT

Have you previously received mental health treatment?

If yes, when?

Previous Therapist / Counselor Name

Previous Psychiatrist Name

Previous Treatment Facility

Dates of Treatment

Previous mental health diagnoses (e.g., depression, anxiety, PTSD, bipolar, etc.):

What treatments or therapies have you tried? (therapy, medication, hospitalization):

PSYCHIATRIC HOSPITALIZATIONS

Have you been psychiatrically hospitalized?

If yes, how many times?

Most recent date

Please describe the circumstances:

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SUBSTANCE USE HISTORY

CURRENT SUBSTANCE USE

Do you currently use alcohol?

How often?

Last use?

Do you currently use tobacco/nicotine?

How often?

Last use?

Do you use marijuana/cannabis?

How often?

Last use?

Do you use other recreational drugs?

If yes, specify:

Last use?

Do you use prescription drugs not prescribed to you?

If yes, specify:

SUBSTANCE ABUSE TREATMENT HISTORY

Have you received substance abuse treatment?

If yes, where?

Type of treatment (inpatient, outpatient, detox)

Dates of treatment

Are you currently in a recovery program?

Sobriety date (if applicable)

Additional substance use details or concerns:

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REASON FOR SEEKING SERVICES

PRESENTING CONCERNS

Please describe the primary reason you are seeking behavioral health services:

How long have you been experiencing these concerns?

Have symptoms worsened recently?

What triggered or worsened your current concerns?

PREVIOUS COPING STRATEGIES

What strategies have you used to cope? (exercise, journaling, meditation, etc.):

TREATMENT EXPECTATIONS

What are your goals for treatment?

Preferred type of therapy (individual, group, family, couples)

Preferred session frequency

Do you have a preference for therapist gender?

Any scheduling constraints?

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CURRENT SYMPTOM CHECKLIST

CURRENT SYMPTOMS — CHECK ALL THAT APPLY

Please check any symptoms you are currently experiencing:

- ☐ Sadness / Depressed mood
- ☐ Anxiety / Excessive worry
- ☐ Panic attacks
- ☐ Difficulty sleeping
- ☐ Loss of interest in activities
- ☐ Irritability / Anger
- ☐ Difficulty concentrating
- ☐ Fatigue / Low energy
- ☐ Changes in appetite / weight
- ☐ Social withdrawal
- ☐ Hopelessness
- ☐ Excessive guilt
- ☐ Mood swings
- ☐ Racing thoughts
- ☐ Flashbacks / Nightmares
- ☐ Compulsive behaviors
- ☐ Hallucinations (seeing/hearing)
- ☐ Paranoia / Suspiciousness
- ☐ Self-harm urges
- ☐ Suicidal thoughts

Additional symptom details or concerns:

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SOCIAL HISTORY

LIVING SITUATION & SUPPORT

Current Living Situation

Who do you live with?

Do you feel safe at home?

If no, please explain:

Support system (family, friends, community, faith)

EDUCATION & EMPLOYMENT

Highest Education Level

Current Employment Status

Occupation / School

Employer / School Name

MILITARY & LEGAL HISTORY

Military / Veteran Status

Branch & Dates of Service

Combat exposure?

Service-connected disability?

VA benefits?

Any current legal issues?

If yes, please describe:

Are you on probation or parole?

Probation/Parole officer name & phone

TRAUMA HISTORY

History of physical, emotional, or sexual abuse?

History of domestic violence?

If comfortable, please briefly describe:

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FAMILY MENTAL HEALTH HISTORY

FAMILY HISTORY — CHECK ALL THAT APPLY

Has anyone in your immediate family been diagnosed with or treated for the following?

- ☐ Depression
- ☐ Anxiety Disorders
- ☐ Bipolar Disorder
- ☐ Schizophrenia / Psychosis
- ☐ Substance Abuse / Addiction
- ☐ Suicide / Suicide Attempts
- ☐ ADHD
- ☐ PTSD
- ☐ Eating Disorders
- ☐ Autism Spectrum Disorder
- ☐ Personality Disorders
- ☐ Dementia / Alzheimer's
- ☐ Intellectual Disability
- ☐ Other

Please provide details (who in the family and condition):

FAMILY RELATIONSHIPS

Relationship with parents/guardians

Relationship with siblings

Relationship with partner/spouse

Number of children

Any current family conflicts or concerns:

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SAFETY SCREENING

SUICIDAL IDEATION SCREENING

Are you currently having thoughts of suicide?

Have you ever attempted suicide?

If yes, when was the most recent attempt?

Method used?

Do you currently have a plan?

Do you have access to means?

SELF-HARM SCREENING

Are you currently engaging in self-harm?

History of self-harm?

If yes, describe type and frequency:

HARM TO OTHERS

Are you having thoughts of harming others?

History of violent behavior?

Do you have access to firearms?

Are firearms safely stored?

SAFETY PLAN

Trusted person to call in crisis

Phone number

Coping strategies that have helped in the past:

National Suicide Prevention Lifeline: 988 | Crisis Text Line: Text HOME to 741741

TREATMENT GOALS & EXPECTATIONS

YOUR GOALS FOR TREATMENT

Please describe what you hope to achieve through treatment:

Goal 1

Goal 2

Goal 3

Goal 4

Goal 5

STRENGTHS & RESOURCES

What personal strengths, skills, or resources do you bring to treatment?

BARRIERS TO TREATMENT

Transportation concerns?

Childcare concerns?

Financial concerns?

Work/school schedule conflicts?

Other barriers or concerns about starting treatment:

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PHQ-9 PATIENT HEALTH QUESTIONNAIRE

DEPRESSION SCREENING

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all (0)	Several days (1)	More than half (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling/staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure	☐	☐	☐	☐
7. Trouble concentrating on things	☐	☐	☐	☐
8. Moving/speaking slowly, or being fidgety/restless	☐	☐	☐	☐
9. Thoughts of being better off dead or hurting yourself	☐	☐	☐	☐

PHQ-9 Total Score

____

FUNCTIONAL IMPAIRMENT

If you checked off any problems, how difficult have they made it for you?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Clinician notes / interpretation

____

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CONSENT FOR TREATMENT

INFORMED CONSENT

I, the undersigned, voluntarily consent to receive behavioral health assessment and treatment services provided by MOFDAPS Behavioral Health and Comprehensive. I understand that my treatment may include individual therapy, group therapy, psychiatric evaluation, psychological testing, medication management, and other therapeutic interventions as deemed appropriate.

NATURE OF SERVICES: Behavioral health treatment involves a collaborative process between the patient and provider. My provider will work with me to develop a treatment plan tailored to my needs. Approaches may include CBT, DBT, EMDR, motivational interviewing, psychoeducation, and other evidence-based modalities.

RISKS AND BENEFITS: While therapy is generally beneficial, there are potential risks including uncomfortable emotions (sadness, guilt, anxiety, anger), recollection of unpleasant events, and temporary worsening of symptoms. Benefits may include improved coping skills, reduced symptoms, better relationships, and enhanced quality of life.

I understand that I have the right to:

- Ask questions about my treatment plan, diagnosis, and procedures
- Refuse or withdraw from treatment at any time without penalty
- Receive information about the qualifications of my treatment provider
- Request a copy of my medical records in accordance with applicable law
- Request a referral to another provider at any time
- Be treated with dignity, respect, and consideration of cultural values
- File a complaint or grievance if I feel my rights have been violated

COMMUNICATION: I understand that my provider may contact me by phone, text, email, or mail for appointment reminders, follow-up, or treatment coordination. I will notify my provider if I wish to opt out of any form of communication.

CONFIDENTIALITY: All information shared during treatment is confidential and protected by federal and state law. Information will only be released with my written authorization, except as required or permitted by law.

BY SIGNING BELOW, I acknowledge that I have read and understand this Consent for Treatment. I voluntarily agree to participate in behavioral health services provided by MOFDAPS Behavioral Health and Comprehensive.

Patient Signature: ____________________ **Date** __________

Parent/Guardian Signature (if minor): ____________________ **Date** __________

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NOTICE OF PRIVACY PRACTICES (HIPAA)

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

MOFDAPS Behavioral Health and Comprehensive is required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of our legal duties and privacy practices.

YOUR PHI MAY BE USED OR DISCLOSED FOR:

- Treatment: To provide, coordinate, or manage your health care
- Payment: To obtain payment for health care services provided to you

DISCLOSURES REQUIRED OR PERMITTED BY LAW

Your PHI may also be disclosed without your authorization in the following circumstances:

- When required by federal, state, or local law
- For public health activities (disease reporting, FDA reporting)
- To report suspected abuse, neglect, or domestic violence
- For health oversight activities (audits, investigations, inspections)
- In response to a court order or subpoena
- To avert a serious threat to health or safety of you or others
- For workers' compensation purposes
- To coroners, funeral directors, and organ procurement organizations

YOUR RIGHTS REGARDING YOUR PHI

- Right to request restrictions on certain uses and disclosures
- Right to receive confidential communications by alternative means
- Right to inspect and copy your PHI (a reasonable fee may be charged)
- Right to request an amendment to your PHI
- Right to receive an accounting of disclosures of your PHI
- Right to obtain a paper copy of this notice upon request
- Right to file a complaint with MOFDAPS or the Secretary of HHS

CHANGES: MOFDAPS reserves the right to change this notice at any time.
COMPLAINTS: If you believe your privacy rights have been violated, file a complaint with our Privacy Officer or the U.S. Dept. of Health and Human Services. No retaliation.

BY SIGNING BELOW, I acknowledge that I have received and reviewed the Notice of Privacy Practices (HIPAA) of MOFDAPS Behavioral Health and Comprehensive. I understand how my protected health information may be used and disclosed.

Patient Signature:	**Date**

Parent/Guardian Signature:	**Date**

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TELEHEALTH CONSENT

INFORMED CONSENT FOR TELEHEALTH SERVICES

I hereby consent to participate in telehealth services provided by MOFDAPS Behavioral Health and Comprehensive. Telehealth involves the delivery of health care services using interactive audio, video, and/or other electronic communications technology.

NATURE OF TELEHEALTH:
- Sessions conducted via secure, HIPAA-compliant video/audio platforms
- Telehealth is not a substitute for in-person emergency services
- Technical difficulties may interrupt or terminate a session at any time
- My provider may determine that telehealth is not appropriate for my needs

BENEFITS:
- Increased access to care
- Reduced travel time and costs
- Scheduling flexibility
- Continuity of care during emergencies

RISKS AND LIMITATIONS:
- Technology may fail, interrupting the session
- Reduced ability to observe non-verbal cues vs. in-person visits
- Security risks despite encryption and HIPAA compliance
- Not all services or assessments can be performed via telehealth

MY RESPONSIBILITIES:
- I will ensure a private, quiet location for sessions
- I will inform my provider of my physical location at each session
- I will not record sessions without prior written consent
- I will have a reliable internet connection and appropriate device
- I understand I may revoke this consent at any time in writing

EMERGENCY: If I experience a medical or psychiatric emergency during a telehealth session, I will call 911 or go to the nearest emergency room. I will provide my provider with the address of my location at the start of each session for emergency purposes.

CONSENT TO RECEIVE TELEHEALTH SERVICES

By signing below, I confirm that I have read and understand the information above regarding telehealth services. I voluntarily consent to receive behavioral health services via telehealth (video, audio, or other electronic means) provided by MOFDAPS Behavioral Health and Comprehensive. I understand the benefits, risks, and [illegible]

I understand I may withdraw this consent at any time by notifying my provider in writing.

Patient Signature:

Date

Parent/Guardian Signature:

Date

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EMERGENCY PROTOCOLS & CRISIS PLAN

CRISIS RESOURCES

In the event of a mental health crisis, please follow these protocols:

IMMEDIATE DANGER (risk of harm to self or others):

- Call 911 or go to the nearest emergency room immediately
- National Suicide Prevention Lifeline: Call or text 988
- Crisis Text Line: Text HOME to 741741

URGENT & AFTER-HOURS PROTOCOLS

URGENT BUT NOT IMMEDIATELY LIFE-THREATENING:

- Contact MOFDAPS Behavioral Health and Comprehensive during business hours
- Leave a detailed message on the after-hours crisis line
- Contact your designated emergency contact person
- Go to your nearest urgent care or behavioral health walk-in clinic

AFTER-HOURS PROTOCOL:

- MOFDAPS does not provide 24/7 emergency services
- Messages left after hours will be returned the next business day
- For emergencies outside business hours, call 911 or go to the ER
- Do not wait for a callback if you are in immediate danger

PERSONAL SAFETY PLAN

Warning signs that a crisis may be developing:

Internal coping strategies (things I can do on my own):

People I can contact for help (name & phone):

Professionals or agencies I can contact:

Steps to make my environment safe:

One thing most important to me / reason for living:

BY SIGNING BELOW, I acknowledge that I have reviewed the emergency protocols and crisis plan above and understand how to access help in an emergency.

Patient Signature:

Date

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CONTROLLED SUBSTANCE AGREEMENT

PATIENT AGREEMENT FOR CONTROLLED PRESCRIPTIONS

I understand that my provider may prescribe controlled substances (stimulants, benzodiazepines, or other scheduled medications) as part of my treatment. I agree to the following:

1. ONE PROVIDER: I will receive controlled substance prescriptions from only one provider at MOFDAPS. I will not seek the same medications from other providers without informing my prescriber.

2. ONE PHARMACY: I will use only one pharmacy for filling controlled substance Rx. I will notify my provider before changing pharmacies.

3. REFILL POLICY: I understand controlled substances require an appointment for refills. No early refills will be provided. Lost, stolen, or damaged medications will not be replaced. I will request refills at least 7 business days before running out.

4. DRUG TESTING: I agree to random urine drug screens or blood tests as requested. Refusal to submit to testing may result in discontinuation of controlled Rx.

5. NO SHARING: I will not share, sell, or distribute my medications to anyone.

6. SAFE STORAGE: I will store my medications in a secure location to prevent theft, misuse, or accidental ingestion by children or others.

7. COMPLIANCE: I will take my medications only as prescribed. Any changes must be discussed with and approved by my provider.

8. MONITORING: My provider may check state prescription drug monitoring databases.

9. TERMINATION: Violation of this agreement may result in tapering and discontinuation of controlled substance prescriptions and/or discharge from the practice.

BY SIGNING BELOW, I acknowledge that I have read, understand, and agree to comply with all terms of this Controlled Substance Agreement.

Patient Signature:	**Date**

Prescriber Signature:	**Date**

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FINANCIAL RESPONSIBILITY & FEES

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

I understand that MOFDAPS, as a courtesy, sends a claim to my insurance company on my behalf. I understand it is my responsibility to be knowledgeable of my own insurance coverage, benefits, and eligibility.

I understand that it is my responsibility to make sure MOFDAPS is an approved provider with my insurance.

I understand that my co-pay / deductible is required at the time of service (in-person visits and Telehealth/TMH visits).

I understand that if I am unable to pay my copay, deductible, or payment on past due balances at the time of my appointment, my appointment will be cancelled and rescheduled to another date when I am able to pay.

I also understand that payment collected is an estimate of my portion due, and that I may have an additional balance due as indicated by my insurance company.

I understand that it is my responsibility to let MOFDAPS Behavioral Health and Comprehensive know of any changes to my address, phone number, name, or medical insurance.

I understand that I am responsible for the cost of any medications prescribed. If I cannot afford a medication, I can inform the medical provider and they will help find an affordable alternative.

I understand I will be charged a fee for a copy of my medical records.

BY SIGNING BELOW, I acknowledge that I have read and understand the Financial Responsibility Agreement above. I agree to all financial terms and conditions as stated.

Patient Signature: ______________________ **Date** __________

Parent/Guardian Signature (if minor): ______________________ **Date** __________

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DOCUMENT SUBMISSION & FINAL SIGNATURES

REQUIRED DOCUMENT UPLOADS

Please attach clear copies of the following documents.

1. GOVERNMENT-ISSUED PHOTO ID (Driver's License, State ID, Passport)

Attach Document Here

Adobe Acrobat: Tools > Comment > Attach File | JPG, PNG, PDF

2. INSURANCE CARD — FRONT

Attach Document Here

Adobe Acrobat: Tools > Comment > Attach File | JPG, PNG, PDF

3. INSURANCE CARD — BACK

Attach Document Here

Adobe Acrobat: Tools > Comment > Attach File | JPG, PNG, PDF

FINAL ATTESTATION & SIGNATURES

BY SIGNING BELOW, I certify that all information provided in this intake packet is accurate and complete to the best of my knowledge. I authorize MOFDAPS Behavioral Health and Comprehensive to use this information for my treatment.

Patient Signature: ____________________ **Date** __________

Parent/Guardian Signature (if minor): ____________________ **Date** __________

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