

Holistic Mental Health, PLLC Brief Intake Sheet

1. Patient Demographic Information:

Name of Patient: _____ Preferred Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Birthday: _____ SS#: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

2. Referral Information:

Name of Referring Provider (if any): _____ Phone Number: _____

If Self-Referred, please list how you learned of this practice: _____

3. Important Medical Contacts & Medication Information:

Primary Care Physician: _____ Phone Number: _____ Fax Number: _____

Pharmacy Name: _____ Phone Number: _____ Fax Number: _____

Current Medications with doses (Including Supplements): _____

Any Allergies to Medications (Include Reaction): _____

4. Treatment Questions:

1. What life events, stresses, or mental health issues have led you to seek treatment at this time?

2. What would you like to accomplish out of your time in treatment? _____
