St. Clair County Community Mental Health Authority

Intake Form

Name:	
Preferred Name:	
Date:	
Social Security #:	

Address:_____

Phone Number(s):_____

Automatic appointment reminders via text? ☐ Yes ☐No

E-mail Address:_____

Gender: ☐Male ☐Female ☐Other (please specify):_____

Parent/Guardian (if applicable):_____

Emergency Contact (Name/Phone):_____

Please check all mental health symptoms you are currently experiencing:

☐Suicidal or Homicidal thoughts ☐Depression ☐Anxiety
☐Panic Attacks ☐Aggression ☐Anger
☐Seeing or hearing thing others do not ☐Appetite changes ☐Sleep Changes

Please check all area you are currently experiencing difficulty function in:

☐Home Environment ☐Work ☐School
☐Legal issues ☐Personal relationships ☐Housing
☐Substance use

INSURANCE INFORMAITON:

Name of PRIMARY insurance:_____

- ID Number:_____
- Group Number: _____
- Phone Number: _____
- Subscriber Name:_____

Name of SECONDARY insurance:_____

- ID Number:_____
- Group Number: _____
- Phone Number: _____
- Subscriber Name:_____

FINANCIAL INFORMATION

Annual income (approximate): $_____ Dependents (including yourself): _____

PLEASE COMPLETE MEDICAL INFORMATION AND MEDICATION CHART ON THE NEXT PAGE

MEDICAL INFORMATION:

Primary Care Doctor: _____

Address: _____

Phone: _____

Date of last appointment: _____

Pharmacy (Name and Phone): _____

NAME OF MEDICAITON	DOSE (i.e., 10mg)	HOW OFTEN DO YOU TAKE IT?	PRESCRIBER	REASON FOR USE