

Healthy Minds Patient Registration Form

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Client Information		
Today's Date:	DOB:	SS#:
Last Name:	First Name:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ <input type="checkbox"/> Choose Not to Disclose		Sexual Orientation:
Cell phone:	Other phone: <input type="checkbox"/> H <input type="checkbox"/> W	
Street Address:		
City:	State:	Zip Code:
Email:		
Employer:	School:	
Primary Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Decline to Answer		
Ethnic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer		
Preferred Language of Client: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: Specify _____ of Legal Guardian: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: Specify _____ Interpreter Needed?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Check if this referral is for a previous Healthy Minds client <input type="checkbox"/> <input type="checkbox"/> N/A If so, please list the: Therapist _____ Psychiatrist: _____		
Marital Status of Legal Guardian: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Re-Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
If the referred client is a minor, please select your relation: <input type="checkbox"/> Biological-Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Person Legally Responsible <input type="checkbox"/> Other: _____ <input type="checkbox"/> Name: _____		
<i>Please note that the legal guardian is responsible for medical/medication decisions and is required to be present for all intakes. *If relation is other than the biological parent please bring documentation that you are legally responsible for this client (e.g. birth cert., adoption decree).*</i>		

RETURN TO:
 INTAKE.COORDINATOR@HEALTHYMINDSLV.COM
 (702) 622-2491

Referral Type:

Check all that apply: ☐ Substance Abuse (SUD) ☐ Therapy ☐ Psychiatry ☐ MRT
 ☐ Telehealth ☐ Group Therapy

Referral Source: ☐ DFS ☐ ADC ☐ FTDC ☐ MHC ☐ CODC ☐ VTC ☐ OPEN ☐ TAP ☐ JDC
☐ Other: _____

***If referred for psychiatric services, please provide the most recent psych evaluation if applicable*

Treatment History: Psychiatry

Has the client been treated by a Psychiatrist previously? ☐ Yes ☐ No *(Skip section if No)*

Psychiatrist Name:	Diagnosis:
--------------------	------------

Phone:	Email:
--------	--------

Current Psychotropic Medications *(Please list all current medications):*

Past Psychotropic Medications:

Treatment History: Mental Health

Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? ☐ Yes ☐ No

Have you ever felt you needed help with your emotional problems, or have you had people tell you should get help for your emotional problems? ☐ Yes ☐ No

Are you currently experiencing any suicidal or homicidal thoughts? (Plan, Means, Intent?) ☐ Yes ☐ No

Has the client been treated by a Therapist previously? ☐ Yes ☐ No *(Skip section if No)*

Therapist Name:	Diagnosis:
-----------------	------------

Phone:	Email:
--------	--------

Treatment History: Substance Use

Do you enjoy a drink now and then? ☐ Yes ☐ No

Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)
☐ Yes ☐ No

Have you used drugs other than those required for medical reasons? ☐ Yes ☐ No

Have you abused prescription drugs? ☐ Yes ☐ No

Are you currently experiencing any withdrawal symptoms, or do you expect to in the near future? ☐ Yes ☐ No

RETURN TO:
INTAKE.COORDINATOR@HEALTHYMINDSLV.COM
 (702) 622-2491

Has the client been treated for Substance Use Disorders previously? ☐ Yes ☐ No (*Skip section if No*)

Provider Name:

Treatment Components:

Phone:

Email:

Payment

☐ Insurance: _____ Provider Phone # (back of card): _____
 Member/Policy Number: _____ Group Number: _____
 Subscriber Name: _____ Subscriber DOB: _____
☐ No Insurance - Self Pay OR Other (*specify*) _____

Presenting Problem

What is the problem that led you to seek services from Healthy Minds?

RETURN TO:
 INTAKE.COORDINATOR@HEALTHYMINDSLV.COM
 (702) 622-2491