FRANNIE PEABODY CENTER
Comprehensive HIV & AIDS Services

Request for Behavior Health Services

Staff completing form:	Date:
Referral Source:	Release: ☐ Yes ☐ No

Name and pronouns:	**DOB:**
Address:	**Phone:**

Referral Questions	YES	NO	Comments
Ok to leave message on phone?	☐	☐	
Health insurance? What type?	☐	☐	

Presenting Issue:

Plan for follow-up (contact within two weeks):

Frannie Peabody Center Behavioral Health Intake Form

Please fill out this form and bring it to your first session along with a valid ID and your current insurance card. The information you provide here is protected as confidential information.

Name: _____

Name of parent/Guardian (if under 18 years): _____

Date of Birth: ____/____/_____ Age: _____ Current Gender Identity: _____

Marital Status:

- ☐ Never Married
- ☐ Married
- ☐ Domestic Partnership
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Please list your family composition _____

_____

_____

_____

Please list any children/age: _____

Insurance: _____Insurance ID#: _____

Referred by (if any): _____

Current grade/school level or highest level achieved _____

_____

_____

Contact Information:

Residential Address:

_____

_____

_____

Mailing Address (if different):

_____

_____

_____

Phone: _____ ☐ Home ☐ Work ☐ Cell

_____ ☐ Home ☐ Work ☐ Cell

Email: _____

May we leave a message on your home phone? ☐ Yes ☐ No ☐ N/A

May we leave a message on your cell phone? ☐ Yes ☐ No ☐ N/A

May we email you? ☐ Yes ☐ No ☐ N/A

May we send information to you in the mail? ☐ Yes ☐ No ☐ N/A

Anything else you'd like us to know about messaging? _____

_____

_____

Emergency contact name _____

Phone: _____

Relationship: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No

If yes, please list name of previous therapist and diagnosis: _____

_____

Are you currently taking any prescriptions or medications? ☐ Yes ☐ No

If yes, please list: _____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please list: _____

Please list any allergies or drug reactions _____

_____

General Health and Mental Health Information

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

If yes, how long have you been experiencing this? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No

If yes, when did you begin experiencing this? _____

_____

Are you currently experiencing any chronic pain? ☐ Yes ☐ No

If yes, please describe? _____

_____

How many days a week do you drink alcohol? _____

Do you engage in recreational drug use? ☐ Yes ☐ No If yes, how often? (please circle)

Daily Weekly Monthly Infrequently

What substances? _____

Are you currently in a romantic relationship? ☐ Yes ☐ No If yes, how long? _____

How would you describe your relationship? _____

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please check	List Family Member
Alcohol/Substance Abuse	☐ Yes No ☐	
Anxiety	☐ Yes No ☐	
Depression	☐ Yes No ☐	
Domestic Violence	☐ Yes No ☐	
Eating Disorders	☐ Yes No ☐	
Obesity	☐ Yes No ☐	
Obsessive Compulsive Behavior	☐ Yes No ☐	
Schizophrenia	☐ Yes No ☐	
Suicide Attempts	☐ Yes No ☐	

Additional Information

Are you currently employed? ☐ Yes ☐ No If yes, what is your current employment situation?

_____
_____
_____

Do you enjoy work? ☐ Yes ☐ No

Is there anything stressfull about your current work? ☐ Yes ☐ No

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No If yes, please describe your faith or belief:

_____
_____
_____

What do you consider to be some of your strengths?

_____
_____
_____

What do you consider to be some of your challenges?

_____
_____
_____

What would you like to accomplish out of your time in therapy?

_____
_____
_____

Frannie Peabody Center can now send automated text and email appointment reminders. Please review the samples below and indicate your preference. You may opt out of this service at any time.

Sample text/SMS message:

> *Reminder: Appt with Keith Riley, Monday, 6/1 @1pm EDT.*
> *Call (207) 774-6877 for assistance. To stop reminders, reply "STOP", otherwise do not respond.*

Text/SMS and voice reminders will be sent from (215) 543-7686. Standard text message rates apply.

Sample Email reminder:

> ***From: Appointment Reminders <appointmentreminders@therapyportal.com>***
>
> ***Sent: Thursday, May 30, 2019 9:01 AM***
> ***Appointment Reminder***
>
> *[Full Name],*
>
> *This is a reminder that you have an appointment with Keith Riley on **Monday June 2nd** at **9:00AM EDT**.*
>
> *Frannie Peabody Center*
>
> *30 Danforth Street Suite 311*
> *Portland, ME, 04101-4574*
>
> *(207) 774-6877*
>
> *Directions*
>
> *Please contact our office with any questions or changes.*
>
> *Email by TherapyPortal.com on behalf of Frannie Peabody Center*
> *Reminder settings or unsubscribe*

My preference for appointment reminders is as follows:

☐SMS/Text only ☐Email only ☐ text and email ☐ None

_____	_____	_____
Print Name	Signature	Date