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Behavioral Health Intake Form

Last Name _____ First Name _____ Male Female

Date of Birth (DOB) _____ Social Security Number (SSN) _____ Occupation _____

Marital Status: Single Domestic Partner Married Divorced Widowed

Partner Name _____ Age _____ Occupation _____

Please list any family members living with you and their age, if you need more space, use back side of paper:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Immediate family members not in living at home (adult children, children living with another parent/guardian, etc)

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Living Situation Rent Own Homeless Other _____

Please provide your contact and insurance information, if not previously provided

Address _____ City _____ State _____ Zip _____

Please check preferred Home Ph. _____ Cell _____ OK to leave a message? Yes No

PRIMARY Medical Insurance Company (if uninsured, write "NONE") _____

Name of policy holder _____ Relationship to patient: Self Parent Spouse Other

Policy holder's address (if different than above) _____ DOB _____


Insurance ID/Policy # _____ Group # _____

Medical History

Hospitalizations and Surgeries (please list event, type, reason and date for each, indicate if more than will fit here):

History of head trauma and/or seizure Yes No

Physician _____ Clinic _____ Phone _____

(over please) 

Chief Complaint _____

How long has this been a problem? _____ Seeing other therapist/counselor Yes No

Previous Treatment Inpatient Outpatient AODA inpatient AODA outpatient Other _____

Any allergies? Yes No If yes, please list _____

Current medications (purpose, dose) _____

Military service? Yes No If yes, Please describe: _____

Do you smoke? Yes No If yes, _____ packs/day for _____ years Never smoked Quit _____ years ago

Are you exposed to second hand smoke? Yes No Drink alcohol? Yes No If yes, _____ drinks/day

Do you use Tobacco? Yes No If yes, _____ amt/day Never

How much caffeine in a day? _____ cups of _____ How much water/day? _____

How much soda, carbonated beverages or sports drinks in a day? _____

Ever used marijuana, cocaine, meth or other drugs not prescribed by a doctor? Yes No

Currently use any of these substances? Yes No

Blood transfusions? Yes No Tattoos? Yes No

Use seat belts? Yes No Weight: Stable Decreased Increased

Please describe: Diet/Nutrition _____

Exercise _____

Sleep _____

With 10 being the highest functioning and 1 being the least, how to you rank your current functioning? _____