Live Well
Behavioral Health Services
EMPOWERED • PROUD • HEALTHY • WHOLE

Mental Health Services Patient Information Form

Referral Source (if applicable) Date of Referral: _____
Referring Provider Name _____ Agency _____ Contact Phone # _____
Reason for Referral _____
_____

Patient Demographic Information
Patient's Name _____ Medical Record Number (if applicable) _____
Address (incl. zip code) _____
Home Phone # _____ Cell Phone # _____ DOB __/__/____
Sex _____ Race _____ Marital Status ___ Single _ Married _ Divorced _ Widowed
Insurance Company: _____Member # _____
Please copy the front and back of your insurance card and attach the copy with this form.
Emergency Contact Name _____ Relationship to Patient _____ Contact # _____
Primary Care Physician _____ Clinic Name _____ Phone _____
Current Type of Housing (e.g., group home): _____ Veteran _ Yes _ No
Preference for Visits? _____Telehealth _____In-person

Diagnosis (*list confirmed if known, if not list suspected*)
Primary Psychiatric Diagnosis _____
Secondary Psychiatric Diagnoses (including substance abuse) _____
Relevant Medical Diagnoses _____
Relevant Social Factors _____

Past Psychiatric History (hx) and Treatment (*please check appropriately*)
Former patient in clinic referred to? _ No _ Yes, details _____
Hx of violence? _ No _ Yes, details _____
Hx of suicide attempts? _ No _ Yes, details _____
Hx of psychiatric hospitalizations? _ No _ Yes, details _____
Previous symptoms and diagnoses _____

Current Psychiatric Treatment & History
Current Symptoms _____
Current suicidal / homicidal thoughts? _ No, _ Yes, details _____
Does patient have a current outpatient mental health provider? _ No _ Yes, details _____
*Reason not returning*_____
Additional Information _____
_____
Current Psychiatric Medications (***name & dose***, attach list if preferred)
_____
_____
_____

Signature _____ Date / Time _____