Mental Health New Patient Screener

Patient Information

Patient Name:	DOB:	SSN:
Address:	City:	Zip:
POA/Guardian:	Phone:	Email:

Insurance Information

Primary Insurance:		Secondary Insurance:	
ID #:	Group #:	ID #:	Group #:
Policy Holder:		Policy Holder:	

Mental Health History

Inpatient Stay		Outpatient Treatment	
Date to/from:	Location:	Date to/from:	Location:
Reason:		Reason:	
Inpatient Stay		Outpatient Treatment	
Date to/from:	Location:	Date to/from:	Location:
Reason:		Reason:	

Self-Harm

Have you ever thought about or attempted suicide? Y N	Have you ever thought about or acted out self-harm? Y N
Any Details:	

Reason for seeking treatment:

Mental Health Diagnoses

Diagnosis	When Diagnosed	Who Diagnosed

Medical Diagnoses

Diagnosis	When Diagnosed	Who Diagnosed

Current Medications

Medication	Dosage	Who Prescribes

Additional

PCP:	Any specialists?	
Pregnant? Y N	How far along?	OBGYN?
Referred by:	Appropriate for Rapha?	
Urgent? Y N	Why?	
Verbal ROIs for:		

Intake Specialist Signature Date

Any Additional Info: