SOJOURN CENTER
MAKING TODAY BETTER. HOPE RESTORED.
LIFE RENEWED.

SOJOURN CENTER PATIENT CONTACT SHEET

For Clinic Use Only

Patient #_____ MR #_____ Admit Date:_____

PATIENT
NAME _____

ADDRESS _____
_____
City, State ZIP

PATIENT LIVES WITH:
_____

BIRTH DATE _____ AGE _____ SEX_____
RACE _____ PATIENT SS#_____
Guarantor SS#_____

GUARANTOR(S) NAME _____
ADDRESS _____
_____
HOME #_____WORK _____
CELL#_____

FATHER'S NAME _____
HOME #_____WORK _____
CELL#_____

FATHER'S NAME _____
HOME #_____WORK _____
CELL#_____

ALTERNATE EMERGENCY CONTACT INFORMATION:

Name: _____ Phone: _____ Relationship: _____

WHO REFERRED YOU TO SOJOURN CENTER?

❑ Permission to Contact? _____ Initials _____

PREFERRED PHARMACY
_____
PHONE _____

REFERRING/INVOLVED THERAPIST (CIRCLE ONE)
NAME _____

PHONE _____ FAX _____

❑ Permission to Contact? _____ Initials _____

REFERRING/INVOLVED PSYCHIATRIST (CIRCLE ONE)
NAME _____

PHONE _____ FAX _____

❑ Permission to Contact? _____ Initials _____

FAMILY THERAPY APPOINTMENT:

DATE_____TIME_____ THERAPIST: _____

STAFF USE ONLY

PHYSICIAN_____ PROGRAM _____
Axis I _____
_____

Axis II _____

Axis III _____
_____

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INTAKE FORM

Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ❑ Male ❑ Female

Marital Status:
❑ Never Married ❑ Domestic Partnership ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Please list any children/age: _____

_____
Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Home Ph: ( ) _____
May we leave a message? □ Yes □ No

Cell/Other Ph: ( )_____

May we leave a message? ❑ Yes ❑ No

E-mail: _____
May we email you? ❑ Yes ❑ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

*How did you hear about us?_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

❑ No

❑ Yes, previous therapist/practitioner:

_____

Previous/Current Diagnosis:_____

Are you currently or have you ever taken any psychotropic medications? If yes, please list:

Past Medications	Doseage/Times	Prescribed By	Taken as Prescribed?
Current Medications	**Doseage/Times**	**Prescribed By**	**Taken as Prescribed?**

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. 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:

_____

_____

2. 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:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in?_____

_____

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

_____

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

❑ No
❑ Yes
If yes, for approximately how long?

_____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

❑ No
❑ Yes
If yes, when did you begin experiencing this?

_____

7. Are you currently experiencing any chronic pain?

❑ No
❑ Yes
If yes, please describe:

_____

8. Do you drink alcohol more than once a week?

❑ No
❑ Yes
If yes, how often?_____ Do you binge drink?_____

9. How often do you engage recreational drug use?

❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently ❑ Never

10. Are you currently in a romantic relationship?

❑ No
❑ Yes
If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. 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 Circle and List Family Member(s)

Alcohol/Substance Abuse yes/no _____

Anxiety yes/no _____

Abuse or Neglect yes/no_____

Bipolar Disorder yes/no_____

Depression yes/no _____

Domestic Violence yes/no _____

Eating Disorders yes/no_____

Schizophrenia yes/no _____

Suicide Attempts yes/no _____

ADDITIONAL INFORMATION:

1. Status: ❑ F/T Employed ❑ P/T Employed ❑ F/T Student ❑ P/T Student *(check one)*

Employer:_____

School:_____

2. Do you consider yourself to be spiritual or religious?

❑ No ❑ Yes If yes, describe your faith or belief:

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

5. What would you like to accomplish during your time in therapy?

_____

_____

_____

_____

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Insurance Information

Patient Name: _____ Date: _____

S.S. #: _____ D.O.B:_____

Name of Insurance Company:_____

Policy ID #_____ Group ID:_____

Subscriber Name:_____ Subscriber DOB:_____

Relationship to Patient:_____

*Any other (secondary) insurance coverage?:_____
If yes, please list:

Policy Identification #_____ Group ID:_____

Subscriber Name:_____ Subscriber DOB:_____

Relationship to Patient:_____

Assignment Of Benefits

I authorize the release of any medical or other information necessary to process this claim to my insurance company. This may also include case managers with your insurance company.
I also authorize payment of medical benefits to Sojourn Center, PLLC, for services rendered to me.

_____ _____
Signature Date

SOJOURN CENTER

PHYSICAL HEALTH AND DRUG SCREENING

Primary Care Physician Name _____ **Telephone #**_____

Date of last physical exam: _____

ALLERGIES (allergic or adverse reactions to any food, medication, drug, or other substances?): **Yes** **No**
If yes, describe substance and type of reaction:

IMMUNIZATION STATUS: (Check all that have been completed)
___DPT and/or Tetanus ___Rubella (German Measles) ___Mumps ___Oral Polio ___Measles

DRUG HISTORY **List any medications client is currently taking**

MEDICATION	STRENGTH	TIMES TAKEN	DATE BEING TAKEN	SIDE EFFECTS

Relevant drug or medication history of family members:

_____

PHYSICAL HEALTH & HISTORY Check current and past problems the client may have had with the following areas:

AREA OF PHYSICAL HEALTH	NO	PAST	CURRENT	IF CURRENT OR PAST, DESCRIBE
Vision (eyes sight, glasses, contacts)				
Hearing (ears hearing impairment, aid)				
Cardiac history, heart structural problems, passing out episodes				
Nervous system (seizure, numbness, tingling)				
Muscles/Bones (breaks, sprains, etc.)				
Digestive (stomach, bowels, etc.)				
Urinary (kidneys, bladder, etc.)				
Reproductive (STD, Rubella, pregnancy)				
Respiratory (lungs, TB, symptoms)				
Hepatic (liver, hepatitis A, B, & C)				
Lymphatic (swollen glands)				
Integument (hair, skin, rash, lesions, etc.)				
Immune (HIV, frequent colds, coughs, infectious)				
Infectious agent (Staph, Mono, blood-borne)				

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PHYSICAL HEALTH AND DRUG SCREENING

List hospitalizations, surgeries or chronic illnesses (please attach additional sheets for more space if needed)

DATES	REASON	LENGTH OF STAY

Screening Health Evaluation – Statement of Purpose: *I understand that a limited evaluation of my general health will be performed. I also understand that this evaluation in no way is intended to provide a comprehensive review for the purpose of establishing previously undiagnosed disease. Specifically, the purpose of the evaluation is to determine the propriety and adequacy of my fitness for Outpatient as opposed to Inpatient Based Management. I will then neither now, nor in the future, hold Sojourn Center responsible for the diagnosis or disease on the basis of this limited health evaluation.*

_____ _____

Patient Signature Date

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Assessment Service Disclosure Statement and Consent to Assessment

The Sojourn Center lawfully and ethically operates an assessment service by a licensed mental health professional. The clinician may refer appropriate patients for outpatient treatment or to a physician for further evaluation or recommend admission to the facility.
Before referring and/or assessing a person, the following disclosures must be made to each person seeking treatment or assessment:

- Sojourn Center is not obligated to provide an assessment by a physician unless deemed necessary by the assessment clinician. Physician assessments are billable services.
- This assessment is voluntary and the client is free to choose whether they want to pursue further treatment.
- The assessment clinician is an employee of Sojourn Center.
- The assessment is confidential unless the client gives permission in writing to release information.
- Specific mental health professionals the client may be referred to are licensed and meet clinical and ethical standards of the facility.
- Financial reimbursements are never given or received by Sojourn Center based on referrals.

I certify that I have read and fully understand the above consent for assessment. I agree to absolve Sojourn Center and its staff rendering the treatment(s) from any liability.

I certify that I am: _____ Patient _____ Biological parent with authority to consent for treatment
_____ Adoptive Parent _____ Foster Parent _____ Legal Guardian (papers are required)

IN CASES INVOLVING DIVORCE/ADOPTION OR FOSTER PARENT ARRANGEMENT PAPERS MUST BE PRESENTED PRIOR TO CONSENT FOR ASSESSMENT.

❑ I Consent to Assessment ❑ I Refuse Assessment

_____ _____
Individual Consenting or Refusing Assessment or Medical Screening Date

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness/Clinician Date