Seacoast Mental Health Center
1145 Sagamore Avenue Portsmouth NH 03801
30 Magnolia Lane Exeter NH 03833

Adult Intake Information

Please fill out this form as best you can and bring it with you when you come to your intake appointment.

First Name: _____ Middle Name: _____ Last Name: _____ Suffix: _____

Previous (maiden) Name(s): _____ Date of Birth: _____

Preferred Name: _____ Last 4 digits SSN: _____

Physical Address: (Street, Town, State, Zip) _____

Mailing Address: (if applicable) _____

Phone: H _____ W _____ C _____

Email: _____

What is the best way to contact you? _____ Okay to leave message? ☐ Yes ☐ No

Who referred you to us? _____

Income information is collected for statistical purposes only and is used in reporting for Federal Grants	# of people in your household: _____	Total annual income: $ _____

Identifying Information:

Sex Assigned at Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ FTM ☐ MTF ☐ Gender Queer ☐ prefer not to disclose ☐ Something else ☐ Unsure/don't know

Pronouns: ☐ Non-binary ☐ Female ☐ Male

Sexual Orientation: ☐ Straight/heterosexual ☐ Gay/lesbian/homosexual ☐ Bisexual ☐ Unsure/questioning ☐ Choose not to disclose ☐ Other: _____

Marital Status: ☐ Single/never married ☐ Married/partnered ☐ Separated ☐ Divorced ☐ Widowed

What is your preferred spoken language? ☐ English ☐ Other:

What is your preferred written language? ☐ English ☐ Other:

Are you Hispanic or Latino/Latina? ☐ Yes ☐ No If yes, specify: ☐ Mexican, Mexican/American ☐ Puerto Rican ☐ Cuban ☐ another Hispanic, Latino/Latina or Spanish origin

Race: (if multiracial, check all that apply)

☐ American Indian or Native Alaskan
☐ Black or African American
☐ White/Caucasian
☐ Filipino
☐ Guamanian or Chamorro
☐ Prefer not to answer
☐ Indian
☐ Chinese
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Korean
☐ Samoan
☐ Japanese
☐ Vietnamese
☐ Other Asian

Current Living Situation:	☐ Private residence without in-home support ☐ Private residence with in-home support ☐ Homeless ☐ New Hampshire Hospital (institutional setting) ☐ Designated Receiving Facility (DRF) ☐ Group home (up to 12-hour care) ☐ Transitional housing ☐ Nursing home ☐ 811- Mainstream housing option	☐ Residential Care (24-hour care) ☐ Crisis Residence ☐ Supported Housing, living alone ☐ Supported Housing, living with others ☐ Jail ☐ Prison ☐ Bridge Housing Option ☐ 811 Project – Rental assistance option ☐ Other: _____
Employment:	☐ Employed full time ☐ Employed part time ☐ Unemployed (looking for work)	☐ Seeking employment ☐ Disabled, not in the workforce ☐ Retired
Your legal status:	☐ No legal involvement/no mandate to treatment ☐ Conditional Discharge ☐ Legal Guardian (☐ Person ☐ Estate)	☐ Court ordered to treatment/MH Court ☐ Probation/Parole ☐ Other: _____

Guardian Contact Information: Name: _____

Address: Phone:

Do you have a Representative Payee? Name: _____

Address: _____ Phone: _____

Have you or anyone in your family served in the military? (check all that apply) ☐ None ☐ Self ☐ Parent(s) ☐ Spouse ☐ Sibling(s) ☐ Child(ren)

<u>If ***you*** served, please complete the following section:</u>

Military service: ☐ Past ☐ Current Branch: _____

Were you in combat? ☐ Yes ☐ No Where? _____

Do you have disability through the VA? ☐ No ☐ Yes Due to: _____

Spouse/Partner: ☐ **Not applicable**

Name: _____ Age: _____

Do you have children? ☐ Yes ☐ No How many? _____ Age(s): _____

Child custody: ☐ Joint Custody ☐ Sole Custody ☐ Parental Rights Terminated ☐ Other: _____

Who can we contact in case of an emergency?

Name: _____ Phone: _____ Relationship: _____

Address:

Why are you seeking services at this time?

Briefly tell us about any history of psychiatric hospitalizations:

Briefly tell us about any previous outpatient mental health treatment:

Briefly tell us about any previous treatment you have had for substance use:

Family History of Mental Illness:

Family member	Diagnosis (if known)	Treatment?
☐ Mother		
☐ Father		
☐ Sibling(s)		
☐ Other: _____		

Family History of Substance Use:

Family member	Substances used (if known)	Treatment?
☐ Mother		
☐ Father		
☐ Sibling(s)		
☐ Other: _____		

Safety Assessment:

Do you, or anyone in your household own/carry a firearm or other weapon? ☐ Yes ☐ No

Do you have access to firearms or other weapons from another source? ☐ Yes ☐ No

If yes, what type of safety precautions are in place? _____

Religious/Spiritual beliefs: _____

Practicing: ☐ None ☐ Infrequently ☐ Frequently

What is the role of Faith in your life? _____

Client signature	Date	Staff signature	Date