

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> FTM <input type="checkbox"/> MTF	<input type="checkbox"/> Gender Queer <input type="checkbox"/> prefer not to disclose <input type="checkbox"/> Something else <input type="checkbox"/> Unsure/don't know	Pronouns: _____	<input type="checkbox"/> Non-binary <input type="checkbox"/> Female <input type="checkbox"/> Male
Sexual Orientation: <input type="checkbox"/> Straight/heterosexual <input type="checkbox"/> Gay/lesbian/homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Unsure/questioning <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other: _____					
Marital Status: <input type="checkbox"/> Single/never married <input type="checkbox"/> Married/partnered <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
What is your preferred spoken language? <input type="checkbox"/> English <input type="checkbox"/> Other: _____					
What is your preferred written language? <input type="checkbox"/> English <input type="checkbox"/> Other: _____					
Are you Hispanic or Latino/Latina? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____					
<input type="checkbox"/> Mexican, Mexican/American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> another Hispanic, Latino/Latina or Spanish origin					
Race: (if multiracial, check all that apply)					
<input type="checkbox"/> American Indian or Native Alaskan <input type="checkbox"/> Black or African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Prefer not to answer		<input type="checkbox"/> Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander		<input type="checkbox"/> Korean <input type="checkbox"/> Samoan <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	

Current Living Situation:	<input type="checkbox"/> Private residence without in-home support	<input type="checkbox"/> Residential Care (24-hour care)
	<input type="checkbox"/> Private residence with in-home support	<input type="checkbox"/> Crisis Residence
	<input type="checkbox"/> Homeless	<input type="checkbox"/> Supported Housing, living alone
	<input type="checkbox"/> New Hampshire Hospital (institutional setting)	<input type="checkbox"/> Supported Housing, living with others
	<input type="checkbox"/> Designated Receiving Facility (DRF)	<input type="checkbox"/> Jail
	<input type="checkbox"/> Group home (up to 12-hour care)	<input type="checkbox"/> Prison
	<input type="checkbox"/> Transitional housing	<input type="checkbox"/> Bridge Housing Option
	<input type="checkbox"/> Nursing home	<input type="checkbox"/> 811 Project – Rental assistance option
	<input type="checkbox"/> 811- Mainstream housing option	<input type="checkbox"/> Other: _____

Employment:	<input type="checkbox"/> Employed full time	<input type="checkbox"/> Seeking employment
	<input type="checkbox"/> Employed part time	<input type="checkbox"/> Disabled, not in the workforce
	<input type="checkbox"/> Unemployed (looking for work)	<input type="checkbox"/> Retired

Education: Current or highest grade completed: _____

Your legal status:	<input type="checkbox"/> No legal involvement/no mandate to treatment	<input type="checkbox"/> Court ordered to treatment/MH Court
	<input type="checkbox"/> Conditional Discharge	<input type="checkbox"/> Probation/Parole
	<input type="checkbox"/> Legal Guardian (<input type="checkbox"/> Person <input type="checkbox"/> Estate)	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)

If you served, please complete the following section:

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:

<u>Family member</u>	<u>Diagnosis (if known)</u>	<u>Treatment?</u>
<input type="checkbox"/> Mother	_____	_____
<input type="checkbox"/> Father	_____	_____
<input type="checkbox"/> Sibling(s)	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

Family History of Substance Use:

<u>Family member</u>	<u>Substances used (if known)</u>	<u>Treatment?</u>
<input type="checkbox"/> Mother	_____	_____
<input type="checkbox"/> Father	_____	_____
<input type="checkbox"/> Sibling(s)	_____	_____
<input type="checkbox"/> 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