Packet for Intake

Date: Client Name: ID#:

Welcome to the Ecker Center for Mental Health. The first step in treatment is completing Intake. Once Intake is completed, a Mental Health Assessment will be conducted to gather information along with your input to assist staff with determining services that you may need at Ecker. **Please fill-out this form in its entirety.**

DEMOGRAPHIC INFO

Guardian Status: ☐ Own Guardian ☐ Biological Parent ☐ Adoptive Parent ☐ Youth In Care

☐ Other Court Appointed ☐ Other:_____

Guardian's Information: Name: _____ Relationship: _____

Phone Number: _____ Address: _____ City:_____

State: _____ Zip Code: _____ County: _____

Emergency Contact Info: ☐ Check if same as Guardian

Name: _____ Relationship: _____

Phone Number: _____ Address: _____ City:_____

State: _____ Zip Code: _____

Members of the Household:

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Other Notable Relationships:

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Established Supports (i.e. Physician, School/Daycare, Counselor/Therapist, Child Welfare Worker, ISC/PAS Agent, Probation Officer, etc.)

Name:_____ Relationship:_____
Phone: _____ Email:_____

Name:_____ Relationship:_____
Phone: _____ Email:_____

Name:_____ Relationship:_____
Phone: _____ Email:_____

Name:_____ Relationship:_____
Phone: _____ Email:_____

Packet for Intake

Date: Client Name: ID#:

TREATMENT

What would you like to accomplish from treatment? _____

_____

_____

What services are being sought out for treatment? (**Please check all that apply**)

☐ Psychiatry/Nursing ☐ Individual Therapy ☐ Case Management ☐ MRT Group

☐ PSR Core Program ☐ CST (Community Support Team) ☐ Crisis Residential

☐ Family Counseling ☐ Other (explain):_____

How were you referred to the Ecker Center for Mental Health? (**Please check all that apply**)

____ Self _____ Hospital ____ School (teacher/counselor) ____ Shelter: _____

____ Family _____ Friend _____ DHS ____ Clergy ____DCFS _____Medical Doctor

____ Renz Center _____Police Dept: ____ _____Insurance Company ____ Court: _____

Other (explain):_____

Have there been any environmental changes recently that have made you seek out treatment?
(Please check all that apply)

☐ Loss of home ☐ Divorce/Separation ☐ Legal Problems ☐ Relocation

☐ Loss of a loved one ☐ Loss of insurance ☐ Problems at school/work

☐ Unable to cut down on alcohol/drugs ☐ Other (explain): _____

What would you like to accomplish from treatment?

Please check the level of difficulty with the following symptoms or behaviors:

Anxiety: (Anxious mood, worry, excessively, panic, shortness of breath, palpitations, sweating)

☐ None	☐ Minor difficulty	☐ More than a little difficulty	☐ Moderate difficulty	☐ Quite a lot of difficulty	☐ Serious difficulty

Manic - like behavior: (Irritability, paranoia, impulsivity, decreased need for sleep, racing thoughts)

☐ None	☐ Minor difficulty	☐ More than a little difficulty	☐ Moderate difficulty	☐ Quite a lot of difficulty	☐ Serious difficulty

Depressive- like behavior: (Depressed mood, tearfulness, crying, fatigue/lack of energy, isolation)

☐ None	☐ Minor difficulty	☐ More than a little difficulty	☐ Moderate difficulty	☐ Quite a lot of difficulty	☐ Serious difficulty

Antisocial behavior: (long-term pattern of manipulating, exploiting, or violating the rights of others)

☐ None	☐ Minor difficulty	☐ More than a little difficulty	☐ Moderate difficulty	☐ Quite a lot of difficulty	☐ Serious difficulty

Hallucination: (where someone sees, hears, smells, tastes or feels things that don't exist outside their mind)

☐ None	☐ Minor difficulty	☐ More than a little difficulty	☐ Moderate difficulty	☐ Quite a lot of difficulty	☐ Serious difficulty

Delusions: (A persistent false psychotic belief regarding the self or persons or objects outside the self that is maintained despite indisputable evidence to the contrary "someone is out to hurt you"

☐ None	☐ Minor difficulty	☐ More than a little difficulty	☐ Moderate difficulty	☐ Quite a lot of difficulty	☐ Serious difficulty

Current/recent suicidal thoughts? _____ yes _____ no
Current/recent homicidal thoughts? _____ yes _____ no
Current/recent self-injurious behaviors? _____ yes _____ no

PHYSICAL HEALTH

How would you rate current health status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do any of the following medical conditions apply **(Please check appropriate box)**:

	YES	NO	DATE		YES	NO	DATE
Acne (severe)				Fibromyalgia			
Arthritis				Gastric or Intestinal Problems			
Asthma				Head Trauma/Injury			
Autism/Aspergers				Hearing Problems			
Cancer				Hepatitis			
Cardiovascular Disease				High Blood Pressure			
Cerebral Palsy				Kidney Disease			
Chronic ear infections				Liver Disease			
Chronic Insomnia				Migraines			
Chronic Pain				Speech Problems			
Diabetes				Thyroid Disease			
Eczema (severe)				Tuberculosis			
Emphysema/COPD				Urinary/Bladder Infections			
Epilepsy/Seizures				Other:			

Date: Client Name: ID#:

NUTRITION

Please circle the best answer:	(0)	(1)	(2)
How many meals do you eat per day?	3 or more	2 meals	Less than 2
How many fruits, vegetables, or milk products do you eat per day?	many	few	none
On average, how many alcoholic drinks do you have per day?	none	1-2	3 or more
Do you have tooth or mouth problems that make it hard to eat?	no	------	yes
How many prescription medications do you take per day?	none	1-2	3 or more
Has a medical condition or illness changed the way you eat?	no	yes	------
Have you lost or gained 10 pounds or more in the last 4 months without wanting to?	no	------	yes
Do you have a history of an eating disorder?	no	------	yes

Do you have difficulty with: ☐ Swallowing ☐ Chewing ☐ Indigestion ☐ Heartburn
☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ No difficulty with any of these

OFFICE USE ONLY:

Nutritional Risk Score = _____
If client scores 9 points or more, reports difficulty with eating or digestion, or reports nutritional issues, please refer to Primary Care Physician or local FQHC.

Client was referred to ☐ Primary Care Physician ☐ local FQHC ☐ Other ☐ None needed

Packet for Intake
Date: Client Name: ID#:

CONSUMER CRISIS CARE PLAN

Emergency Contact:	Phone #	Primary Physician: Dr.	Phone #
Support Individual:	Phone #	Pharmacy:	Phone #
Psychiatric Emergency Program Sherman Hospital	847-888-2211	Insurance: Insurance #	Phone #
Psychiatrist: Dr. Ecker Center for Mental Health	847-695-0484	Insurance: Insurance #	Phone #

Please list any medications (prescriptions, over-the-counter, herbal) or vitamins that are **currently** prescribed:

MEDICATION	PRESCRIBER	DOSE	START DATE	END DATE	REASON

Any known adverse reactions or allergies to drugs or food? ☐ Yes ☐ No **If yes, please describe:**

ALLERGY	TYPE OF REACTION

To be completed with staff:

ACKNOWLEDGEMENT OF CRISIS CARE PLAN

1. I acknowledge with staff the purpose and development of a crisis care plan.
2. I accept a formatted crisis care plan to be utilized in the development of an individualized crisis care plan.

Client Signature: _____ Date: _____
Parent/Guardian: _____ Date: _____
Staff Signature: _____ Date: _____

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION (PHI) BY ALTERNATE MEANS

Current Mailing Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the Ecker Center for Mental Health to leave a voicemail or message as described below. I understand that this voicemail or message may contain my protected health information.

(Please check all that apply)

☐ May leave detailed message on voicemail:
Home #: _____
Cell #: _____
Work #: _____
Other #: _____

☐ May leave detailed information with: _____ _____
Name Relationship

☐ Do not leave any messages. Only speak with me directly at the following phone #:
Home #: _____
Cell #: _____
Work #: _____
Other #: _____

Please note that "detailed information" may include information about appointments, insurance and billing, referrals to other clinicians, and/or lab tests. If a selection is not made above, Ecker Center staff will leave voicemails or messages stating only their name, the service provider, appointment information (date and time), and a call-back number. If the phone number is not active, information may be mailed to the address listed above.

To be completed with staff:

AUTHORIZATION TO LEAVE PHI BY ALTERNATE MEANS

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify Ecker Center if I would like to change one or more of the telephone numbers listed above.

_____ _____ _____ _____
Signature of Client Date Witness Signature Date

(Clients 12 to 17 of age must sign in addition to the Parent or Legal Representative. If signed by the Legal Representative, indicate the relationship to the client or authority to act for the client.)

_____ _____ Relationship: _____
Signature of Parent or Legal Representative Date