5060 Allatoona GTWY,
Acworth, GA 30101
(470) 507-3067
info@healthstarbehavioral.com

HEALTHSTAR BEHAVIORAL HEALTH SERVICES

NEW ADULT INTAKE FORM

PERSONAL INFORMATION:

Personal Information:

- Full Name: _____
- Date of Birth: _____
- Gender: _____
- Marital Status: _____
- Occupation: _____
- Address: _____
- City: _____
- State: _____
- Zip Code: _____
- Phone Number: _____
- Email Address: _____

EMERGENCY CONTACT:

Emergency Contact:

- Full Name: _____
- Relationship to Patient: _____
- Phone Number: _____

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INSURANCE INFORMATION:

Insurance Information:

- Insurance Provider: _____
- Policy/Member ID: _____
- Group Number: _____
- Primary Policy Holder (if different): _____

MEDICAL HISTORY:

Medical History:

- Primary Care Physician: _____
- Any Chronic Health Conditions (e.g., diabetes, hypertension): _____
  _____
- Allergies (food, medication, environmental): _____
  _____
- Current Medications (prescription, over-the-counter, supplements): _____
  _____
- Previous Surgeries or Hospitalizations: _____
  _____
- Family History of Mental Health or Substance Use Disorders: _____
  _____

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MENTAL HEALTH HISTORY:

Mental Health History:

- Reason for Seeking Treatment: _____
  _____
- Previous Mental Health Diagnoses (if any): _____
  _____
- Previous Mental Health Treatments (therapy, medication): _____
  _____
- Substance Use History (alcohol, drugs): _____
  _____
- History of Trauma or Abuse: _____
  _____

Current Symptoms:

- Description of Current Symptoms or Concerns: _____
  _____
- Onset and Duration of Symptoms: _____
- Triggers or Stressors: _____
  _____
- Impact on Daily Functioning (work, relationships, activities): _____
  _____

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Psychiatric Assessment:

- Current Mood (e.g., depressed, anxious): _____
- Sleep Patterns: _____
  _____
- Appetite and Weight Changes: _____
  _____
- Energy Level: _____
- Concentration and Memory: _____
  _____
- Suicidal or Homicidal Thoughts: _____
- Hallucinations or Delusions: _____

SOCIAL AND FAMILY HISTORY:

Social and Family History:

- Living Situation (e.g., alone, with family): _____
- Support System (friends, family, community): _____
- Education Level: _____
- Employment History: _____
  _____
- Relationship Status: _____
- Significant Life Events or Stressors: _____
  _____

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ADDITIONAL INFORMATION:

Additional Information:

- Preferred Language:
- Cultural or Religious Considerations:
- Goals or Expectations for Treatment:
- Any Additional Information or Concerns:

CONSENT AND AUTHORIZATION:

Consent and Authorization:

- I authorize the release of information to my insurance company for billing purposes.
- I authorize the exchange of information between my primary care physician and mental health provider.
- Signature of Patient: _____
- Date: _____