

Website Intake Form

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##### Member Name: D.O.B:

##### Gender: Social Security #:

Legal Guardian #1:

Current Telephone #: Alternate Telephone #: Click here to enter text.

Can we text this number: Email Address: Click here to enter text.

Member’s Address: Zip Code: Enter text.

MA/Insurance Policy #: Primary Insurance ID#:

School: Grade: Click here to enter text.

What services are you looking for? Intensive Behavioral Health Services Outpatient Services Psychological Eval Psychiatric Eval

Adult Mobile Services (MMHT)  Other

Does the member already receive therapy? Yes  No  Current Provider/Service?

Transfer from other agency? Yes  No  If yes what agency?

Prior Treatment:  Early Intervention  Outpatient Therapy  BHRS/STS Services

Partial/Inpatient Hospital Inpatient discharge within last three months? Yes  No

Location and date of last service:

Current Mental Diagnosis? Yes  No  Current/Previous treatment for Alcohol/Substance Abuse? Yes  No

Diagnosis:

Medical Issues:

Current Medications?

What are the presenting concerns?

What are your two most significant concerns regarding your (or your child’s) behaviors:

Therapist Preference (s)?

Session Day and Time Preference?

Please fax (484-550-6655) or email ([Tbryant@pmhccares.org](mailto:Tbryant@pmhccares.org)) completed form to

Attn.: Thelma Bryant, Intake Manager

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