Associates In Psychiatry, PLLC
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Date: **Pre-Visit Intake Requested Provider:** Select

Person Completing Form: Relationship:

Patient LName: Patient FName: Middle Init:

Patient Date of Birth: **Age:** Gender:

How do you want to be address:

Patient phone#'s:

Address (Street, Apt, City, State, Zip):

Preferred Method of Contact (choose one): Select email:

Emergency Contact Name: Relation: Phone#:

Patient Employment Status: Patient Employer:

Marital Status: Select Spouse/Partner Name:

Referral source: Referral Name & Phone#:

The reason you are seeking care (description, problems, symptoms, etc:

Family Physician: Phone#:

Therapist Name: Phone#:

Primary Insurance & Phone#:

Subscribers Name: Relation: Subscriber DOB:

Subscribers Employer:

Member ID#: Group#/Other:

Medicaid Coverage: **Select** ☐ Disclaimer: Providers are not accepting new Medicaid Primary or Secondary insurance and they are NON-Participating with Medicaid HMO's. Visits and Medication will not be covered and referral to insurance will be made for in-network providers.

Secondary Insurance & Phone#:

Subscribers Name: Relation: Subscriber DOB:

Subscribers Employer:

Subscriber ID#: Group#/Other:

Date/Time: First Name: Last Name: Date of Birth:

Therapist Name: Phone#:

Our practice will coordinate care with your current therapist. However, you are not required to be in therapy. The providers of AIP will complete psychiatric evaluation, diagnosis, and psychopharmacology treatment plan. If you agree to treatment plan you will continue with medication management. Individual Psychotherapy also known as "Talk-Therapy", is not provided. Please provide a list of in-network therapist that participate with your insurance and the psychiatrist will try to make recommendation.

☐ **OUR DOCTORS DO NOT PROVIDE THERAPY or complete paperwork for work comp/auto/disability**

Urgency estimates:

Suicidality/Homicidality: Are you currently having thoughts of harming yourself or others: Select

If yes to suicidal thoughts, do you have a plan: **If yes to suicidal plans, do you have intent:**

If yes to homicidal thoughts, do you have a plan: **If yes to homicidal plans, do you hav intent:**

Our practice provides outpatient psychiatric services, and is not equipped for emergency services. Please be advised if you experience an escalation in symptoms, resources are available. Patients with plan and/or intent of harm to self or others should go to the nearest hospital emergency room. If you are in crisis or mental health distress dial or text 988 for the National Suicide and Crisis Lifeline. Dialing 911 is also available for life threatening emergencies.

Is the evaluation required for an auto or work disability claim? Auto? Work?

Is the evaulation required for on any type of Medical Leave of Absence? * Reason:

Is the evaluation required for legal proceedings?* Civil: Criminal: Other:

Ok, now I need to ask about Substance Use:

Are you currently using medical marijuana?

Do you have State of MI Marijuana Card? Frequency: Type:

Are you currently using recreational marijuana? Frequency: Type:

Any Use of Alcohol? Frequency: Quantity:

Any Use of Tobacco? Frequency: Quantity:

Are you Abusing OTHER Substances? Substance: Last Used:

Allergies: Type: Allergy Comments:

COVID Vaccination Status: **Select** COVID Other:

Current Medications,dose,strength: (list name, dose, and frequency)

What is your preferred local Pharmacy Name & Phone#?

Do you consent to have your prescription history pulled electronically?

Who the Current Prescriber? Phone#:

Have you had a recent Medical Hospitalization? If yes, reason:

Hospital Name: Hospital Discharge Date:

Have you had past Psychiatric Hospitalization(s)? Quantity: Discharge Date:

Psychiatric Hospital Name:

Questions/Comments/Notes/Accommodation Request: