MHS Oregon Mental Health Services, LLC

Date_____
Name_____ DOB_____
Phone: Home_____ Work _____ Other _____
Address_____City_____ Zip_____

Emergency Contact _____
Relationship_____ Phone _____

Primary Physician _____ Last exam_____
Address_____City_____
State _____ Zip_____ Phone _____Fax_____

Treatment provided, medications prescribed _____
_____

Current Psychiatrist_____ Last exam_____
Address_____ City_____
State _____ Zip_____ Phone _____ Fax_____

Treatment provided, medications prescribed _____
_____

Other Current and previous Health or Mental Health providers:
_____

Primary Insurance _____Policy #_____ Group# _____

Policyholder_____ Date of Birth_____

Secondary Insurance _____Policy # _____ Group # _____

Policyholder_____ Date of Birth_____

Person responsible for this account_____Relationship_____

Address_____ State_____ Zip_____ Phone_____

I authorize Oregon Mental Health Services to release the information necessary to my insurer(s) to process payment of claims for mental health treatment. I authorize direct payment of all claims to Oregon Mental Health Services. I understand that I am responsible for all charges, irrespective of insurance payments.

Signature_____Date_____

Responsible Party Signature_____ Date_____

165 W Netherwood St. Suite A
Oregon, WI 53575

101 East Fountain St. Suite 2
Dodgeville, WI 3553

Ph: 608-835-5050
Fx: 608-835-5010
www.oregonmentalhealthservices.com

MHS Oregon Mental Health Services, LLC

Name_____

Preferred Pronoun_____

Person completing this form_____

Who are your current support systems? Please include family, school, employment, and community organizations, religious or spiritual affiliations.

_____
_____
_____

Check the symptoms which you are currently experiencing or have experienced within at least the last two weeks:

☐sad or depressed mood	☐sleep problems	☐trauma history	☐suicidal
☐mood swings	☐over/under eating	☐flashbacks	☐thoughts
☐decreased pleasure	☐guilty	☐dissociation	☐plan
☐excessive crying	☐headaches	☐hallucinations	☐attempts
☐decreased energy	☐GI problems	☐delusions	☐homicidal
☐irritable	☐fatigue	☐racing thoughts	☐thoughts
☐anxiety/panic attacks	☐oppositional	☐repetitious behaviors	☐plan

Other:_____
_____
_____

What illnesses or injuries have you experienced?

_____
_____
_____

What do you want to change by coming to therapy?

_____
_____

Other information that will assistance in your treatment:

_____
_____
_____
_____

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