Randolph Behavioral Health Services
966 Park Street, Building A Suite A-2
Stoughton, MA 02070
Phone: (781) 885-7530
Fax: (781) 573-4961 | E-fax: (855) 284-1305

ADULT INTAKE FORM

Date:

GENERAL INFORMATION: Please provide the following information and answer the questions below. Information you provide is confidential and won't be released to any institution without your approval.

INTAKE METHOD:	**PHONE**	**FAX**	**EMAIL**	**COURT MANDATED:**	**YES**	**NO**	
REFERRAL SOURCE (NAME OR AGENCY):							
PHONE NUMBER:							

Client Information

Name:	**Date of Birth:**	**Gender: Male Female**
Address:	**Apartment Number:**	
City & State:	**Zip Code:**	
Race/Ethnicity:	**Preferred Language:**	
Phone Number: **May we leave a message?**	**Email (for scheduling):**	
Emergency Contact:	**Phone Number:**	

Insurance Information

Insurance:	Member ID:
Subscriber's Name:	Subscriber's Date of Birth:

Reason for Referral (Presenting Issue)

1. Are you seeking counseling or medication management?

2. Please explain why in a few words:

3. How long have you been dealing with your situation?

4. What areas of your life are impacted? (Work, home, school etc.)

5. Have you ever been formally diagnosed with a mental illness?

6. Are you currently taking any medications?

7. Do you prefer a male or female clinician?

8. Are you pregnant or breastfeeding?

Goals for Therapy

What are your goals for treatment?

Clinical Information

Is Client currently: Suicidal	Yes	No	N/A		Homicidal	Yes	No	N/A

Is client currently hospitalized:	Yes	No	If yes, where?

Any substance abuse, past or present?	Yes	No	Cigarettes	Alcohol	Drugs (type):

Disposition (Administrative use only)

Accepted for service-appointment	Date:	Time:

Assigned Provider:

Referred elsewhere?	YES	NO	IF YES, WHY?

Waiting list date:	Informed referrer date:	Informed family date:

Final Disposition:	Assigned	Referred Out	Unassigned (closed out)	

Returning Client?	Yes	No	ID#:	**Contact Referral & Document in notes. **

Notes (Additional information)