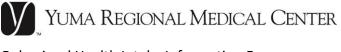
To help us provide the best treatment for you, please answer the questions on this form and return it to the clinic as soon as possible to assist us with scheduling your first appointment.

> You may also submit Online via Secured Email: behavioralhealth@yumaregional.org or Faxing: 926-336-2490

Name:	Date:			
		Email:		
DOB:		Sex:		
Primary Physician:		Phone:		
Current Therapist:	Phone:			
	Con	nplaint		
What is your major com	plaint?			
Start Date:	Have you previous	y suffered from this complai	nt?	
Previous therapist(s) see	en for complaint:			
	Current Symptoms	(Check All That Apply)		
□ Anxiety	□Hallucinations	□ Irritability	□ Risky Activity	
, □Appetite Issue	□Loss of Interest	□ Panic Attacks	\Box Sleep Changes	
Avoidance	□ Excessive Energy	□ Racing Thoughts		
□Crying Spells	□ Fatigue	□Guilt		
		Libido Changes		
	Madia	al History		
		-		
Exercise Frequency:		Exercise Type (s):		
Allergies:				
Previous diagnoses/mer	ntal health treatment:			
Previously treated by:				
Previous medications:				
Previous medical condit	ions:			
ricelled incalcul condit				

Patient Information



Behavioral Health Intake Information Form Department: Behavioral Health C360#: 002486 Date: 12/23 To help us provide the best treatment for you, please answer the questions on this form and return it to the clinic as soon as possible to assist us with scheduling your first appointment.

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	Family	History		
Were you adopted?	If yes, at what age?	Foster care?	How long?	
Are your parents marrie	d?Div	vorced?		
Did your parents remarr	y?	If yes? How old were you	u?	
If a patient is a minor un	der 18 years old and parent	ts are divorced, who is medic	al decision maker?	
Who raised you?	sed you?Where did you grow up?			
		nding?		
special education?				
Medications:				
	Early Dev	velopment		
How often did you move	and where?			
	you left home?			
		Who?		
		Who?		
Describe any neglect voi	suffered, and by whom:			

beschibe any neglect you surrened, and by		
Trauma suffered and by whom:		
Abuse suffered and by whom:		
Highest education level completed:	Date completed and location:	
Have you ever served in the military?	If yes, where?	
Date of service:	Highest Rank achieved	

Present Situation

Work: 🗆 Full-time	□Part-time	□Student	□Unemployed □Disabled	□Retired
Are you married?	If yes, date of marriage:			
Are you divorced?		If yes	, date of divorce:	
Prior marriages?	ges?If yes, how many?			
What are your preferred pronouns?				

Patient Information

YUMA REGIONAL MEDICAL CENTER

Behavioral Health Intake Information Form Department: Behavioral Health C360#: 002486 Date: 12/23 To help us provide the best treatment for you, please answer the questions on this form and return it to the clinic as soon as possible to assist us with scheduling your first appointment.

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How is your	relationship with your partner?			
List anyone	else who lives with you:			
Are you a m	ember of a religion/spiritual gro	up?		
What is you	r level of involvement?			
			why?	
Are you und	er court ordered treatment?			
	Have You Ever Tried	the Following? (Check All	That Apply)	
□Heroin	Methamphetamines	Cocaine	Stimulants (Pills)	
□Ecstasy	□Methadone	Tranquilizers	□Pain Killers	
□Tobacco	□Marijuana	□Hallucinogens	□Alcohol	
If yes to any	, list frequency/dates of use:			
Have you ev	er been treated for drug/alcoho	l abuse?If yes, when?		
	ibstances?			
•	ke cigarettes?If yes, how	· · · ·		
Have you ev	er abused prescription drugs?	If yes, whic	h ones?	
	Anything Else	You Want the Doctor to I	Know	
Signature:			Date:	
Legal Guard	ian Name:	Signature:	Date:	
	Patient Information	Y	jma Regional Medical Cen	JTER
			al Health Intake Information Form	
			al Health Intake Information Form It: Behavioral Health	
		C360#: 002		
		Date: 12/2	3	