

Patient Information									
Full Name			DOB			Today's Date			
Address			City			State	Zip		
SSN	SN Phone			Email					
I Authorize SBHP to Leave Detailed Voice Messages at the Above Number:					□ No Text Reminders: □ Yes □ No				
Legal Sex	Gender	Pronouns			Marital Status: □Single □Married □Widowed				
Emergency Contact	Emergency Contact Ro			Relationship		Phone			
Ethnicity: Hispanic/Latino Mexican Mexican American Non-Hispanic or Latino									
Race: □ Caucasian □ African American □ Asian □ Native American/American Indian □ Alaska Native □ Hawaiian/Pacific Islander □ Other:									
Are you a Stillaguamish Tribal Member or Relative?									
Employer Grull Time Grant Time									
Primary Care Provider Location									
Are you: □ Deaf/Heard of Hearing □ Blind/Vision Impaired Interpreter Needed: □No □Yes: □ASL □Other:									
Referral Information									
Are You Court or Probation Ordered to Complete an Assessment? Yes						Yes	No		
If Yes, Case Number				Jur	risdiction				
Are You Under Supervision by the Department of Corrections?						Yes	No		
If Yes, Correction Officer's Name					Phone				
Do You Need to Report an Assessment to the Department of Licensing? Yes No									
Are you Involved with ICW, DCYF, Family Court or Open Guardianship Case?							Yes	No	
If Yes, Assigned Case Worker				Ph	Phone				
Are You a Registered Sex Offender or Do You Have Any Pending Charges of This Nature? Yes No							No		
Billing Information									
Primary Insurance	rimary Insurance ID Number				Group Number				
Subscriber Name				Subscrib			riber DOB		
Secondary Insurance	econdary Insurance ID Number				Gro	Group Number			
Subscriber Name					Sub	Subscriber DOB			
Consent to Bill									
I authorize SBHP to file a claim with my insurance carrier for services rendered. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance and I will be billed directly for those services.									
Privacy Statement									
SBHP complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have received the SBHP Notice of Privacy Practices and Client Rights.									
Consent For Treatment									
By signing this form, I consent to and authorize my provider(s) at SBHP to provide me treatment. I understand that I have the right to discuss all treatments with my provider(s) and I have the right to refuse treatment. All of my information is true and correct to the best of my knowledge.									
My Signature Below Indicates That I Understand and Accept the Contents of this Form									
Signature					Dat	te			



Name		DOB	Date					
Mental Health Intake Questionnaire								
Problems & Concerns		Comments						
☐ Family/Relationship								
□ Anxiety/Panic								
☐ Depression/Sadness/ Grief								
□ Trauma								
□ Anger								
☐ Court Ordered/Related to Court C	ase							
□ Other -Please describe								
988 Suicide & Crisis Lifeline								
People can call or text 988 or chat 988lifeline.org for themselves or if they are worried about a loved one who may need crisis support.								
988 serves as a universal entry point so that no matter where you live in the United States, you can reach a trained crisis counselor who can help.								
988 offers 24/7 access to trained crisis counselors who can help people experiencing mental health-related distress. That could be:								
 Thoughts of suicide Mental health or substance use crisis, or Any other kind of emotion distress 								
FRONT DESK STAFF USE								
Date received:								
	CLINICAL STAFF USE							
	Clinician assigned:							
Clinical notes:								