MHSU PATIENT COLLATERAL FORM

TO BE FILLED OUT BY PATIENT OR CAREGIVER
PLEASE PROVIDE AS MUCH INFORMATION AS YOU FEEL COMFORTABLE/SAFE SHARING
MUST ACCOMPANY PHYSICIAN MHSU INTAKE REFERRAL FORM

BACKGROUND INFORMATION FOR PSYCHIATRIC ASSESSEMENT
Patient Name:_____ **Date of Birth:**_____
What is your understanding of why you have been referred to psychiatric services by your family physician or nurse practitioner and what do you hope to get from an assessment: Click here to enter text.
Place of birth and where did you grow up: Click here to enter text.
Highest Level of education: Click here to enter text.
Source of Income: Click here to enter text.
Information about employment (type of work, hours, retired, etc.): Click here to enter text.
Relationship status (how long, concerns, etc.): Click here to enter text.
Housing (stable housing, own or rent, etc.): Click here to enter text.
Children (number and ages): Click here to enter text.

History of mental health or substance use services (when, how long, where, etc.):
Click here to enter text.

Previous psychiatry/previous diagnosis (when, where, what, etc.):
Click here to enter text.

Substance use, including alcohol, tobacco, cannabis, street drugs, misuse of over-the-counter medication, misuse of prescription medication (including how much, how often, route of injection, etc.):
Click here to enter text.

Physical health concerns:
Click here to enter text.

Previous or current legal issues:
Click here to enter text.

History of trauma/abuse:
Click here to enter text.

Family history of mental health or substance misuse concerns (diagnosed or suspected):
Click here to enter text.