MPHP INTAKE FORM

Please do not leave any section blank.

Name: **Date:**

Date of Birth:

SS#

Home Address:

Home phone number: **Cell phone number:**

Email:

Name, address, and phone number of spouse or significant other:

Name and phone number for emergency contact person at work:

Name and phone number for additional emergency contact person:

PRACTICE INFORMATION:

Specialty:

List ALL State(s) where license held: Primary: Other:

Status of MS license: Active Inactive Out of State Retired Unlicensed

Primary Medical (Other) School Attended: Grad Year:

Residency: Grad Year:

Residency: (other specialties) Grad Year:

Practice Address and phone number:

Staff Privileges:

Are you supervising, or in collaboration with, Nurse Practitioners? Yes or No

If yes, indicate number ____________ and setting(s) ________________________________

MSMA Member: Yes or No

PRIOR TREATMENT, THERAPY, EVALUATION OR PSYCHIATRIC HOSPITALIZATION(S)

For each treatment, include: 1. Dates of treatment; 2. Diagnosis; 3. Duration of treatment and 4. Discharge status (e.g., AMA discharge, or appropriate discharge)

List all Psychiatric Diagnosis or Comorbidity (Dual Diagnosis):

Axis I:

Axis II:

List ALL substances abused:

Date of Sobriety:

HEALTH CARE PROVIDER INFORMATION:

(Include name, address and phone number for each)

Primary Care Physician:

Psychiatrist (if applicable):

Therapist (if applicable):

Prescription Medications, Dose and Frequency:

REASON FOR MPHP CONTACT (WHY YOU ARE HERE)
Please use separate sheet, if necessary.

Participant Signature: ______________________________