PEACEFUL MINDS
A Wellness Center for Combat Veterans

516-395-7007 • info@peacefulmindsnyc.org • www.PeacefulMindsNYC.org • P.O. Box 232, Atlantic Beach, NY 11509

INTAKE FORM

Person completing this form: _____

Relationship to patient: _____

Patient Information:

Date of Birth _____/_____/_____

Social Security Number: _____/_____/_____

Circle: Female Male

Military Rank: _____

Deployments: _____

Relationship Status: (circle) Single Married Divorced Separated

Mailing Address_____

Home Phone _____

Work Phone _____

Cell Phone _____

Phone number that you would like to be reached at: (circle) Home Work Cell

Email _____

In case of Emergency contact _____ Phone_____

Highest Degree of Education_____

Occupation _____

Name of Primary Care Physician _____

Phone _____

Address_____

How did you hear about Peaceful Minds?_____

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Patient Name:_____

CLINICAL INFORMATION

The patient is requesting the following: (please circle as many as you'd like)

Acupuncture Reiki Massage Supportive Counseling

What are your reasons for seeking services at this time?

_____

_____

_____

Does you/patient have any physical disabilities, limitations, or health problems that you are aware of? If Yes, please describe:

_____

_____

_____

Please list current medication(s), dosages, and frequency of administration:

_____

_____

If you/patient is taking medication(s), provide the name and phone number of the prescribing physician:
Dr._____Phone:_____

Has you/patient ever been hospitalized for physical illness or surgery? Yes No
If Yes, please describe_____

Has you/patient ever been hospitalized for mental illness? Yes No
If Yes, please describe_____

Has the patient ever received psychological help of any kind in the past? Yes No
If Yes, what issues were addressed?_____

Name(s) of previous mental health provider(s) & dates of service:

_____

_____

_____