Office Use Only:

Accepted first available appointment

Yes No

NORTHERN WYOMING MENTAL HEALTH CENTER

INTAKE PACKET- Page 1

CLIENT INFORMATION

Today's Date ____________

Legal Last Name ____________ Legal First Name ____________ M.I. ______

Maiden Name: ____________ Date of Birth: ____________ Age ______ Male Female

Mother's First Name ____________ Birth City and State ____________

Social Security # (*complete SSN required*) ______ / ______ / ______

Mailing Address ____________ Apt. # ______ City ____________ Zip ______

May we send you information at this address? Yes No

Physical Address (if Different from Mailing) ____________ Apt. # ______ City ____________ Zip ______

Email Address ____________ May we send information to you at this address? Yes No Is this a shared address? Yes No

Phone Numbers: Home ____________ Work ____________ Cell ____________ Cell Phone Provider ____________

May we contact you or leave a message at these numbers? Yes No Yes No Yes No

Please check one from each category listed below					
Resident Type	Foster Home	Private Home	Group Home	**Marital**	Married/Living As, Divorced
	Jail / Inmate	Hospital	Other		Never Married, Widowed
	Homeless	Residential Treatment			Separated, Minor Child
Employment	Full-time (over 30 hours)	Unemployed	Disabled/Unemployed	Child (under 15 yrs)	Inmate
	Part-time (under 30 hours)	Retired	Homemaker	Student (over 15 yrs)	
Primary Income Source	Self	Family (Parent/Guardian)	Other Unemployment	Supplemental Security Income (SSI)	
	Retirement	DFS (Department of Family Services/Welfare)	Other Disability	Social Security Disability Income (SSDI)	
Military Status	Are you a veteran? YES NO		Combat veteran? YES NO		
Admission Referral Source	Court (not Title 25 Client)	Community Mental Health Center	Employer		
	Court Order (Title 25)	Private Psychiatrist	Attorney		
	DVR (Division of Vocational Rehabilitation)	Department of Corrections	Drug Court		
	Drug/Alcohol Abuse Treatment Center	Early Childhood Setting	Medical Hospital		
	DD (Developmental Disability)	Police/ Law Enforcement	Shelter		
	Juvenile Probation (DFS)	Clergy	Schools		
	Adult probation and Parole	Other Physician	Nursing Home		
	Wyoming State Hospital	Veterans Affairs	Family/Friends		
	DFS (Department of Family Services/Welfare)	Other Private Mental Health Practitioner	Other		
	Self	Other Inpatient Psychiatric Service			
Race	White	Native American/Alaskan	Asian	More than one race	
	Black	Hawaiian/Pacific Islander	Other		
	➢ *If Hispanic, Please check Origin -*	Cuban	Puerto Rican	Mexican	Other Hispanic, Unknown

NORTHERN WYOMING MENTAL HEALTH CENTER

INTAKE PACKET- Page 2

Client's highest level of Education or highest grade completed: ______________________________

Annual Gross Income: ______________________________

Insurance information (if applicable): ______________________________

Number of Dependents: ________ Please list Names of Dependents: ______________________________

____

PERSON RESPONSIBLE FOR PAYMENT

Relationship to the Client: ______________________________

First Name: ______________ Middle Initial: _______ Last Name: ______________

Social Security #: ______________ Date of Birth: ______________

Mailing Address: ______________ Phone #: ______________

Employer: ______________ Work Phone #: ______________

GUARDIAN INFORMATION

Relationship to the Client: ______________ Date of Birth: ______________

First Name: ______________ Middle Initial: _______ Last Name: ______________

Mailing Address: ______________ Phone #: ______________

EMERGENCY CONTACT INFORMATION

Name of Contact: ______________ Relationship to Client: ______________

Contact's phone: Home ______________ Work ______________ Cell ______________

Contact's Address: ______________________________

CONSENT FOR TREATMENT – ADULT:

Thank you for choosing Northern Wyoming Mental Health Center as your service provider. Your signature authorizes your agreement and consent to participate in **therapeutic and/ or psychiatric treatment and/or evaluation** services offered to you.

______________________________ ______________________________

Date and Client Signature Date and NWMHC Staff Signature

CONSENT FOR TREATMENT – MINOR: (Substance Abuse Tx - MINOR MUST sign the bottom signature line)

- Northern requires the approval and consent of the custodial parent or legal guardian for the identified minor to participate in **therapeutic and/or psychiatric treatment and/or evaluation services** offered to a minor child.
- Because Wyoming state law requires parental consent for a minor to obtain alcohol or drug treatment, the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State Law to act in the minor's behalf only if:

  A. The minor has given written consent to the disclosure

  OR

  B. The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director, as outlined in Federal Regulation 42 CFR, Part B.

Although I am under 18 years of age and legally a minor under Wyoming law, I declare myself to be:

Now or previously legally married In Military Service Living apart from my parents/ guardian and managing my own affairs.

______________ ______________________________

Date MINOR'S Signature

______________ ______________________________

Date Parent, Guardian or Personal Representative Signature

____

Address Phone Number

______________ ______________________________

Date NWMHC Staff Signature