Patient Name:_____

Medical Record Number:_____

GUNDERSEN HEALTH SYSTEM®

La Crosse, WI 54601

ADULT INTAKE SCREENING FORM

Who referred you to our clinic? _____

Do you wish others to be involved in your care? If so, please give name(s) and relationship to you:

_____

Please describe the reason you are seeking services: _____

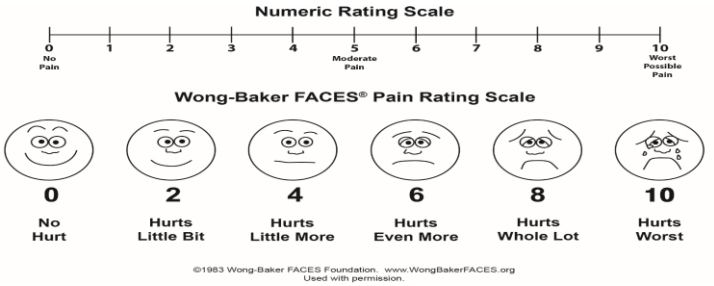
_____

Please list any prior mental health treatment: _____

Please circle any of the following that apply to you:

- ☐ Family problems
- ☐ Social Problems
- ☐ School/Work Problems
- ☐ Physical abuse (current/past)
- ☐ Emotional abuse (current/past)
- ☐ Thoughts of ending your life
- ☐ Spirituality/religious concerns
- ☐ Learning problems
- ☐ Problems with appetite
- ☐ Weight Loss or Gain
- ☐ Others concerned about your eating/weight
- ☐ Sexual abuse (current/past)
- ☐ Legal Issues
- ☐ Thoughts of hurting yourself or others
- ☐ Feelings of hopelessness
- ☐ Past suicide attempt(s)

Physical pain: ☐ Yes ☐ No If yes, please rate:



Medical History

Primary Care Physician: _____

Current Medications: _____

_____

AODA

Have you ever felt you should cut down on your drinking?	☐ Yes	☐ No
Have people annoyed you by criticizing your drinking?	☐ Yes	☐ No
Have you ever felt guilty about drinking?	☐ Yes	☐ No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes	☐ No

Are you currently using tobacco? ☐ Yes ☐ No If yes, do you desire help with quitting? ☐ Yes ☐ No

Are you currently or have you ever served in the military? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____