St. Clair County Community Mental Health Authority

Intake Packet

Date:_____

Basic Demographic information

First Name: _____ Last Name:_____ Middle Initial: _____

Address:_____ City:_____

State:_____Zip:_____ Phone #:_____

Health Information

Primary Care Physician:_____

Address:_____ City:_____

State:_____Zip:_____ Phone #:_____

Other Doctors you Have Seen:_____

_____

Your Primary Pharmacy:_____

Last Dental Appointment:_____

Last Vision Appointment:_____

Number of Hours You Sleep at Night:_____

Number of Meals You Eat Daily:_____

Do You Use Drugs and/or Alcohol? YES or NO

Do You Use Any Type of Tobacco Product (Including Vape)? YES or NO

****PLEASE TURN PAPER OVER TO LIST YOUR MEDICATIONS YOU CURRENTLY TAKE****

Please list all medications you currently take below:

NAME of MEDICATION	DOSE	HOW OFTEN YOU TAKE IT