MEDICATION MANAGEMENT ADULT INTAKE

Client's Full Legal Name: _____ Date: _____

Preferred Name: _____ Pronouns: _____

DOB: _____ Age: _____ Gender Identity: _____

Sexual Orientation: _____ Marital Status: _____

Partner/Spouse Name: _____

Legal Custodian (if applicable): _____

Employment Information

Are you currently employed? ☐ Yes ☐ No

Employer Name: _____

Employer City: _____ Employer State: _____

Primary Physician Information

Do you have a Primary Physician: ☐ Yes ☐ No

Name of Primary Physician: _____

Name of Clinic: _____

Clinic City: _____ Clinic State: _____ Date of last exam? _____

Primary Pharmacy Information

As a benefit to our patients, we have partnered with Capsule to offer free, same day delivery of your medications – they accept all major insurance plans and identify coupons to save you money. Capsule services the Twin Cities and the greater surrounding area. To verify your zip code is within service range, please copy and paste this link: https://bit.ly/3DBenSa. For more information, please speak with your provider.

☐ Yes – I would like to try Capsule
☐ No – I would like to use an alternative pharmacy (listed below)

Name of Preferred Pharmacy: _____

Pharmacy Address: _____

Pharmacy City: _____ Pharmacy State: _____

Therapist Information (if outside of Ellie Mental Health)

Name of Therapist: _____ Clinic: _____

Clinic City: _____ Clinic State: _____

Mental and Medical Health Concerns/History

What concerns are you seeking to treat with medications, and how do you think they can help?

Is treatment required or requested by your employer, a court of law, or as a part of mental health commitment? ☐ Yes ☐ No

If yes, explain (County, Case Manager info):

Have you been diagnosed with any conditions (medical and/or mental health) in the past?
☐ Yes ☐ No

If yes, list all previous diagnoses you have received (medical and/or mental health):

Current Life Stressors:

Are you currently taking any medications (prescribed or over-the-counter)?

☐ Yes ☐ No

Please list all medications (prescribed or over-the-counter) you are currently taking:

Medication	Dosage	Since when?	Adverse effects (if any)

Have you taken any mental health medications (prescribed or over-the-counter) in the past?

☐ Yes ☐ No

Please list all past mental health medications (prescribed or over-the-counter) and reasons for stopping:

Medication	Max Dosage	Frequency	Month/Year Started	Adverse Effects (if any)

Are you allergic to any medications or drugs? ☐ Yes ☐ No

If yes, list medication and reaction:

Please provide information regarding your blood relatives. **NOTE: This section can be blank IF the patient is adopted or information is unknown.

Mother:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Father:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Brother(s):
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Sister(s):
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Children:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Maternal Grandmother:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Maternal Grandfather:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Paternal Grandmother:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Paternal Grandfather:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Other: _____

Chemical/Substance Use History

Please provide information on past and/or current chemical use history (if applicable):

	Never	Current	Past
Caffeine			
Alcohol			
Nicotine			
Marijuana			
Cocaine/Crack			
Heroin/Opiates			
Inhalants			
Hallucinogens			
Methamphetamine			
Prescription Drugs			
Valium/Librium/Xanax/Benzodiazepines			
Over-the-Counter			

Please list any others not in the above list:

Mental Health Treatment History

Please provide your history with the following treatments or conditions:

	Yes	No	Month/Year(s)	Facility/Clinic
Counseling/Psychotherapy				
Drug/Alcohol Treatment				
Inpatient Treatment				
Groups, PHP or IOP				
Genetic Testing				
Psychological Testing				

Please list any others not in the above list:

Please provide your history with the following:

	Yes	No	Month/Year(s)
Self-Harm			
Suicidal Ideation			
Suicide Attempts			

Personal History

Tell us about your education:

What is your marital/relationship status?

Tell us about your current friends/relationship connections:

Who do you live with?

What are your favorite hobbies/sports/activities?

Tell us what your typical nutrition/diet consists of:

Tell us about your sleep habits:

Tell us about your exercise/physical activity habits:

Do you have a history of trauma, abuse or neglect?