



Family and Youth Guidance Center ♦ 424 S. Oakes ♦ San Angelo, Texas 76903

Dear Parent(s)/Legally Authorized Representative(s),

Welcome and thank you for choosing MHMR Concho Valley to help you meet your child's mental health needs. Our practice provides the best possible care for your child. We know you have many options to choose from and appreciate your having selected us to assist you with this important process. This cover letter and attached forms are designed to prepare you for the intake process and help us to better able to assist you.

The patient **MUST** be accompanied at the appointment by the biological parent or other legally authorized representative. Documentation regarding guardianship will be verified before the intake appointment begins. If legal guardianship cannot be confirmed, the intake appointment will be rescheduled.

The purpose of an intake appointment is to determine if the patient is eligible for services with the Center. Medications are not prescribed at an intake appointment. A proper and thorough intake appointment can take up to TWO hours. Please make arrangements in your schedule to be at the Center for the entire two hours.

**In order to make your upcoming intake appointment run smoothly we ask that you bring the following documentation.**

- Proof of Guardianship
  - Birth Certificate- The center will need this for every child.
  - Divorce Decree- If child's biological parents are divorced, the center will have to have a copy of the divorce decree.
  - Adoption Decree- If the child has been adopted, the center will have to have a copy of the court paperwork granting the adoption.
  - Medical Consenter Form- If the child is in CPS custody, the center will need to have the Form 2085 B- Medical Consenter Form that appoints someone as the child's medical consenter and that specific person must attend the appointment with the child.
  - Any other legal paperwork that appoints someone as the child's current legal guardian  
(e.g. Child Support Review Order, Suit Affecting the Parent Child Relationship)
  
- Insurance Card (if applicable)
  
- Proof of monthly household income - The center needs this for all patients that have Medicaid, CHIP, or no insurance.

Additional Items that would help make your upcoming intake appointment run smoothly are:

- Picture ID
- Social Security Card
- Psych Evaluations
- Active Diagnoses
- Discharge Records
- Proof of Income
- Physicals



## INTAKE FORM

Today's Date: \_\_\_\_\_

## DEMOGRAPHIC INFORMATION

Patient's Legal Name: \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Gender:  Male  Female

Name of Parent or legal Guardian: \_\_\_\_\_

If guardian is someone other than biological parent what is their relation to the child? \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

How many people live in the home: \_\_\_\_\_ Other family members in MHMR services:  
\_\_\_\_\_

Is someone in your family a member of, or retired from, the U.S. Armed Forces?  Yes  No  
 Veteran

## RACIAL/ ETHNIC\_IDENTITY

African American  Asian American  Hispanic/Latino  Native American  
 Pacific Islander  White/Caucasian  Other

## EDUCATION

Current grade: \_\_\_\_\_ School: \_\_\_\_\_

Is the patient currently on probation?  Yes  No (If yes, please list Parole Officer's Name below):

\_\_\_\_\_

### INSURANCE INFORMATION

Medicaid  Chip  Tricare  Other: \_\_\_\_\_

ID or Policy Number: \_\_\_\_\_ Group Number (if applicable): \_\_\_\_\_

### EMERGENCY CONTACT:

Name of Emergency Contact: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Primary Care Physician (Pediatrician): \_\_\_\_\_

### MENTAL HEALTH INFORMATION

Have you experienced any form of trauma?  Yes  No

How did you hear about our services? \_\_\_\_\_

What is the reason for your visit at the clinic today? \_\_\_\_\_

\_\_\_\_\_

List any previous treatments for mental health issues. This includes any inpatient hospitalization, private psychiatrist, medical doctor, or other MHMR clinic. (Include dates)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any current medication(s): \_\_\_\_\_

\_\_\_\_\_