REGISTRATION / INFORMATION WORKSHEET

Today's Date: _____ **Time of Arrival:** _____ **AM PM (Circle One)**

I, _____, give the staff of **Lakeside Behavioral Health System**
(Patient/guardian signature) permission to perform an assessment and to verify insurance benefits.

Patient Name: _____ Patient SSN: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

County: _____ e-mail_____

Home Phone #: _____ Cell #: _____ W #: _____

Date of Birth: _____ Age: _____ Sex: _____ Race: _____ Marital Status: _____

Patient's Occupation: _____ Employer: _____

Employer's Address: _____
Employer's Phone #: _____ Length of Employment: _____
Do you have an Employee Assistance Program? **Y or N** If YES, Who? _____
Patient's Biological Mother: _____ Patient's Biological Father: _____

In Case of Emergency, contact: _____ Phone #: _____
What is their relationship to the Patient? _____
Additional Contact: Name _____ Phone #: _____
What is their relationship to the Patient? _____

Primary Care Physician (PCP) Name: _____
PCP Address & Phone Number: _____
Who referred you for services at **Lakeside**? _____
What agency are they with (address)? _____
Does the Patient have a Living Will? **Y or N** Effective Date: _____
Is there Durable Power of Attorney? **Y or N** If YES, who holds this? _____
Effective Date: _____

Areas of Concern: (please check or explain)

_____ Appetite/Sleep Disturbance_____ Marital or Relationship Stressor_____
_____ Problems at Work/School_____ Feelings of Anger_____
_____ Excessive Worry or Unwanted Thoughts_____ Having to do certain things over and over_____
_____ Difficulty Concentrating_____Easily annoyed/Irritated/Tense/Nervous_____
_____ Depression/Sadness/Crying Spells _____Loss of Interest/Enjoyment in Sexual Activity _____
_____ Alcohol or Drug Use_____
_____ Temper Outbursts/Destructive to Property_____
_____ Impulsiveness/Acting Without Thinking_____
_____ History of Physical or Sexual Abuse_____
_____ Feelings that others are out to get you_____
_____ Seeing things that others do not see_____
_____ Hearing things that others do not hear_____
_____ Feelings of wanting to harm others_____
_____ Feelings of wanting to harm self_____
_____ List the date you last felt suicidal _____
_____ How strong is your desire to die right now? Strong _____ Moderate_____ Weak _____ None _____
_____ Do you have a plan as to how you would harm yourself? Yes _____No_____ Explain _____
_____ Have you ever attempted suicide in the past? _____ When? _____

What recent events/problems have brought about your request for help today? _____
_____

What level of Treatment are you requesting today? (Circle One or more)
Inpatient treatment Partial (Day Treatment) Intensive OP Outpatient Treatment Recommendations

Guarantor/Guardian Information:

☐ *Check here if information is the same as the patient*

Guarantor/Guardian Name*: _____ Guarantor SSN: _____
*(the guarantor/guardian is the one who will actually be signing the paperwork should admission be necessary)

Guarantor Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Date of Birth: _____ Age: _____ Sex: _____ Race: _____ Marital Status: _____

What is the Guarantor's relationship to the patient? _____

Guarantor's Occupation: _____ Guarantor's Employer: _____

Guarantor's Employer's Address: _____

Employer's Phone #: _____ Length of Employment: _____

Do you have an Employee Assistance Program? Y or N If YES, Who? _____

Insurance Information – Must Provide both Primary and Secondary Insurance Policies

PRIMARY Insurance: _____ Policyholder Name: _____

Policyholder DOB: _____ Policyholder SSN: _____

Policy ID #: _____ Group Name or Number: _____

Insurance Customer Service or Verification Phone #: _____

Policyholder Employer, City and Phone #: _____

Relationship to Patient _____ Policyholder Home #: _____ Cell #: _____

Policyholder Address: _____

SECONDARY Insurance: _____ Policyholder Name: _____

Policyholder DOB: _____ Policyholder SSN: _____

Policy ID #: _____ Group Name or Number: _____

Insurance Customer Service or Verification Phone #: _____

Policyholder Employer, City and Phone #: _____

Relationship to Patient _____ Policyholder Home #: _____ Cell #: _____

_____: Initial here if you acknowledge that you DO NOT have a secondary policy.

If a staff member completes this form for the patient, please print your name here: _____
(*** staff members need to fully complete form and ask patient about both primary and secondary insurances)

If admission is required, what payment method will you be using today? (Please circle all that apply)
CASH / CHECK / MONEY ORDER / MASTERCARD / VISA / DISCOVER / AMERICAN EXPRESS

LAKESIDE
BEHAVIORAL HEALTH SYSTEM

Patient Identification _____

Patient Self Triage Form – Needs Assessment

Name: _____ Date of Birth: _____ Today's Date: _____

Name of Person Completing Form: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____ Contact Number: _____

Who referred you to Lakeside today? _____ Contact Number: _____

Assessment Information:

Have you had any previous psychiatric hospitalizations? ☐Yes ☐No When? _____

Name of Hospital: _____ Reason for admission: _____

What level of service are you seeking today?

____Inpatient Treatment ____Intensive Outpatient ____Treatment Recommendations
____Partial (Day Treatment) ____Obtaining Psychiatrist/Psychologist ____Medication Management

Areas of Concern: (please explain)

_____ Appetite/Sleep Disturbance_____
_____ Martial or Relationship Stressor_____
_____ Problems at Work/School_____
_____ Feelings of Anger_____
_____ Excessive Worry or Unwanted Thoughts_____
_____ Having to do certain things over and over_____
_____ Difficulty Concentrating_____
_____ Depression/Sadness/Crying Spells _____
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_____ Feelings that others are out to get you_____
_____ Seeing things that others do not see_____
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_____ Feelings of wanting to harm others_____
_____ Feelings of wanting to harm self_____
_____ List the date you last felt suicidal _____
_____ How strong is your desire to die right now? Strong _____ Moderate_____ Weak _____ None _____
_____ Do you have a plan as to how you would harm yourself? Yes _____No_____ Explain _____
_____ Have you ever attempted suicide in the past? _____ When? _____

What recent events/problems have brought about your request for help today? _____
_____

Reviewed by: _____Date / Time: _____