Healthier Life PLLC
8300 Health Park, Suite 201
Raleigh, NC 27615
www.healthierlife.biz
919-676-9699 ext 8

Carolina Performance
FOR EXCELLENCE IN SPORTS, LIFE AND BUSINESS

Patient Intake Form

Name: ______________________ **Date:** ______________________

Mailing Address: **Physical Address** (if different)**:**

______________________ ______________________

______________________ ______________________

Do you provide consent to receive mail at the mailing address (circle one)**?** Yes No

Email (ONLY if you want automated appointment reminders): ______________________

Telephone Numbers (Provide only numbers at which you provide permission to receive calls)**:**
Home: ______________________ **May leave a detailed message?** Yes No
Mobile: ______________________ **May leave a detailed message?** Yes No

Date of Birth: ____________ **Age:** ______ **Relationship Status:** ____________
Student status/Occupation: ______________________

Contact Person (in case of Emergency)**:**
Name: ____________ **Relation:** ____________ **Phone:** ____________

Primary Care Physician: ______________________ **Phone:** ____________

History:

> **Medical Problems:** ______________________

> **Current Medications:** ______________________

> **Allergies:** ______________________

> **Hospitalizations** (Medical, Psychiatric, Substance Abuse) (include place and year): ____________

Question				
> **Have you ever engaged in therapy before** (circle one)**?**	Yes	No		
> **Worked with a psychiatrist before** (circle one)**?**	Yes	No		
> **Family history of mental illness** (circle one)**?**	Yes	No		
> **Family history of substance abuse** (circle one)**?**	Yes	No		
> **Family history of suicide attempts** (circle one)**?**	Yes	No		
> **Personal history of suicide attempts** (circle one)**?**	Yes	No		
> **Personal history of violent behavior/assault/domestic violence** (circle one)**?**	Yes	No		
> **How often do you smoke** (circle one)**?**	never	monthly	weekly	daily
> **How often do you drink alcohol** (circle one)**?**	never	monthly	weekly	daily
> **How often do you use drugs** (circle one)**?**	never	monthly	weekly	daily

Goals:

What would you like to gain from working with Dr. Green at Healthier Life PLLC? What are your goals?

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Insurance (optional)**:**

**** Dr Green at Healthier Life PLLC does not accept insurance. ****

**** You may wish to leave on file for lab-work and for medication prior authorization ****

Plan Name: ____________________ Group: ____________________

Insured Name: ____________________ Insured ID: ____________________

RECORD RELEASE AUTHORIZATION:

I hereby authorize Healthier Life PLLC to furnish information to insurance carriers concerning my illness/treatment, including for medication prior authorization requests.

______________________________________ ____________________

Signature of Client (or Guardian if under 18) Date

CONSENT FOR TREATMENT:

Your signature below indicates that you have read the Healthier Life PLLC - Patient Services Agreement, agree to its terms and as an acknowledgement that you have received the HIPAA notice form.

______________________________________ ____________________

Signature of Client (or Guardian if under 18) Date

______________________________________ ____________________

Printed Name Signature of Provider