MINNESOTA
WellCare

10519 165th Street W
Lakeville, MN 55044
P: 952.248.2720
F: 888.286.9823

New PATIENT Intake

First and Last Name: ______________________________

Date of Birth (MM/DD/YYYY): ______________________________

Home Address (inc. city, state, zip): ______________________________

Phone Number: ______________________________

Email: ______________________________

Emergency Contact: ______________________________

Race/Ethnicity:

_____ American Indian or Alaska Native _____ Asian _____ Black or African American

_____ Native Hawaiian or other Pacific Islander _____ Hispanic or Latino _____ White _____ Other

Gender:

_____ Male _____ Female _____ Transgender Male

_____ Transgender Female _____ Non-binary

Employment Status:

_____ Employed _____ Unemployed _____ Full-Time Student

_____ Part-Time Student _____ Retired

Marital Status:

_____ Single _____ Married _____ Divorced

Insurance Company: ______________________________

Subscriber ID#: ______________________________

Group No.: ______________________________

Policy Holder's Name: ______________________________

Policy Holder's Date of Birth (MM/DD/YYYY): ______________________________

Policy Holder's Relationship to Client:

_____ Self _____ Spouse _____ Father

_____ Mother _____ Guardian _____ Grandparent

Policy Holder's Employer: ______________________________

Who can we thank for your referral to Minnesota WellCare? ______________________________

What is your reason for coming to Minnesota WellCare?

____

What are your goals and expectations with seeking care with Minnesota WellCare?

____

Are you working with a therapist? _____ Yes _______ No

If yes, please provide their name and any contact information that you have.

____

Who is your primary medical provider and what clinic do they practice at?

____

Have you previously received psychiatric care? _____ Yes _______ No

If yes, why did you leave their practice? What did or didn't you like about it?

____

____

Have you been diagnosed with any of the following?

_______ Depression _____ Anxiety _____ Bipolar

_____ Obsessive Compulsive Disorder _____ Borderline Personality Disorder _____ ADHD

_____ Substance Abuse _____ Insomnia _____ Schizophrenia

_____ None

Have you taken medication(s) for any of the above conditions? If yes, please list medication(s) and anything you remember about them such as side effects, whether they were effective, and why you stopped taking them.

____

____

____

Have you been through any type of treatment program? _____ Yes _______ No

If yes, please provider additional details (when, where, why, etc.).

____

____

____

Have you been hospitalized for mental illness?

_____ Yes _______ No

If yes, please provider additional details (when, where, why, etc.).

____

____

Allergies	Type	Severity	Reactions

Medication/Supplements Name	Intake Details

To the best of my knowledge, all of the preceding questions have been answered accurately.

CLIENT/GUARDIAN SIGNATURE: ____

Date (MM/DD/YYYY): ____

Guardian name (if applicable): ____

Relationship of signer to client:

_____ Self _____ Mother _____ Father _____ Legal Guardian