New Patient Intake

Boynton Health Service – Mental Health Clinic

Welcome to the Boynton Health Service Mental Health Clinic

The Mental Health Clinic is open to degree-seeking University of Minnesota Twin Cities campus students who have been assessed the Student Services Fee at the time of service or current Graduate Assistants covered by the Graduate Assistance insurance plan offered through the University of Minnesota. If you have any questions about eligibility, please speak with a receptionist or call the front desk at 612-624-1444.

If you are new to the mental health clinic or have not been seen in over one year:

- Please complete the full intake packet.
- Give the packet, your student ID card, your insurance card and the date of birth of the insurance policy’s main subscriber to the front desk staff.

There are some services that we are presently unable to offer or offer on a limited basis:

- **ADD\ADHD**: Boynton Health Service has specific guidelines regarding the diagnosis and treatment of ADHD. If you are seeking ADHD assessment of treatment, please speak with a receptionist or review these guidelines on our website.

- **Eating Disorders**: We provide an Eating Disorder Therapy program in coordination with medical and nutrition services. We do not offer intensive Eating Disorder Treatment (including treatment for anorexia). Contact the Medical Social Worker for resources– 612-624-8182.

- **Long Term Therapy**: The Mental Health Clinic utilizes a short-term model of psychotherapy. This means that we are able to offer eleven individual or couples therapy visits within the period of one year. The Medical Social Worker can provide you with other outside resources– 612-624-8182.

- **Legal Assessments**: We are unable to provide legal assessments, with the exception of chemical health assessments. The Medical Social Worker can provide you with resources– 612-624-8182.

*If you are feeling acutely suicidal you must notify the Mental Health Clinic front desk so they can arrange for you to speak with our triage nurse or urgent counselor.*
## COMMON INTAKE FORM

Boynton Mental Health Clinic, 4th Floor, 410 Church Street SE  
Student Counseling Services, 340 Appleby Hall, 128 Pleasant Street SE

<table>
<thead>
<tr>
<th>Today’s Date:</th>
<th>First Name:</th>
<th>Middle Name:</th>
<th>Last Name:</th>
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<thead>
<tr>
<th>Date of Birth:</th>
<th>Age:</th>
<th>Student I.D.:</th>
<th>Preferred Name:</th>
<th>Preferred Pronouns:</th>
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<tr>
<th>Cell Phone:</th>
<th>OK to call cell phone?</th>
<th>Home Phone:</th>
<th>OK to call home phone?</th>
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Email:  □ OK to Email

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<thead>
<tr>
<th>Local Address: (OK to contact you at home)</th>
<th>Permanent Address:</th>
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<tbody>
<tr>
<td>Street</td>
<td>Street</td>
</tr>
<tr>
<td>City</td>
<td>City</td>
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<tr>
<td>State/ZIP</td>
<td>State/ZIP</td>
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Emergency Contact Person:
Relationship to You:  
Telephone:  

What kind of help are you seeking?  Select all that apply:

- □ Individual therapy /counseling
- □ Medication management (BHS)
- □ Group counseling
- □ Couples counseling (BHS)
- □ Substance use counseling (BHS)
- □ Medical social work/Case management
- □ Academic Counseling (SCS)
- □ Career counseling (SCS)

Other:  

How did you happen to come to Boynton Mental Health and/or Student Counseling Services (check all that apply):

- □ Academic Advisor
- □ Dean (College)
- □ Mental Health Professional
- □ Aurora Center
- □ Disability Resource Center
- □ Previous Use
- □ Boynton Health Services
- □ Faculty
- □ Stress Check-In
- □ Clergy/Pastoral
- □ Family
- □ Student Counseling Services
- □ College office or program
- □ Friend
- □ Student Conflict Resolution
- □ Community Advisor/Res Hall Staff
- □ General knowledge
- □ Website

Undergrad Student: □ Fresh  □ Soph  □ Junior  □ Senior  □ PSEO  □ Other

<table>
<thead>
<tr>
<th>College:</th>
<th>Major:</th>
<th>Minor:</th>
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- □ Grad School Masters  Program:
- □ Grad School Ph.D.  Program:
- □ Professional School  Program:

Current Credit Load:  
Anticipated Graduation Date:  

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COMMON INTAKE FORM
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Gender: Please check the appropriate box or fill in below:
☐ Male  ☐ Female  ☐ Transgender  ☐ Fluid
☐ My description (please fill in):
☐ Prefer Not to Answer

Sexual Orientation: Please check the appropriate box or fill in below:
☐ Asexual  ☐ Bisexual  ☐ Gay  ☐ Hetero/straight
☐ Questioning  ☐ My description (please fill in):
☐ Prefer Not to Answer

Relationship Status: ☐ Single  ☐ Dating  ☐ Married  ☐ Partnered  ☐ Divorced  ☐ Separated  ☐ Other:

Please describe your primary parental figures:

<table>
<thead>
<tr>
<th>Parent #1</th>
<th>Parent #2</th>
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<tbody>
<tr>
<td>How related to you</td>
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<tr>
<td>Education</td>
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<tr>
<td>Occupation</td>
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Number of siblings
Full:   Half:   Step:

Military Service Status: ☐ Active  ☐ Vet  ☐ ROTC  ☐ National Guard  ☐ None  ☐ Other:

Country of Citizenship:    Ethnic Background:

Languages Spoken:

Religious or spiritual affiliation:

Other organizations important to you:

How satisfied are you with your academic progress?
☐ Very satisfied  ☐ Satisfied  ☐ Neutral
☐ Dissatisfied  ☐ Very dissatisfied

What barriers, if any, are impeding your academic progress so far?

What do you like best about college and college life?

What do you like least about college and college life?

What are your long term education and vocational goals?

Other important long-term plans and goals?

How sure are you about these future plans?
☐ Very Certain  ☐ Certain  ☐ Uncertain  ☐ Very uncertain
What is your primary reason for seeking help?

Are you currently experiencing a crisis?  ☐ Yes  ☐ No
Describe the nature of the crisis:

What other significant concerns do you have?

What convinced you to get help now?

Are you requesting to have a form or letter completed on your behalf?  ☐ Yes  ☐ No
If yes, please describe:

Please list any previous or current mental health therapy and any previous hospitalizations:

<table>
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<tr>
<th>Provider/Clinic</th>
<th>Condition/Issue</th>
<th>Date(s)</th>
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Do you have any health problems?

Please list any current medications (psychiatric, medical, and over-the-counter):

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<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Benefits/Side Effects</th>
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Please fill this section out if you are seeking medication evaluation or other treatment at Boynton Mental Health Clinic

List any previous medication trials:

<table>
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<th>Medication</th>
<th>Dose</th>
<th>Dates</th>
<th>Benefits/Side Effects</th>
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Medication Allergies:


Family Mental Health History:

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<tr>
<th></th>
<th>Mother</th>
<th>Father</th>
<th>Sibling</th>
<th>Other (List)</th>
<th>What treatment?</th>
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<tbody>
<tr>
<td>Anxiety</td>
<td>☐</td>
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<tr>
<td>Depression</td>
<td>☐</td>
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<tr>
<td>Bipolar Disorder</td>
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<tr>
<td>Substance Abuse</td>
<td>☐</td>
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<tr>
<td>Other</td>
<td>☐</td>
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Family Medical Health History:

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<th>Father</th>
<th>Sibling</th>
<th>Other (List)</th>
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<td>Diabetes</td>
<td>☐</td>
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<td>Heart Problems</td>
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<td>High Blood Pressure</td>
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<td>High Cholesterol</td>
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<td>Thyroid</td>
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Are you concerned about past or present alcohol or drug use? ☐ Yes ☐ No

If yes, please describe:


I, __________________________ understand that missed or late-cancelled appointments interfere with my treatment and that of other students who might have been seen at that time. I agree to the following:

- I will attend all scheduled appointments and group sessions.
- If I arrive 10 or more minutes late I may be asked to reschedule and be charged the late cancel fee.
- If I cannot attend a scheduled appointment or group session, I will cancel the appointment by 4:30PM of the business day prior to the appointment.

There is a $10 late-cancel fee for any appointment or group session that I do not cancel by 4:30PM of the business day before the appointment.

There is a $20 no-show fee for any missed appointment or group session.

I understand that email reminders are a courtesy provided by Boynton Health Service. If I do not receive an email reminder, I am still responsible for keeping my appointment and late cancel/fail fees apply.

Fees are due when billed. Fees that are not paid may be transferred to student accounts receivable and may interrupt my care. Student accounts receivable may assess additional fees to collect this balance.

I acknowledge that failing or late-cancelling two consecutive appointments or three appointments within six months at the Mental Health Clinic may result in a scheduling hold being placed on my account. This means I will not be able to schedule appointments with the Mental Health Clinic. This hold can only be removed by presenting in person at the Boynton Health Service Patient Accounting Office (N325). All outstanding late cancel or fail fees must be paid at that time. Once the hold is removed, I must present in person at the Mental Health Clinic to schedule my next appointment.

If I do not take steps to remove the hold, Boynton Mental Health Clinic may terminate care with me. Termination of care will end the responsibility of the Mental Health Clinic to see me as a patient. I understand it will then be my responsibility to find another mental health provider to continue my care and that the Mental Health Clinic will work with me to facilitate this transfer of care. In such circumstances the Mental Health Clinic will be willing to provide urgent consultation for up to 30 days after I have received notification of my ineligibility to be seen at the Mental Health Clinic.

I recognize that Boynton Health Service will be under no obligation to pay for any mental health care following termination from the Mental Health Clinic. It will be my sole responsibility to cover these expenses.

Signature___________________________________                 Date________________

A reproduction of this form is as valid as the original.