St. Paul Location:
Spruce Tree Centre
1600 University Avenue West,
Suite 12
St. Paul, MN 55104

Office: 651-796-3971
Fax: 651-379-5159
Email: ARMHS@natalispsychology.com
Website: www.natalispsychology.com

Adult Rehabilitative Mental Health Services (ARMHS) Intake Form

Date: ______________

GENERAL INFORMATION.
PLEASE WRITE LEGIBLY.

Client Name: ________________________________

Preferred Name: ________________________________

DOB: _____ / ____ / ______ Age: ________ Social Security #: ______ - ________ - __________

Home Phone: ______ - ________ - __________ Other Phone: ______ - ________ - __________

Cell Phone: ______ - ________ - __________ Leave messages at: ☐ Home ☐ Cell ☐ Other

May we text this number? ☐ Yes ☐ No May we email you? ☐ Yes ☐ No

Email Address: ________________________________

Address: ________________________________ City: ______________

Apt #: ________ State: MN Zip: __________ County: ______________

Legal Guardian: ________________________________

Phone: _____ - ______ - _______ Allergies? ☐ Yes ☐ No To: ______________

Pets: ☐ Yes ☐ No Type: ______________ Smoke: ☐ No ☐ Yes ☐ In Home?

Primary Care Physician: ______________ Clinic: ______________

Phone: _____ - ______ - ________

Psychiatrist: ______________ Phone: ______ - _____ - ________

Individual Psychotherapist: ______________ Phone: ______ - _____ - ________

REFERENT INFORMATION

Person Referring: ______________ Phone: ______ - _____ - ________

Email: ______________ Fax: ______ - _____ - ________

Referent Address: ______________ City:

Release of Information Included: ☐ Yes ☐ No Referent Agency: ______________

If so, Name: ______________ Relation: ______________

Phone: _____ - ______ - ______

DEMOGRAPHIC INFORMATION

Gender Identity: __________ Preferred Pronouns: ______________

Sexual Orientation: __________ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Race: ☐ African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Caucasian ☐ Hispanic/Latino
☐ Native Hawaiian or other Pacific Islander ☐ Other (specify): ______________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Civil Commitment ☐ Other:

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SERVICE INFORMATION

Practitioner Preference: ☐ Male ☐ Female ☐ Either **Dates/Times Preferred:** ____________________

Other Practitioner Preferences: ____________________

Interpreter Needed? ☐ No ☐ Yes **Language:** ____________________

Any Major Medical Conditions: ____________________

Do you have any infestations in your home? (roaches, bed bugs, etc): ☐Yes ☐ No ☐ Previously yes ☐ Unknown

Date exterminator cleared your home (provide paper copy): ____________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ____________________

Relationship: ____________________ **Phone Number:** ________ - ________ - ________

INSURANCE INFORMATION. CLIENT MUST HAVE MA/PMAP FOR ARMHS. SECTION MUST BE COMPLETELY FILLED OUT FOR INTAKE.

PMI/MA number ____________________

Does the client have Medicare? Yes ____ No _____ If Yes, Medicare ID ____________________

Does the client have straight MA? Yes ____ No ____ If No, Please provide insurance information below.

Insurance Name ____________________

Insurance ID ____________________

Group Number ____________________

DIAGNOSTIC INFORMATION

Current Diagnoses (if known): ____________________

Natalis
Counseling
& Psychology
Solutions

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ARMHS REFERRAL QUESTIONAIRE. WHAT DOES THE CLIENT NEED HELP WITH?

Mental Health Symptom Management: ____________________

Mental Health Service Needs: ____________________

Sobriety: ____________________

Vocational: ____________________

Educational: ____________________

Social Functioning: ____________________

Interpersonal Functioning: ____________________

Self-care and Independent Living: ____________________

Medical and Dental Health: ____________________

Financial Assistance: ____________________

Housing: ____________________

Transportation: ____________________

Legal: ____________________

Other: ____________________