

**Fayetteville Psychiatric Associates**  
2587 Ravenhill Dr.  
Fayetteville, NC 28303  
Office (910) 323-1543 ext 261, Fax (910) 483-2026

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Date: \_\_\_\_\_

## Fayetteville Psychiatric Associates, PC ----Intake Triage Form

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Sex:  Male  Female      Marital Status: Single  Mar  Div  Sep  Wid

SSN #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Mother's work #: \_\_\_\_\_ Father's work #: \_\_\_\_\_

Legal Guardian Name: \_\_\_\_\_ Legal Guardian work #: \_\_\_\_\_

Person/Provider making referral: \_\_\_\_\_ Ref. phone #: \_\_\_\_\_

Referring provider NPI #: \_\_\_\_\_ Ref. Fax #: \_\_\_\_\_

Referral Address: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Any known Behavioral Treatment and Medications in the past 12 months:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>SCREENING QUESTIONS</b>
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Is the patient seeking treatment for>>>>> (Check one)  **Therapy**       **Medication Management**

Are there handicap issues:  YES  NO

Please List: \_\_\_\_\_  
\_\_\_\_\_

Does the patient speak/understand English:  YES  NO

Is the patient suicidal or homicidal  YES  NO

Has the patient had a mental health evaluation in the past 6 months:  YES  NO

Are there any hallucinations:  YES  NO

Are there concerns of the patient being a sexual offender:  YES  NO

Is there a present or upcoming legal/court involvement:  YES  NO

Are there any custody issues:  YES  NO

Are there any substance abuse issues:  YES  NO

Are there any issues with violence (active, past):  YES  NO

(Please Specify): \_\_\_\_\_  
\_\_\_\_\_

### FOR PATIENTS WHO ARE UNDER 18

Who has custody of patient > Name: \_\_\_\_\_ Title: \_\_\_\_\_

Does the child reside at a group home:  YES  NO      **If yes, name of home:** \_\_\_\_\_

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**PRIMARY INSURANCE**

Insurance Carrier: \_\_\_\_\_ Subscriber #: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security#: \_\_\_\_\_ Relationship to Pt: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Insurance Phone #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Authorization required:  YES  NO  
Authorization # \_\_\_\_\_  
Co-Pay: \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Carrier: \_\_\_\_\_ Subscriber #: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security#: \_\_\_\_\_ Relationship to Pt: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Insurance Phone #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Authorization required:  YES  NO  
Authorization # \_\_\_\_\_  
Co-Pay: \_\_\_\_\_

**OUR OFFICE ONLY**

Date received: \_\_\_\_\_  
Date entered: \_\_\_\_\_ Appointment Date: \_\_\_\_\_  
Date letter was sent: \_\_\_\_\_ Appointment Time: \_\_\_\_\_  
Appointment Scheduled With: \_\_\_\_\_