UC DAVIS HEALTH Trainee Mental Health Clinic

Patient Intake Form

Required fields are marked with an asterisk (*). Please complete, save, and email the form as directed in your welcome materials.

PATIENT DEMOGRAPHICS

UCDMC #

Date *

Social Security Number

First and Last Name *

Date of Birth *

Sex Assigned at Birth *

Gender Identity *

Pronouns *

Trainee Role (e.g., student, resident, or fellow) *

PERSONAL CONTACT INFORMATION

Street Address *

City *

State *

ZIP *

Phone Number *

Email Address *

Marital Status *

EMERGENCY CONTACT *

Name *

Relationship *

Phone *

INSURANCE INFORMATION *

Insurance Name *

Member ID # *

Group # *

Insurance Phone *

PSYCHIATRIC HISTORY *

Current / Past Psychiatric Diagnoses *

Current Psychiatric Medications *

Current Psychiatrist *

Primary Care Provider (PCP) *

Current Therapist (if applicable) *

Have you ever completed psychoeducational testing? *

PRIMARY CONCERNS * (CHECK ALL THAT APPLY)

- Depression
- Bipolar disorder
- Suicidality
- Self-harm
- Hearing/seeing things others don't
- Anxiety / panic
- Trauma symptoms
- ADHD
- New diagnosis support
- Continued diagnosis support
- Other

PRIMARY CONCERNS (CONTINUED)

If Other, please describe:

BRIEF NARRATIVE OF PRESENT CONCERNS *

Please provide a brief summary of your current concerns: *

PATIENT ACKNOWLEDGMENT

This clinic is NOT an emergency service and response times may vary. If you are in immediate danger, call or text 988 (Suicide & Crisis Lifeline) or go to your nearest Emergency Department. For urgent (non-emergency) mental health concerns, contact your nearest urgent care facility. By signing and dating below, I agree to this statement, and I confirm that the information provided in this form is accurate to the best of my knowledge.

Patient Signature *

Date *