SUNSHINE WELLNESS, LLC
Mental & Sexual Health
60 Boston Post Rd, Madison, CT 06443 | 📞 (203) 208-9682 | 📠 (855) 538-5510
contact@sunshinewell.org
www.sunshinewell.org

Patient Intake Form

Full Name: _____

- Date of Birth: ____ / ____ / _____ Age: _____
- Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____
- Gender Identity: _____
  Sexual Orientation (optional): _____
- **Marital/Relationship Status:**
  ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Other: _____
- **Employment Information:**
  - Employer: _____
  - Role/Position: _____
  - Work Phone: _____
  - Work Email: _____
- Address: _____
- Phone (Primary): _____
- Email (Primary): _____
- Preferred Contact: ☐ Phone ☐ Email ☐ Text

Emergency Contact

- Name: _____
- Relationship: _____
- Phone: _____

Insurance Information

- Provider: _____
- Policy Number: _____
- Subscriber Name (if not patient): _____

Primary Care Physician (PCP): _____ Phone:_____

4. Current Medications

Medication Name	Dose	Time of day taken

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5. Allergies (medication and reaction): _____

_____

6. Past Medical Conditions/Surgeries:

_____

_____

_____

_____

7. Psychiatric / Mental Health History

- Have you ever been or are you currently in therapy? ☐ Yes ☐ No
  If yes, with whom? _____
  Dates: _____
- Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
  If yes, please provide details (when, where, reason):
  _____
- Have you ever been in an outpatient psychiatric or substance treatment program?

☐ Yes ☐ No
If yes, please provide details (when, where, and reason):_____

_____

- Have you ever attempted suicide? □ Yes □ No.
  - If yes, please specify:
    _____
- Do you struggle with drug or alcohol use? □ Yes □ No
  - If yes, please specify:
    _____

8. Lifestyle & Support

1. **Tobacco Use:**
   ☐ Yes ☐ No
   If yes:
   • How many per day? _____
   • For how long? _____ years

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2. **Alcohol Use:**
   ☐ Yes ☐ No
   If yes:
   • Type of alcohol: _____
   • Frequency: ☐ Socially ☐ Minimally ☐ Frequently ☐ Infrequently
   • Average number of drinks in one setting: _____
3. **Recreational Drug Use:**
   ☐ Yes ☐ No
   If yes:
   • Type of drug(s): _____
   • Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
   • Duration of use: _____ years
4. **Exercise Frequency:**
   ☐ Daily ☐ Weekly ☐ Rarely ☐ Never
5. **Do you have supportive relationships in your life?**
   ☐ Yes ☐ No. if yes, who is person:
6. **Sleep disturbances?** ☐ Yes ☐ No. if yes: explain:

9. Family Medical History (parents, siblings, grandparents):

☐ Diabetes
☐ High Blood Pressure
☐ Heart Disease
☐ Stroke
☐ Cancer (type: _____)
☐ Mental Health Conditions (e.g., depression, anxiety, bipolar)
☐ Substance Use Disorder
☐ Other: _____

Additional details:

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10. Family Mental Health History

Has anyone in your family ever:

- Been diagnosed with a mental illness? ☐ Yes ☐ No
- Had a psychiatric hospitalization? ☐ Yes ☐ No
- Attempted suicide? ☐ Yes ☐ No

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- Struggled with drug or alcohol use? ☐ Yes ☐ No

If yes, please provide details below (relation, condition, treatment, medications):

Relation	Condition	Treatment	Medications

Additional notes / free text:

What mental health services are you seeking (Check all that apply.)
☐ Psychiatry ☐Therapy/counseling
Why are you seeking mental health treatment at this time?

1. _____
2. _____
3. _____

What do you hope to gain from mental health treatment? What would you like to be different?
1. _____
2. _____
3. _____

What do you like about yourself? What are your personal strengths?
_____
What are your interests and hobbies?
_____
What is important to you?
_____

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What helps you to feel calm? _____

8. Consent / Acknowledgement / Signature
I acknowledge that the information provided is accurate to the best of my knowledge.

- Signature: _____
- Date: _____
- Name: _____
- Relationship to Patient:_____
- Contact Number:_____
- ☐ Form completed by patient ☐ Form completed by parent/guardian ☐ Form completed by other