Laurie Muhlbauer, PMHNP, LLC

Adolescent Intake Screening/Request Form

If you or the adolescent is needing immediate assistance, contact the Psychiatric Crisis Center at 503-585-4949 or Youth and Family Crisis Services at 503-576-4673. For psychiatric or medical emergencies, contact 911 or go to the nearest emergency department.

By completing this paperwork, it does not guarantee that the adolescent will become a patient of Laurie Muhlbauer, PMHNP-BC. This is to help determine the fit between the individual and provider. A response will usually be provided within one to two weeks after this form is received. It can be mailed to Laurie Muhlbauer, PMHNP-BC at 910 Capitol St NE, Building C, Salem, OR, 97301, faxed to Laurie Muhlbauer, PMHNP-BC at 855-541-6860, or emailed to LaMuhlbauer@protonmail.com.

General Adolescent Information:

First name:	Last name:	Referred by:
Birthdate:	Gender:	
Contact # (if applicable):	Messages/texts on this number? Yes No	
Email:	Messages to this email address? Yes No	
Address:		
Parent/Guardian First name:	Parent/Guardian Last name:	
Contact #:	Messages on this number? Yes No	
Email:	Messages to this email address? Yes No	

Health insurance provider for adolescent:	Policy number:

Please describe the reasons for wanting the adolescent to be seen, including mental health concerns.

Current provider? What is the reason for changing providers (if applicable)? Is there a concern about the adolescent's care with past providers?

Past and current psychiatric/mental health diagnoses for adolescent:

Current medications including names, dosages, start dates, effectiveness, and side effects:

Does the adolescent have a therapist or counselor? Yes No
If not, are they willing to see a therapist? Yes No
If yes, what is their name, number, and location and how long have they been seen?

Has the adolescent had previous psychiatric hospitalizations or attended intensive outpatient programs or substance use programs? Yes No
If yes, please describe.

Has the adolescent had recent suicidal thinking with attempts, planning, or considered acting on thoughts? Yes No
If yes, please, describe.

Has the adolescent had past suicidal thinking with attempts, planning, or considered acting on thoughts? Yes No
If yes, please, describe.

Is there a current concern with drug addiction or substance use for the adolescent? Yes No
If yes, please describe.

Is the adolescent needing to be seen for SSI or disability claims/evaluation, court hearings, custody cases, or truancy issues? Yes No
If yes, please, describe.

Does the adolescent have any legal charges pending or legal issues? Yes No

Adolescent Signature: _____ Date: _____

Parent Signature: _____ Date: _____