Monarch

Name: **Medicaid ID #:** **Record #:**

Today's Date: ________ Time: _______

What is your full, legal name? (First, middle and last name):

Have you been discharged from a hospital or treatment facility in the last 7 days? ☐ No ☐ Yes
Date you were discharged: I don't remember: ☐
How long were you there? days I don't remember: ☐
Name of facility:

Reason for Admission (check all that apply): ☐ Medical ☐ Mental Health ☐ Substance Use

Have you been released from jail or prison in the last 7 days? ☐ No ☐ Yes
Date you were discharged: I don't remember: ☐
How long were you there? days I don't remember: ☐

Maiden Name (if applicable):

Preferred Name (if different from legal name; First, middle and last name):

Social Security Number: - - I don't know: ☐ Date of Birth:

Phone Number: ( ) - (home) AND/OR ( ) - (cell)

Full Address: House Number / City/ State/ Zip/ County of Residence:

Mailing Address (if different from above):

Email Address: @

Preferred Method of Communication (check one): ☐ cell phone ☐ home phone ☐ email

Preferred Method for receiving reminders for your appointments (check one):
☐ Phone ☐ Text ☐ Email ☐ Email AND Text

In order to determine what, if any, portion of the cost of your treatment you will be responsible for:
What is your gross monthly household income (total before taxes)? $
Number of dependents (you, plus spouse, plus number of children)?

Marital Status: ☐ Married ☐ Single/Unmarried ☐ Legally Separated ☐ Divorced ☐ Widowed ☐

How would you describe your race?
☐ Caucasian/White ☐ African-American/Black ☐ Native American/American Indian ☐ Alaska Native
☐ Pacific Islander ☐ Multi-racial ☐ Other ☐ Prefer not to answer

How would you describe your ethnicity?
☐ Hispanic, Mexican ☐ Hispanic, Puerto Rican ☐ Hispanic, Cuban ☐ Hispanic, Other ☐ Non-Hispanic origin
☐ Prefer not to answer

How would you describe your gender identity?
☐ Female ☐ Male ☐ Female-to-Male/Transgender Male ☐ Male-to-Female/Transgender Female
☐ Genderqueer, neither exclusively Male or Female ☐ Other, please specify
☐ Prefer not to answer

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Do you smoke cigarettes or use any other tobacco products? ☐ Yes ☐ No

Do you have a Psychiatric Advanced Directive? ☐ Yes ☐ No Do you have a copy? ☐ Yes ☐ No
If not, would you like more information about Psychiatric Advanced Directives? ☐ Yes ☐ No

Emergency Contact 1:
First/Last Name Phone Relationship
Check all that apply:
☐ Monarch may contact this person ONLY in case of emergency
☐ Monarch may communicate with this person about my appointments and/or other details regarding my treatment

Emergency Contact 2 (if applicable):
First/Last Name Phone Relationship
Check all that apply:
☐ Monarch may contact this person ONLY in case of emergency
☐ Monarch may communicate with this person about my appointments and/or other details regarding my treatment

Are there any additional family members or friends who you would like to be involved in your treatment?
First/Last Name Phone Relationship
First/Last Name Phone Relationship

Do you have a Mental Health Provider?
☐ No ☐ Yes
Name of Provider/Practice: I don't know: ☐
Type of provider you see (i.e. therapist, psychiatrist, case worker, etc): I don't know: ☐
Address: I don't know: ☐
Phone Number: I don't know: ☐
Would you like to give us permission to communicate with this provider? ☐ Yes ☐ No

Do you have a Primary Care Provider?
☐ No ☐ Yes
Name of Provider/Practice: I don't know: ☐
Address: I don't know: ☐
Phone Number: I don't know: ☐
Would you like to give us permission to communicate with this provider? ☐ Yes ☐ No

If you are pregnant, do you have an Ob/Gyn provider?
☐ No ☐ Yes
Name of Provider/Practice: I don't know: ☐
Address: I don't know: ☐
Phone Number: I don't know ☐
Would you like to give us permission to communicate with this provider? ☐ Yes ☐ No

MEDICAL HISTORY

Are you currently pregnant? ☐ Yes ☐ No

Are you currently experiencing pain? ☐ No ☐ Yes
Pain location(s):

On a scale of 1 to 10 (1 = a little pain, 10 = the worst pain you've ever experienced), how would you rate your pain right now?

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Is your pain new or longstanding? ☐ New (Acute) ☐ Longstanding (Chronic)

How is your pain being treated? ☐ Heat ☐ Ice ☐ Seeing provider ☐ Medications

If you are not seeing a provider for pain, would you like us to connect you with a provider for pain? ☐ Yes ☐ No

Have you had, or do you currently have, any of the following conditions? (check all that apply):

☐ High Blood Pressure
☐ High Cholesterol
☐ Diabetes
☐ Heart Attack
☐ Congestive Heart Failure
☐ Stroke
☐ Seizure
☐ Head Injury
☐ Asthma
☐ COPD/Emphysema
☐ Tuberculosis
☐ HIV/AIDS
☐ Hepatitis B
☐ Hepatitis C
☐ Cancer
☐ Dental Problems
☐ Acid Reflux
☐ Chronic Kidney Disease
☐ Diarrhea for greater than 1 week
☐ Nausea/Vomiting for greater than 1 week
☐ Appetite Changes for greater than 1 week
☐ Weight loss OR gain of more than 10 pounds over the last 3 months
☐ Obesity
☐ Other
☐ No conditions to report

Would you like us to connect you with a provider for any of the conditions checked above? ☐ No ☐ Yes
Please specify which conditions:

Do you have any allergies? ☐ No ☐ Yes
If yes, please list:

What is the main reason for your visit today? Do you have any specific goals for your visit today?

Were you referred to Monarch? ☐ No, I found Monarch on my own ☐ Yes
If Yes, please specify referral source:

☐ Medical Provider (Primary Care, Pediatrician, or other):
☐ Mental Health Provider:
☐ Guardian:
☐ School:
☐ Hospital/ER:
☐ Friend/Family:
☐ DSS/Justice System:
☐ Insurance Carrier:

Who is completing this form (check all that apply??

☐ Self/Patient
☐ Parent or guardian
☐ Monarch staff member
☐ Other:

If Monarch wasn't an option for your services today, where would you have gone?

☐ Hospital Emergency Department
☐ Another agency like Monarch
☐ My Primary Care Provider
☐ An Urgent Care Center
☐ Nowhere; I would not have gotten services
☐ Other: