Dear Community Member,

Thank you for your interest in the Lester Daigle Behavioral Health Program at TAN Healthcare.

We are honored that you've considered us as a partner on your mental and emotional health journey. At TAN Healthcare, we believe that mental health is health — and every person deserves care, support, and dignity.

While we strive to serve as many individuals as possible, there are times when our current availability, provider capacity, or scope of services may not be the best fit for your needs. In those cases, our goal is not to turn you away — but to help guide you toward the care that best supports your healing.

To help us better understand how we can support you, we ask that you complete the enclosed intake packet. This information helps our team evaluate your needs and determine whether our services align with your care goals and whether we have timely availability to begin treatment. The more thorough you can be in your responses, the more clearly we can assess how to proceed.

If we're able to move forward with care at TAN Healthcare, someone from our eligibility and scheduling team will contact you to begin next steps. Your intake will also serve as part of your initial evaluation, which supports the development of a personalized treatment plan.

Please note: while we are committed to continuity of care, we may not be able to continue certain existing medications. If a referral is determined to be the best course of action, we'll do our best to recommend trusted community resources that can support you.

We deeply appreciate your patience as we complete this review process. You may not receive a response immediately — it could take up to two weeks — so we encourage you to continue exploring other local care options while we assess your packet.

We're here to support you — whether that's through care at TAN Healthcare or helping you find the right path forward.

Warmly,
The Lester Daigle Behavioral Health Services Team
TAN Healthcare

Intake Questionnaire For New Patients

This questionnaire will help us get to know you better and provide the best possible mental health services.
Please complete this form as honestly and completely as possible.
All information you provide us will be confidential as state and federal law requires.

Date: _____ **Social Security Number:** _____

Name: _____ **Date of Birth:** _____ **Age:** _____

Home Address: _____ **City/State/Zipcode:** _____

Home Phone: _____ **Cellular/Alternate Phone:** _____

Marital Status: single married separated divorced widowed

In your own words, describe the current problems as you see them:

_____

_____

How long has this been going on?

_____

What made you come in at this time?

_____

What do you hope to gain from this evaluation and/or counseling?

_____

_____

What have you done to cope if you had difficulties in the past? Was it helpful?

_____

_____

Initials: _____ *DOB:* _____

Symptoms

*Please **check** any symptoms or experiences that you have had **in the last month***

- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed mood
- ☐ Feeling numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Flashbacks
- ☐ Difficulty falling asleep, staying asleep, or waking early in the morning
- ☐ Avoiding people, places, activities, or specific things
- ☐ Difficulty concentrating or thinking
- ☐ Thoughts about harming or killing yourself
- ☐ Persistent, repetitive, intrusive thoughts, impulses, or images
- ☐ Unusual visual experiences such as flashes of light or shadows
- ☐ Hear voices when no one else is present
- ☐ Self-mutilation/cutting
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Sense of lack of control
- ☐ Abusive relationship
- ☐ Anger or irritability
- ☐ Changes in eating/appetite
- ☐ Decreased energy

Please describe any other symptoms or experiences you have had problems with:

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before?

☐ No ☐ Yes If so, please list the name and profession: _____

_____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ Yes, If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Initials: _____ *DOB:* _____

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	How long have you been taking it?

Have you been on **PSYCHIATRIC** medication in the past? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? ☐ No ☐ Yes If YES, describe:

Any past suicidal thoughts and/or ideas? ☐ No ☐ Yes If YES, describe:

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? ☐ No ☐ Yes If YES, describe:

_____

List any PRIOR illnesses, surgeries, and/or accidents

_____

List any drug allergies:

_____

FAMILY

Please place a checkmark in the appropriate box if these are or have been present in your relatives:

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Alcohol Abuse/Misuse							
Drug Use							

Education

Highest grade level completed: _____
Degree obtained, if applicable: _____
Did you have any disciplinary problems in school? _____
If yes, please explain: _____
Were you considered hyperactive/ADHD in school? _____
If yes, were/are you on any medication? _____
If yes, were/are you on any medication? _____
If so, which medication? _____
What kinds of grades did you get in school? _____

Have you served in the military? _____
If yes, please describe briefly: _____
_____

What type of discharge (separation) did you get? _____

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: _____
_____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? _____ If yes, age of first use _____
How much do you drink? _____
How often do you drink? _____
Have you ever passed out from drinking? _____ How often? _____
Have you ever blacked out from drinking? _____ How often? _____
Have you ever had the "shakes"? _____ How often? _____
Have you ever felt you should cut down on your drinking/drug use? _____
Have people annoyed you by criticizing your drinking/drug use? _____
Have you ever felt bad or guilty about your drinking/drug use? _____
Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? _____
Do you use tobacco? _____
If yes, how often? _____

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you? _____

_____

_____

_____

Initials: _____ *DOB:* _____