Name:_____
Student ID:_____
DOB:_____

New Patient Intake

Boynton Health – Mental Health Clinic

Welcome to the Boynton Health Mental Health Clinic

The Mental Health Clinic is open to degree-seeking University of Minnesota Twin Cities campus students who have been assessed the Student Services Fee at the time of service or current Graduate Assistants covered by the Graduate Assistance insurance plan offered through the University of Minnesota. If you have any questions about eligibility, please speak with a receptionist or call the front desk at 612-624-1444.

If you are new to the mental health clinic or have not been seen in over one year:

- Please complete the full intake packet with a black ink pen.
- Give the packet, your student ID card, your insurance card and the date of birth of the insurance policy's main subscriber to the front desk staff.

There are some services that we are presently unable to offer or offer on a limited basis:

- **ADD\ADHD:** Boynton Health has specific guidelines regarding the diagnosis and treatment of ADHD. If you are seeking ADHD assessment of treatment, please speak with a receptionist or review these guidelines on our website.

- **Eating Disorders:** While the Mental Health Clinic does not provide specific eating disorder treatment, we do offer a comprehensive Eating Disorder Evaluation which will assist you in determining a diagnosis and recommending the best course of treatment for you. If you need more intensive treatment, we will assist you in establishing care with an eating disorder specialty clinic in the community.

- **Long Term Therapy:** The Mental Health Clinic utilizes a short-term model of psychotherapy. This means that we are able to offer ten individual or couples therapy visits within the period of one year. The Medical Social Worker can provide you with other outside resources 612-624-8182.

- **Legal Assessments:** We are unable to provide legal assessments, with the exception of substance use assessments. The Medical Social Worker can provide you with resources 612-624-8182 or University Legal Services 612-624-1001.

- **Emotional Support Animal:** ESA support letters will be considered only for students who are receiving active, ongoing treatment in the Boynton mental health clinic. We do not see students solely to assess for an ESA or to write an ESA support letter. An ESA can only be recommended as an essential part of a treatment plan designed to address a disability associated with a clearly diagnosed psychiatric condition -- and then always at the provider's discretion.

Urgent counseling is available during clinic hours. Services are limited between 11:45AM-1PM and after 4PM. Please check which of these apply, and indicate if you would like to speak to someone urgently:

☐ **I DO feel at risk of harming myself or someone else**
☐ **I DO NOT feel at risk of harming myself or someone else**

COMMON INTAKE FORM

Boynton Mental Health Clinic, 410 Church Street SE

Student Counseling Services, 340 Appleby Hall, 128 Pleasant Street SE

Today's Date:	First Name:	Middle Name:	Last Name:

Date of Birth:	Age:	Student I.D.:	Preferred Name:	Pronouns:

Cell Phone:	OK to call cell phone?	Home Phone:	OK to call home phone?
	☐		☐

Email:	☐ OK to Email

Local Address: (OK to contact you at home) ☐	Permanent Address:
Street	Street
City	City
State/ZIP	State/ZIP

Emergency Contact Person:
Relationship to You:
Telephone:

What kind of help are you seeking? Select all that apply:

☐ **Individual therapy /counseling**	☐ **Medication management (BH)**	☐ **Group Counseling**
☐ **Career Counseling (SCS)**	☐ **Substance Use Assessment (BH)**	☐ **Medical social work/Case management**
☐ **Academic Counseling (SCS)**	☐ **Couples Counseling (BH)**	☐ **Eating Disorder Evaluation**
Other:		

What is your primary reason for seeking help?

Are you currently experiencing a crisis?	☐	Yes	☐	No
Describe the nature of the crisis:				

What other significant concerns do you have?

What convinced you to get help now?

Are you requesting to have a form or letter?	☐	Yes	☐	No
If yes, please describe:				

COMMON INTAKE FORM

Boynton Mental Health Clinic, 410 Church Street SE

Student Counseling Services, 340 Appleby Hall, 128 Pleasant Street SE

How satisfied are you with your academic progress?	☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very dissatisfied

What barriers, if any, are impeding your academic progress so far?

What do you like best about college and college life?

What do you like least about college and college life?

What are your long term education and vocational goals?

Other important long-term plans and goals?

How sure are you about these future plans?	☐ Very Certain ☐ Certain ☐ Uncertain ☐ Very uncertain

Please list any previous or current mental health therapy and any previous hospitalizations:

Provider/Clinic	Condition/Issue	Date(s)

Do you have any health problems?

Please list any current medications (psychiatric, medical, and over-the-counter):

Medication	Dose	Benefits/Side Effects

Please describe your primary parental figures:

	Parent #1	Parent #2
How related to you		
Education		
Occupation		

Number of siblings	Full:	Half:	Step:

COMMON INTAKE FORM

Boynton Mental Health Clinic, 410 Church Street SE

Student Counseling Services, 340 Appleby Hall, 128 Pleasant Street SE

Gender: Please check the appropriate box or fill in below: ☐Male ☐Female ☐ Transgender ☐Fluid ☐My description (please fill in): ☐ Prefer Not to Answer	Sexual Orientation: Please check the appropriate box or fill in below: ☐Asexual ☐Bisexual ☐ Gay ☐Hetero/straight ☐Questioning ☐ My description (please fill in): ☐ Prefer Not to Answer

Relationship Status: ☐Single ☐ Dating ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Other:

Undergrad Student: ☐Fresh ☐ Soph ☐ Junior ☐Senior ☐ PSEO ☐ Other

College:	Major:	Minor:

☐	Grad School Masters	Program:
☐	Grad School Ph.D.	Program:
☐	Professional School	Program:

Current Credit Load:	Anticipated Graduation Date:

Military Service Status:	☐Active ☐Vet ☐ROTC ☐National Guard ☐None ☐Other:

Country of Citizenship:	Ethnic Background:

Languages Spoken:	International Student: ☐Yes ☐No

Religious or spiritual affiliation:	
Are you a member of a fraternity or sorority?	☐ Yes ☐ No
Other organizations important to you:	

How did you happen to come to Boynton Mental Health and/or Student Counseling Services (check all that apply):

☐	Academic Advisor	☐	Dean (College)	☐	Mental Health Professional
☐	Aurora Center	☐	Disability Resource Center	☐	Previous Use
☐	Boynton Health	☐	Faculty	☐	Stress Check-In
☐	Clergy/Pastoral	☐	Family	☐	Student Counseling Services
☐	College office or program	☐	Friend	☐	Student Conflict Resolution
☐	Community Advisor/Res Hall Staff	☐	General knowledge	☐	Website

Boynton Mental Health Clinic, 410 Church Street SE

Please fill this section out if you are seeking medication evaluation or other treatment at Boynton Mental Health Clinic

List any previous medication trials:

Medication	Dose	Dates	Benefits/Side Effects

Medication Allergies:

Family Mental Health History:

	Mother	Father	Sibling	Other (List)	What treatment?
Anxiety	☐	☐	☐		
Depression	☐	☐	☐		
Bipolar Disorder	☐	☐	☐		
Substance Abuse	☐	☐	☐		
Other	☐	☐	☐		

Family Medical Health History:

	Mother	Father	Sibling	Other (List)
Diabetes	☐	☐	☐	
Heart Problems	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
High Cholesterol	☐	☐	☐	
Thyroid	☐	☐	☐	
Other	☐	☐	☐	

Are you concerned about past or present alcohol or drug use?	☐	Yes	☐	No
If yes, please describe:				

Are you concerned about past or present eating behaviors?	☐	Yes	☐	No
If yes, please describe:				

BOYNTON HEALTH
MENTAL HEALTH CLINIC
FAIL/LATE CANCEL POLICY

Print Name: _____

Student ID **#: _____**

I, _____ understand that missed or late-cancelled appointments interfere with my treatment and that of other students who might have been seen at that time. I agree to the following:

- **I will attend all scheduled appointments and group sessions.**
- **If I arrive 10 or more minutes late I may be asked to reschedule and be charged the late cancel fee.**
- **If I cannot attend a scheduled appointment or group session, I will cancel the appointment by 4:30PM of the business day prior to the appointment.**

There is a $10 late-cancel fee for any appointment or group session that I do not cancel by 4:30PM of the business day before the appointment.

There is a $20 no-show fee for any missed appointment or group session.

I understand that email reminders are a courtesy provided by Boynton Health. If I do not receive an email reminder, I am still responsible for keeping my appointment and late cancel/fail fees apply.

Fees are due when billed. Fees that are not paid may be transferred to student accounts receivable and may interrupt my care. Student accounts receivable may assess additional fees to collect this balance.

I acknowledge that failing or late-cancelling two consecutive appointments or three appointments within six months at the Mental Health Clinic may result in a scheduling hold being placed on my account. This means I will not be able to schedule appointments with the Mental Health Clinic. This hold can only be removed by presenting in person at the Boynton Health Patient Accounting Office (N325). All outstanding late cancel or fail fees must be paid at that time. Once the hold is removed, I must present in person at the Mental Health Clinic to schedule my next appointment.

If I do not take steps to remove the hold, Boynton Mental Health Clinic may terminate care with me. Termination of care will end the responsibility of the Mental Health Clinic to see me as a patient. I understand it will then be my responsibility to find another mental health provider to continue my care and that the Mental Health Clinic will work with me to facilitate this transfer of care. In such circumstances the Mental Health Clinic will be willing to provide urgent consultation for up to 30 days after I have received notification of my ineligibility to be seen at the Mental Health Clinic.

I recognize that Boynton Health will be under no obligation to pay for any mental health care following termination from the Mental Health Clinic. It will be my sole responsibility to cover these expenses.

Signature_____ **Date_____**

A reproduction of this form is as valid as the original.