WORKERS COMPENSATION INTAKE FORM

2572 West State Rd. *Suite 3056 *Oviedo, FL 32765*Office 407-706-6580*Fax 407-706-6586

Name:	Date of Birth:	Gender (circle): ☐M ☐F	Marital Status: **MARK ONE** ☐Single ☐Married ☐Widowed ☐Divorce
Address:			State: / Zip Code
Phone Number	Email:	**Last four digits of SSN**	In Case of an Emergency Who should we Contact? ☐**Husband** ☐**Wife** ☐**Friend** ☐**Other** **Name:** **Contact #:** ☐**Patient declined to provide Next of Kin information** **For staff use only: Initials:_____ Date:_____**

Date of Injury	**Nature of Injury / Incident:**	**Employer Name:**
Employee Status: ☐**Active** ☐ **Medical Leave** ☐**Terminated** ☐**Other**	**OCCUPATION**	**Employer Address:**
Workers Compensation Insurance Carrier	**Telephone Number:**	**Adjuster's Name:** **Phone Number:**

Claimant's Attorney, Adjuster and Case Manager Information

Attorney's Name:
Phone#:
Law Firm Address:
Nurse Case Manager Name: **Phone#:**

CLINICAL INFORMATION

Primary Care Physician	**Phone Number:**	**Fax Number:**	
Do you currently see a Mental Health Therapist or Psychologist? ☐**Yes** ☐ **No**		**Name:**	**Telephone Number:**

I affirm that all the information provided above is accurate to the best of my knowledge. I have thoroughly reviewed MindHope office policies, accessible on their official website and available within the waiting room area. I hereby give my consent to the stipulated terms. I authorize my workers' compensation insurance carrier or my attorney to directly pay MindHope of Oviedo for the service(s) that will be rendered to me.

I understand that referrals to MindHope may be for **psychiatric evaluation only** or for **evaluation and treatment**. If I am referred for evaluation only, I acknowledge that no ongoing doctor-patient relationship is established, and no treatment will be provided unless separately authorized. If my referral includes treatment, I understand that a doctor-patient relationship is established. I further acknowledge that if my workers' compensation claim is formally settled, I will no longer be eligible for workers' compensation benefits, and any continued care or follow-up appointments will be my ***sole financial responsibility***, payable directly to MindHope.

I understand this is legally binding, and any failure to fulfill the agreed-upon financial obligations will be deemed a breach of the financial agreement.

Patient or Guarantor Signature_____Date:

Client's Right: Rules Under Chapter 440, Florida Statutes. "In Florida, an injured worker has the right to select a pharmacy or pharmacist. Florida Law prohibits interference with the right the patient has to choose a pharmacy at any time a patient becomes dissatisfied with their pharmacy or pharmacist's services, they can seek another pharmacy to fill their prescription. The Insurer, Attorney, Adjuster or Case Manager, Physician, or Nurse cannot interfere with their rights to choose which pharmacy they prefer.

Revised 2026

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
HON HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We want to bring to your attention our Notice of Privacy Practices, which outlines your rights regarding the use and sharing of your personal information. A printed copy of this document is conveniently available at the reception desk.

By appending your signature to this form, you acknowledge that we have provided you access to the abovementioned information. Furthermore, your signature signifies your acceptance of the terms and conditions outlined therein.

In conducting examinations, diagnoses, treatments, and referrals, we must gather what is legally Protected Health Information (PHI) concerning you. This information is imperative in guiding our decisions regarding your optimal treatment regimen and providing that treatment. It is important to note that specific circumstances may necessitate sharing this information with other medical professionals involved in your care, entities responsible for facilitating payment for the treatments provided, or other pertinent business or governmental functions.

It is crucial to underscore that in the absence of your signature on this consent form, signifying your agreement to the terms outlined in our Notice of Privacy Practices, we are regrettably unable to proceed with providing treatment. We understand that you might have reservations regarding using certain aspects of your information. In such a scenario, you have the prerogative to formally request that we abstain from utilizing your information for treatment, payment, or administrative purposes. This request must be presented in writing, specifying the exact nature of your preferences. While we strive to honor your preferences, we must recognize that adherence to these limitations is not legally mandated. However, should we comply with your stipulations, we assure you that our commitment to adherence will be in accordance with the legal framework.

Please do not hesitate to contact us if you require additional clarification or have any inquiries.

Patient Name: **Date of Birth**:

I acknowledge that **MINDHOPE OF OVIEDO** has provided a copy of their Notice of Privacy Practices, which is available for review in the waiting room area. I can also request a copy of it. Additionally, it is available on their website at www.mindhopehealth.com. **Effective: Date**: Click or tap here to enter text.

Signature (patient or authorized representative):_____

Relationship/Authority (***if signed by authorized representative***):

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PATIENT HEALTH QUESTIONNAIRE

All questions contained in this form(s) are strictly confidential.

Patient Name	Date of Birth	Claim Number	Date of Accident	Adjuster's Name

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED:
Do you have any pain in your body? ☐YES ☐NO rate your pain 10 been extremely painful ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Is this pain interfering with your work and/or personal life? ☐YES ☐NO
Have you ever had a blood transfusion? ☐Yes ☐No When:

Surgeries:		
Year	Reason	Hospital
Other hospitalizations		
Year:	Reason:	Hospital:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Medication Name	Strength	Frequency Taken
Allergies to medications		
Name the Medication	Reaction You Had	

Patient Initials:

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HISTORY OF MENTAL HEALTH PROBLEMS

Is stress a major problem for you?	☐Yes	☐No
What stresses you the most?		
Do you feel depressed? ☐YES ☐NO How long have you been feeling depressed?		
Do you panic when stressed?	☐Yes	☐No
Do you dislike yourself?	☐Yes	☐No
If you feel angry, do you tend to keep quiet about it initially but later erupt and lose your temper?	☐Yes	☐No
Have you experienced repeated or unexpected "attacks" during which you suddenly are overcome by fear for no apparent reason	☐Yes	☐No
Do you have upsetting or distressing thoughts, impulses, or images that happen in your mind repeatedly?	☐Yes	☐No
Has there ever been a time when you felt so good or so hyper that other people thought you were not your usual self or you were so hyper that you got into trouble?	☐Yes	☐No
Do you cry frequently?	☐Yes	☐No
Have you ever attempted suicide? ☐**YES** ☐**NO** How long ago Was this your first time ☐**YES** ☐**NO** If No, how many other times have you attempted suicide? What made you change your mind?		
Have you ever seriously thought about hurting yourself? ☐YES ☐NO Please explain: Have you ever thought of hurting someone else? Any mental health hospitalization or Rehabilitation in the last 2 years? ☐Yes ☐No How long ago? .		
Do you have trouble sleeping?	☐Yes	☐No
Have you ever been treated at a methadone clinic or received Suboxone treatment in the last two years?	☐Yes	☐No
Have you ever been to a counselor? ☐**YES** ☐ **NO** How long ago?		
Have you ever seen a psychiatrist before? ☐ **YES** ☐**NO** How Long?.		
When was the last time you saw your psychiatrist? .		

PLEASE CHECK ALL THAT APPLIES TO YOU

☐ **Depressed** ☐ **Sadness** ☐**Crying Spells** ☐**Loss of Interest** ☐**Anxiety** ☐**Panic Attack**
☐ **Irritability** ☐**Rages** ☐**Fearfulness** ☐**Feelings of hopelessness** ☐**Insomnia**
☐**Feelings of helplessness** ☐**Hypersomnia** ☐**Fatigue** ☐**Forgetfulness**
☐**Poor concentration** ☐**Headaches** ☐**Weight loss** ☐**No appetite**
☐ **Increased appetite** ☐ **Bingeing** ☐**Thoughts of Suicide**

Smoking/Alcohol History

Have you ever smoked tobacco products? (e.g., cigarettes, cigars, pipes)
☐**Yes** ☐ **No**
If yes, please specify: How many years did you smoke?
How many cigarettes per day did/do you smoke?
Have you quit smoking?
☐ **Yes** ☐ **No**
Do you consume alcoholic beverages?
☐ **Yes** ☐ **No**
How often do you drink alcohol?
☐ **Daily** ☐ **Weekly** ☐ **Occasionally** ☐ **Rarely** ☐ **Never**
Have you ever used recreational or illicit drugs? ☐ **Yes** ☐ **No**
Please note that all information provided is confidential and will be used solely to assist in your care and treatment.

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PHQ-9 DEPRESSION ASSESSMENT FOR

Patient Name(print): **Date of Birth:**

Mark with an "X" to indicate your answer	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0☐	1☐	2☐	3☐
2. Feeling down, depressed, or hopeless	0☐	1☐	2☐	3☐
3. Trouble falling or staying asleep, or sleeping too much	0☐	1☐	2☐	3☐
4. Feeling tired or having little energy	0☐	1☐	2☐	3☐
5. Poor appetite or overeating	0☐	1☐	2☐	3☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0☐	1☐	2☐	3☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0☐	1☐	2☐	3☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0☐	1☐	2☐	3☐
9. Thoughts that you would be better off dead, or of hurting yourself	0☐	1☐	2☐	3☐

After you have added each individual column then add the total of the three columns and write that total number in the TOTAL SCORE SECTION >>>>>>>>>>>>

		+	

= TOTAL SCORE:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Signature: **Date:**

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