SanctumTools User Intake Form

Purpose: This form provides critical context for your AI assistant, healthcare providers, emergency contacts, and disability reviewers.

IMPORTANT: NO PRESSURE TO COMPLETE EVERYTHING NOW

This form is intentionally comprehensive, and that might feel overwhelming.

You do NOT need to fill out everything at once.

Start with what you know right now: - Your diagnosis and current medications (most important) - One emergency contact - Your psychiatrist's information

Fill out the rest as you go: - Add information when you have it - Update sections as things change - Skip sections that don't apply to you - Come back to this anytime

This is a living document. It grows with you. Start small, build as you need.

Minimum to get started: - Section: Primary Diagnosis - Section: Current Medications - Section: Emergency Contacts (at least one person) - Section: Healthcare Providers (at least your psychiatrist)

Everything else can wait.

BASIC INFORMATION

Full Name: _____

Preferred Name: _____

Date of Birth: _____

Current Date: _____

Location/Timezone: _____

PRIMARY DIAGNOSIS

Primary Diagnosis: _____

Example: Bipolar I Disorder, Ultra-rapid (ultradian) cycling

Additional Diagnoses: - _____
- _____
- _____

Date of Diagnosis: _____

Diagnosing Provider: _____

CURRENT MEDICATIONS

Medication 1: - Name: _____
- Dosage: _____
- Frequency: _____
- Prescribing Doctor: _____
- Start Date: _____
- Purpose: _____

Medication 2: - Name: _____
- Dosage: _____
- Frequency: _____
- Prescribing Doctor: _____
- Start Date: _____
- Purpose: _____

Medication 3: - Name: _____
- Dosage: _____
- Frequency: _____
- Prescribing Doctor: _____
- Start Date: _____
- Purpose: _____

Additional Medications: - _____
- _____

Medications to AVOID (allergies/adverse reactions): - _____
- _____

HEALTHCARE PROVIDERS

Psychiatrist

Name: _____

Practice/Organization: _____

Phone: _____

Email: _____

Address: _____

Next Scheduled Appointment: _____

Appointment Frequency: _____

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Therapist/Counselor (Optional - Fill out if applicable)

Name: _____

Practice/Organization: _____

Phone: _____

Email: _____

Next Scheduled Appointment: _____

Therapy Type: _____
(e.g., DBT, CBT, etc.)

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Primary Care Physician (Optional - Fill out if applicable)

Name: _____

Practice/Organization: _____

Phone: _____

Email: _____

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Other Specialists (Optional - Fill out if applicable)

Specialist 1: - Name: _____
- Specialty: _____
- Phone: _____

Specialist 2: - Name: _____
- Specialty: _____
- Phone: _____

EMERGENCY CONTACTS

Emergency Contact 1: - Name: _____
- Relationship: _____
- Phone: _____
- When to call: _____
- Can access home? (Yes/No): _____

Emergency Contact 2 (Optional): - Name: _____
- Relationship: _____
- Phone: _____
- When to call: _____
- Can access home? (Yes/No): _____

Emergency Contact 3 (Optional): - Name: _____
- Relationship: _____
- Phone: _____
- When to call: _____
- Can access home? (Yes/No): _____

SUPPORT TEAM (Optional - Fill out as you build your support network)

AI Assistants

Primary AI Assistant: - Name: _____
(e.g., Fred) - Platform: _____
(e.g., Claude) - Role: _____
(e.g., Daily mood tracking, DBT coaching)

Secondary AI Assistant: - Name: _____
(e.g., Keira) - Platform: _____

(e.g., Gemini) - Role: _____
(e.g., Weekly pattern analysis)

Additional AI Assistants: - Name: _____
- Platform: _____
- Role: _____

_____

Human Support Network (Optional)

Support Person 1: - Name: _____
- Relationship: _____
- Role in support: _____
(e.g., Daily check-ins, holds medications) - Phone: _____

Support Person 2: - Name: _____
- Relationship: _____
- Role in support: _____
- Phone: _____

Support Person 3: - Name: _____
- Relationship: _____
- Role in support: _____
- Phone: _____

_____

CRISIS RESOURCES

National Crisis Lines (Always Available): - 988 Suicide & Crisis Lifeline:
Call or text 988 - Crisis Text Line: Text HOME to 741741 - SAMHSA National
Helpline: 1-800-662-4357

Local Crisis Resources (Fill out when you have time):

Local Crisis Center: - Name: _____
- Phone: _____
- Hours: _____

Preferred Hospital/ER: - Hospital Name: _____
- Address: _____
- Phone: _____
- Notes: _____
(e.g., Has psychiatric unit)

Mobile Crisis Team: - Organization: _____
- Phone: _____
- Coverage Area: _____

SAFETY PLAN (Fill out when you're ready - this is important but not urgent)

Warning Signs I'm Entering Crisis: 1. _____
2. _____
3. _____

Coping Strategies That Help: 1. _____
2. _____
3. _____

People/Places That Help Me Feel Safe: 1. _____
2. _____
3. _____

Reasons for Living: 1. _____
2. _____
3. _____

MEDICAL ALERTS (Fill out if applicable)

Known Allergies: - _____
- _____
- _____

Other Medical Conditions: - _____
- _____
- _____

Recent Hospitalizations: - Date: _____ Reason:
_____
- Date: _____ Reason: _____

Surgical History (if relevant): - _____
- _____

INSURANCE & LEGAL INFORMATION (Fill out when needed for appointments/disability)

Health Insurance: - Provider: _____
- Member ID: _____

- Group Number: _____
- Phone: _____

Pharmacy: - Pharmacy Name: _____
- Phone: _____
- Address: _____

Disability Application Status: - Applied for SSDI/SSI? (Yes/No):
_____
- Application Date: _____
- Case Number: _____
- Next Interview/Hearing: _____
- Attorney/Representative: _____

Advance Directives (Optional - but recommended): - Healthcare Power
of Attorney: _____
- Living Will: (Yes/No): _____
- Psychiatric Advance Directive: (Yes/No): _____
- Location of Documents: _____

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DAILY ROUTINE & TRIGGERS (Fill out as you learn your patterns)

Typical Sleep Schedule: - Bedtime: _____
- Wake Time: _____
- Sleep Issues: _____

Medication Schedule: - Morning: _____
- Afternoon: _____
- Evening/Night: _____

Known Triggers (Add as you discover them): 1. _____
2. _____
3. _____
4. _____
5. _____

Protective Factors (What helps you stay stable): 1. _____
2. _____
3. _____

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AI ASSISTANT INSTRUCTIONS (Optional - helps personalize your experience)

Communication Preferences: - Tone preference: _____
(e.g., Direct, Supportive, Clinical) - Avoid these topics/words: _____
- Helpful reminders: _____

Tracking Priorities: - Primary focus: _____
(e.g., Mood cycling frequency, Medication effectiveness) - Secondary focus:
_____
- What to alert about: _____

DBT Skills Focus: - Skills to practice: _____
(e.g., Distress Tolerance, Emotion Regulation) - Skills already mastered:
_____
- Skills to learn: _____

NOTES & ADDITIONAL INFORMATION (Optional)

Important Context AI Should Know:

_____

_____

_____

_____

_____

Goals for Using SanctumTools:

1. _____
2. _____
3. _____

_____

CONSENT & ACKNOWLEDGMENT

I understand that: - This information will be referenced by my AI assistant during mood tracking - This information may be shared with healthcare providers when generating reports - I am responsible for keeping this information updated - In an emergency, this information may be accessed by emergency contacts - **I can fill this out gradually - there's no deadline**

Date Started: _____

Signature (when comfortable): _____

UPDATE LOG (Track changes as you add information)

Date: _____ **Updated By:** _____
Changes: _____

Date: _____ **Updated By:** _____
Changes: _____

Date: _____ **Updated By:** _____
Changes: _____

QUICK START CHECKLIST

To get started with SanctumTools, you only need:

☐ Your diagnosis (Primary Diagnosis section)
☐ Your current medications (Current Medications section)
☐ Your psychiatrist's name and phone (Healthcare Providers section)
☐ One emergency contact (Emergency Contacts section)

That's it. You're ready to start tracking.

Everything else can be added later when you're ready.

File Location: Save as `my_intake_form.md` in your SanctumTools directory

Keep Private: This file contains sensitive medical and personal information. Do not share publicly.

AI Assistant Access: Your AI assistant should reference this file at the start of each session for context.

Remember: This is YOUR tool. Fill it out at YOUR pace. No pressure. No judgment.