We set an initial appointment to have an opportunity to get to know each other. It does not guaranty that we will accept you as a patient. At the initial appointment we will make that decision.

Patient Information:

Date:

Name: Date of Birth:

Gender: Male ○ Female ○ Social Security Number:

Primary Phone # Email:

Marital Status: Married Widowed Divorced Single Domestic Partner

Address:

Primary Physician’s: Phone # Last Seen Date:

Does this visit pertain to Worker’s Compensation, FMLA, or Disability? Yes ○ No ○

Are you covered by insurance? Yes ○ No ○

Primary Insurance Company:

Policy/ID #: Group #: Phone #:

Policy Holder’s Name: Relationship: DOB:

Policy Holder’s Address:

Policy Holders Employer:

Secondary Insurance Company:

Policy/ID #: Group #: Phone #:

Policy Holder’s Name: Relationship: DOB:

Policy Holder’s Address:

Policy Holders Employer:

Medical History

What is the reason for your visit?

Have you received psychiatric treatment in the past? If yes please list providers, hospitalizations and prior-suicidal, homicidal attempts and prior psychiatric diagnosis.

Have you ever been hospitalized in a psychiatric facility? \_\_\_No \_\_\_Yes If so, where and when?

Were any medications ever prescribed to you by a psychiatrist or other providers for psychiatric illness or symptoms? \_\_\_No \_\_\_Yes, if so what was prescribed and for how long? Why did you stop taking your medication(s) if you did?

Current Psychiatric Medication(s), Dose/Frequency:

Past Psychiatric Medication(s), include dose and duration of time you took them:

Other Medications you take:

Allergies (Medication/Food): What occurs when you have a reaction?

Please list medical conditions you are or have been treated for:

Have you ever tried drugs and when was date of last use?

Marijuana Yes ○ No ○ \_\_\_\_\_ Cocaine Yes ○ No ○\_\_\_\_\_ Methamphetamines Yes ○ No ○ \_\_\_\_\_

Heroine Yes ○ No ○\_\_\_\_\_ Others:

How much alcohol are you currently using?