New Patient Intake Form

Patient Name: ____

Patient DOB: ____

Patient Address: ____

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Patient Phone #: ____

Reason For Seeking Care: ____

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Current and Past Psychiatric Medication and Year/s of Use: ____________________

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Past Mental Health Care Including Past Psychiatrists, Therapists, Inpatient Hospitalizations, Partial and Intensive Outpatient Hospitalizations and the Years: _______

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Past Suicide Attempts/Year:____

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Family Psychiatric History including biological parents, siblings, grandparents, etc: _____

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Current/Past Psychiatric Diagnosis: ______________________________________

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New Patient Intake Form

Do you have access to guns in the home or elsewhere? ____________________________
Are they locked up?____

Reproductive History including menstrual cycle length, pregnancies, elective abortions, miscarriage, fertility treatment/ Years: ____
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History of Menstrual Cycle, Menopause or Pregnancy/Postpartum related mental health concerns: ____
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Substance Use Present and Past including current use, last use and years of use:
Alcohol: ____
Nicotine: ____
Marijuana: ____
Opiates/Heroin: ____
Cocaine: ____
Acid/Molly/LSD: ____
Prescription Misuse or Addiction: ____
Other: ____

Single, Married, Divorced, Widowed: ____
Children number/age: ____
Parental Divorced, if so how old were you: ____
Difficulties in school Y/N, if so what: ____
____
Higher Level Education/where attended/year graduated: ______________________________
____
Current Occupation: ____

Past/Current Medical Diagnosis and Surgeries/Years: _________________________________
____
____
Current Medical Medications: ____
____
____

New Patient Intake Form

Emergency Contact Information

Name of Contact: ____

Phone Number of Contact : ______________________________________

Relation of Contact: ____

Address of Contact: ____

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Emergency Contact Information

Name of Contact: ____

Phone Number of Contact : ______________________________________

Relation of Contact: ____

Address of Contact: ____

____

Emergency Contact Information

Name of Contact: ____

Phone Number of Contact : ______________________________________

Relation of Contact: ____

Address of Contact: ____

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Other Information of Importance: _________________________________

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