Initial Visit Form:

Patient Name: _____

Date of Birth: / /

Address: _____

_____

Phone Number: ( ) -

Pharmacy:

Reason for Visit:

Past Psychiatric History:

Previous psychiatric hospitalization (please include dates, location, and length of hospitalization if known):

Current psychiatrist:

Previous psychiatrists:

Current therapist:

Previous therapists:

Psychiatric diagnosis:

Previously tried psychiatric medication (please include response to medication or side effects experienced).

Medical History:

Current primary care physician:

Medical diagnoses:

Current medication list (please attach if needed):

Allergies to medication:

Family history of mental illness:

Social history:

What is your highest level of education?

Are you currently working?

If yes, how often:

If no, how do you financially support yourself:

Who do you live with (family, friends, roommate, alone)?

What are your hobbies/interests?

Please describe your support system: