

Emergency Care Information

Primary Care Physician: Name: _____

Phone: _____

Address: _____
Street

_____ City _____ State _____ Zipcode

May we contact your personal physician to discuss medical or medication issues and/or coordinate your care?

No ___ Yes ___ If yes, please complete/sign "Consent" form in attached paperwork.

Family and/or friends to be contacted in an emergency:

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Current Concerns

Please provide a brief description of the major concerns that led you to seek treatment/therapy at this time:

Previous Psychiatrist/Therapist

Name of clinician: Phone Number/ Treatment dates

MEDICATIONS:

Please list all current drugs/medications, including over-the-counter:

Name of medication:	Dose	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any previous psychiatric drugs/medications:

Name of medication:	Dose	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ALLERGIES:

Physical Health Status

Do you have any existing medical problems or current physical symptoms of concern to you? If so, please describe.

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:

Date: _____

Health Insurance Information

Type: _____

PPO: Yes _____ No _____

Member ID number: _____

Group ID name and/or number: _____

Phone: _____

Address: _____

Street

City

State

Zipcode

Pharmacy Information

Name: _____

Phone: _____

Address: _____

Street

City

State

Zipcode
