Geriatric and Adult Psychiatry, LLC

NEW PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of birth: _____ Gender: ____Male ____Female _____Other

Social Security #: _____ Preferred language: _____

Race: Caucasian /African American /Hispanic /Latino/Asian/ Other: _____

Marital Status: Single ___ Married ___ Divorced ____ Widowed ____ Civil Union ___

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home Phone: _____

Work Phone: _____ Other Phone: _____

Where would you prefer us to leave messages? Home: __ Work __ Mobile: __ Other: _____

If other, please identify contact person's name: _____

Contact Person/Phone #: _____ Relationship: _____

Do you live alone? If not, with whom? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation to self: _____

Primary Phone #: _____ Other Phone #: _____

LEGAL AUTHORITY INFORMATION

Can you sign your own legal documents? Yes: ____ No: ___ If no, please complete the following:

If someone has legal authority for the patient, bring in legal documentation. Indicate the type of legal authority: Conservator: ____Executor of Estate: _____ Power of Attorney:__ Guardian: _____

Last Name: _____ First Name: _____

Mobile Phone: _____ Other Phone: _____

Relationship to patient: _____

LEGAL HISTORY

Do you have any criminal history? Yes ____ No ____

If yes, what charges/convictions?_____

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Patient Clinical History

Last Name: _____ First Name: _____

What is the primary reason for your visit today? _____

_____

Please circle any symptoms that have been present in the last month.

Forgetfulness	Hearing difficulties	Chronic pain
Confusion	Vision difficulties	Homicidal thoughts
Poor concentration	Dental problems	Constipation/diarrhea
Hallucinations	Headaches	Urinary incontinence
Depression	Chest pain	Agitation/restlessness
Anxiety /fears	Skin rashes	Shortness of breath
Lack of interest	Suicidal thoughts	Neurological problems
Change in energy	Sleep apnea	Joint or muscle pain
Change in appetite	Weight loss	Other: _____

OUT PATIENT CARE

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Other doctors involved in your care in the last year:

Physician: _____ Phone #: _____

Physician: _____ Phone #: _____

PSYCHIATRIC HISTORY Yes ____ No ____ If yes, detail below:

Past Diagnosis: _____

Previous Clinicians (Name and City) _____

Psychiatric Hospitalizations (Name, City and Year) _____

_____

Past Psychiatric Medications:

	Medication Name	Side Effects or Benefits
1.	_____	_____
2.	_____	_____

Allergies	Reactions
1. _____	_____
2. _____	_____

MEDICATIONS - List ALL prescriptions and over-the-counter medications you are currently taking. If this list is too lengthy, you can bring in all of your medication bottles or provide a list to include with this packet.

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Local Pharmacy: _____ Phone #: _____

Mail Order Service: _____ Phone #: _____

Name of Pharmacy Plan: _____ Plan ID: _____

PAST MEDICAL HISTORY - List past 3 hospitalizations

Reason for Hospitalization	Name of Hospital	Year
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

CURRENT MEDICAL PROBLEMS (Diabetes, Hypertension, Hepatitis, Gallstones, Ulcers, etc.)

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Do you smoke? Yes _____ No _____ If yes, how many packs per week? _____

Do you drink alcohol? Yes _____ No _____ If yes, how many drinks per week? _____

Do you use recreational drugs? Yes _____ No _____ If yes, which ones? _____

Do you have a living will? Yes _____ No _____

FAMILY HISTORY

	Health/Psychiatric Problems/Cause of Death	Age or Age at Death
Mother	_____	_____
Father	_____	_____
Brothers/Sisters	_____	_____
Brothers/Sisters	_____	_____
Brothers/Sisters	_____	_____