Peachtree Family Psychiatry Clinic
1720 Peachtree Street NW, Suite 320
Atlanta, Georgia 30309

Initial Information

Name_____Date_____DOB_____

Please use the back for additional space if necessary.

1. List the main reason for this consultation

2. How would you describe the problem that brought you here?

3. Why do you think this problem occurred?

4. Who referred you here? How did you choose us?

5. Have you ever had psychiatric treatment in the past? If yes, list below. (Include hospitalization, marriage or sexual counseling, individual psychotherapy, child or adolescence treatment, etc.).

6. What physicians have you consulted in the past year? When was your last physical examination?

7. List any major illness, surgeries, or hospitalization.

8. Have you ever had a bad experience with a doctor or other health care person? If yes, explain.

9. How much alcohol do you drink per week?_____
   How much tobacco per week?_____
   How much exercise per week and what kind?_____
   Have you ever any recreational drugs (Marijuana, Cocaine, etc.)?_____
10. List all prescription and over-the-counter medications you have taken in the past 90days.

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11. Describe any contacts you have had with the law, such as lawsuits, arrests, jail, DUI's etc.

12. Do you have sources of relief that doctors don't know about that you would feel would help?

13. Has anyone in your family had emotional problems, drug addictions, alcoholism, or the like? If so, have they been treated for this? By whom?

14. Apart from what we can do to help you, how do you think you can get better?

15. Has anyone help you with this? If so, what did they recommend? Do you agree? Did you try it?

16. What problems have your illness caused you and your family?

17. List all allergies

18. Do you have spiritual/religious beliefs? How do they make the problem better or worse?

19. If you need someone other than yourself to give us history or background information on you, who may we contact? Please give their address and phone number

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Signature