## **Adult Intake Form**

Patient Name:	DOB:	/ /	Gender:
Address:			
City/State/Zip:		Phone: (	)
Prior Mental Health Treatment? Y/N	Psychiatric l	Hospitalizat	tion? Y/N
Primary Care Physician (PCP):			
PCP's Address:			
City/State/Zip:			
PCP's Phone: ( )	Fax: (	)	
Date of Last Physical: / /			
Referred by:			
Reason for referral:			
Emergency Contact:			
Emergency Contact's Phone: ( )			
Pharmacy Name and Address:			
City/State/Zip:			
Pharmacy's Phone: ( )	Fax: (	)	

Please Complete prior to your appointment with Dr. Basheer Lotfi-Fard.