Patient Screening Form

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This screening is to evaluate that our services are the best fit for your needs. Please complete all questions and sign before returning it.

Patient's Name: _____ _____ _____
(First Name) (Middle Initial) Last Name
Age:_____ Date of Birth: _____

Address: _____City: _____ State:_____ Zip: _____

Email: _____ Cell No: _____Home Tel No: _____

*Check one ☐ Self-Pay ☐ Insurance

(If you are paying out of pocket, please skip insurance section)

Name of the Primary Insurance: _____
ID#_____
Name of the Subscriber:_____ _____ _____
(First Name) (Middle) (Last Name)

Telephone Number of the subscriber: ( ) _____ _____
Address of the subscriber (if different from patient's address) ☐ Same as Patient
Address:_____
City: _____ State:_____ Zip: _____
Relation with subscriber: _____

Name of the Secondary Insurance: _____ ☐ Not Applicable
ID#_____
Name of the Subscriber:_____ _____ _____
(First Name) (Middle) (Last Name)

Telephone Number of the subscriber: ( ) _____ _____
Address of the subscriber (if different from patient's address) ☐ Same as Patient
Address:_____
City: _____ State:_____ Zip: _____
Relation with subscriber: _____

1. How did you hear about us? _____
2. What do you do for living? _____
3. What is the reason of visit us? _____
4. Name of your primary care physician? _____

Tel: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip: _____

5. Name of your Psychiatrist? _____

   Tel: _____ Fax: _____

   Address: _____ City: _____ State: ____ Zip: _____

6. Have you ever been diagnosed for any Psychiatric illness or condition? ☐ Yes ☐ No

   If yes, what is your diagnosis? _____

7. Please name all prescription or over the counter medications, you are taking?

   i. _____ Dose: _____

   ii. _____ Dose: _____

   iii. _____ Dose: _____

   iv. _____ Dose: _____

   v. _____ Dose: _____

8. Do you take any of the following drugs, Xanax, Ativan, Adderall? ☐ Yes ☐ No

   If yes Name of Drug: _____

   Start Date: _____ Stop Date: _____ ☐ On going

9. Have you ever been hospitalized for **psychiatric reason**? If yes, what was the reason?

   _____

   _____

10. Have you ever visited emergency room for psychiatrist reason? ☐ Yes ☐ No

    Is yes, what was the reason? _____

11. Do you think that life is not worth living, you better be dead? ☐ Yes ☐ No
12. Did you ever have a thought of harming or killing yourself? ☐ Yes ☐ No
13. Have you ever been arrested by the police? ☐ Yes ☐ No

    How many times? _____

    Reason of arrest? _____

14. Do you hear voices which other people can't hear? ☐ Yes ☐ No

    If yes, please explain what you hear? _____

15. Do you have certain belief that is difficult for others to believe? ☐ Yes ☐ No

    If yes, please explain what belief you have? _____

16. Did you ever take recreational or street drug? ☐ Yes ☐ No

    If yes, what drugs have you used so far? _____

17. Do you drink alcohol? ☐ Yes ☐ No ☐ Socially
18. Do you smoke? ☐ Yes ☐ No
19. If yes how many cigarettes per day or per week? _____
20. Do you have your blood workup report done within past six months? ☐ Yes ☐ No

_____ _____

Print your name Signature

Date: _____