Staten Island Medical & Behavioral PC
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Patient Screening Form

Note: Submitting a form does not guarantee an appointment. Each patient is evaluated with careful consideration of their safety, privacy, and health benefits.

This screening is to evaluate whether 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
Gender: ☐ Male ☐ Female ☐_____Age:_____Date of Birth: _____

Address: _____City: _____ State:_____ Zip: _____

Email: _____ Cell No: _____Home Tel No: _____

*Check one ☐ Insurance ☐ Self-Pay ☐ Self-Pay sliding scale

(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: _____ ☐ Spouse ☐ Dependent

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? ☐ Friend
   ☐Therapist
   ☐ Primary Care Doctor
   ☐ Insurance
   ☐ Psychology Today
   ☐ Internet search
   ☐ Web Site www.simbpc.com
2. What do you do for living? _____
3. Why do you want to see a psychiatrist?
   - ☐ Anxiety
   - ☐ Depression
   - ☐ PTSD
   - ☐ Post Partum Depression
   - ☐ Personality Disorder
   - ☐ Paranoia
   - ☐ Hallucination
   - ☐ Delusions (false beliefs)
   - ☐ Suicidal Thoughts
   - ☐Memory Issues
   - ☐ I want to get second opinion
   - ☐ I want to change my psychiatrist because_____
4. Do you need paperwork for legal/immigration/job/ or marital issues? ☐ Yes ☐ No
5. Have you ever been diagnosed for any Psychiatric illness or condition? ☐ Yes ☐ No
   If yes, what is your diagnosis? _____
   Who diagnosed you_____
6. Are you taking any psychiatry medication? ☐ Yes ☐ No (if no, skip to No. 6)
   a. If yes who is the prescriber? _____
   b. Please name all prescription or over the counter medications you are currently taking?
      i. _____Dose:_____ Start Date:_____
      ii. _____Dose: _____ Start Date: _____
      iii. _____Dose: _____ Start Date: _____
      iv. _____ Dose: _____ Start Date: _____
      v. _____ Dose:_____ Start Date: _____
      vi. _____ Dose: _____ Start Date: _____

Who has prescribed you these medications? _____

7. Do you take any of the sedative's drugs like: Xanax, Ativan ☐ Yes ☐ No
8. Do you take any of the sedative's drugs like, 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 for 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 beliefs 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. Have you ever had your blood workup report done within past six months? ☐ Yes ☐ No
    Date for the last blood workup report: _____

_____ _____

Print your name Signature

Date: _____