Max Psychiatry

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Initial Information Sheet

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Phone Number: _____ Referred by: _____

Please briefly describe your reason for today's visit:

What are your current stressers?

Describe any physical symptoms such as sleep problems, appetite change, headache, fatigue etc.:

Describe any medical problems that are being treated by your Primary Care doctor:

List allergies:

List all the medication you are currently taking including vitamins, OTC, herbs:

Patient/Guardian's Signature _____Date_____