Premium Psychiatry Services of Central Jersey, LLC
901 West Main Street
CSMC- Ambulatory Campus
Bldg A, Suite 367 (CN505)
Freehold, NJ 07728
Ph: 732-637-6323 Fax: 732-845-5407

INTAKE FORM

Patient Information:

Name: ______________________________ Date of Birth: ____________________

Address: ____

____

Phone (primary): ____________________ Phone (secondary): ___________________

(We will use the numbers provided to leave a message related to your appointment and/ or treatment- unless specified otherwise)

E-mail ID: ____

(Email correspondence is not considered to be a confidential medium of communication)

Emergency contact person: __________________ Relation: ______________________

Emergency contact number: ____

Pharmacy: __________________________ Phone: __________________________

Prescription ID number: ____

Have you received any type of mental health treatment in past (psychotherapy, psychiatric services, etc.) □ No □ Yes: ____

Have you been prescribed any psychiatric medication: □ No □ Yes - Please list and provide dates:____

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Parent / Guardian Information: (for patient under 18 years old)

Name: ____________________________ Relation: _________________________

Phone: ____________________________ Email: ___________________________

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General Physical Health and Mental Health Information:

How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific health problems you are currently experiencing: ____________________

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How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific sleep problems you are currently experiencing: ____________________

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How many times per week do you generally exercise? __________________________________

Please list any difficulties you experience with your appetite or eating patterns: ______________

____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? ____

Have you experienced any thoughts of suicide in the past or currently having any thoughts of hopelessness or suicide? □ No □ Yes

If yes, when was the last time you had those thoughts ____________________________________

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? ____

Do you drink alcohol or use cannabis more than once a week? □ No □ Yes

How often do you engage in recreational drug or alcohol use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Do you Vape or use E-Cigarettes? □ No □ Yes

If yes, do you vape Nicotine or Cannabis- i.e. THC?

How often do you vape? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

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Family Mental Health History:

In the section below identify if there is a family history of any the following.

Mental Health Condition:	Please Circle	Family Member
Alcohol/ Substance use	No / Yes	
Anxiety	No / Yes	
Depression	No / Yes	
Bipolar Disorder (Manic-Depression)	No / Yes	
Domestic Violence	No / Yes	
Eating Disorder	No / Yes	
Obesity	No / Yes	
Obsessive Compulsive Behavior	No / Yes	
Schizophrenia	No / Yes	
Suicide Attempts	No / Yes	

Additional Information:

Please provide any additional information you wish to share with us in the below space:

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Office Policies and Consent:

- ✓ It is necessary to inform us of any cancellations or rescheduling at least 24 hours in advance. This policy extends to cancellations for any reason. You will be charged a fee for the cancelled or missed session unless notification is given. In case you need to reschedule any appointment please make sure not to go beyond 60 days of the last office visit.
- ✓ Our office is not established to deal with emergencies that require immediate attention during or beyond office hours. If this does occur, you should go to your nearest hospital emergency room to receive immediate attention.
- ✓ You may leave a message on the voicemail and we will answer your call. Any messages left after 2:00 PM on Fridays will be answered on Monday the following week. Our office is closed over weekends and major holidays.
- ✓ You are responsible for monitoring your own supply of medication. At your scheduled session, inform us if a refill is needed. We would suggest that you call at least 5 to 7 business days before you run out of medications. Dr. Desai will not be able to refill any medications if you have not been seen for over 90 days.
- ✓ Our office considers any Drug/ Alcohol issue to be a serious clinical issue with potential safety implications, and hence we bare the right to discuss this matter with family members or the appropriate concerned party, overriding the patient-physician confidentially policy.

PHI and EHR Consent: When we examine, diagnose, treat, or refer you, we will be collecting Protected Health Information. We need this information to provide treatment and for health care options. Some of the information can be used to receive medication authorization with your insurance company. Some non-medical information can be used to collect payment. For faster medication refills, our office prescribes electronically using Electronic Health Records.

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Telehealth: Our office uses “doxy.me” for telehealth appointments. This tool does not require any downloads on your end and can be used on any smart devices (just make sure to select “allow access” to microphone and camera when using a tablet or phone). This tool is HIPPA/ PHIPA & HITECH compliant.

By signing below, I consent to use and disclosure by my provider and the business associates of my protected health information for purposes of treatment, payment and healthcare operations.

______________________________	______________________________
Signature	Date
______________________________	______________________________
Print name	Relation to patient