Psychiatric Remedy PLLC

Psychiatric Remedy PLLC FL
7901 4th Street N, STE 300
St. Petersburg, FL - 33702

New Patient Intake

Legal First Name: *

Legal Last Name: *

Middle Name:

Date of Birth: *

Gender assigned at birth: * ☐ Female ☐ Male

Primary Phone Number: *

Email Address: *

Street Address: *

City and State: *

Zip Code: *

Social Security Number: *

Driver's License Number: *

Reason for visit: *

Pharmacy Name: *

Pharmacy Full Address and Zip Code: *

Pharmacy Number: *

Marital Status * ☐ Single ☐ Married ☐ Other

Race & Ethnicity: *

Referred by: *

Emergency Contact Name: *

Emergency Contact Relation: *

Emergency Contact Number: *

Authorized person(s) to discuss your treatment and contact information: *

Have you seen a psychiatrist before? * ☐ Yes ☐ No

ALLERGIES

Environmental: * ☐ Yes ☐ No

Food: * ☐ Yes ☐ No

Latex: * ☐ Yes ☐ No

Medication: * ☐ Yes ☐ No

If you answered yes to any allergies, please provide allergy source and symptoms: *

VITALS

Height: *

Weight: *

MEDICAITIONS AND SUPPLEMENTS

LIST ANY CURRENT MEDICATIONS (if any): *

ARE YOU CURRENTLY PREGNANT?

Please choose below: * ☐ Yes ☐ No ☐ Not Applicable

PHYSICAL AND MENTAL HEALTH HISTORY

ADD/ADHD health problems *	☐ Yes	☐ No
Anxiety Disorder *	☐ Yes	☐ No
Autism Diagnosis *	☐ Yes	☐ No
Bipolar Disorder *	☐ Yes	☐ No
Diabetes *	☐ Yes	☐ No
Congenital Heart Defect *	☐ Yes	☐ No
Cutting Behavior *	☐ Yes	☐ No
Heart Disease *	☐ Yes	☐ No
High Blood Pressure *	☐ Yes	☐ No
Insomnia or Trouble Sleeping *	☐ Yes	☐ No
Kidney Disease *	☐ Yes	☐ No
Liver Disease *	☐ Yes	☐ No
Major Depressive Disorder *	☐ Yes	☐ No
Seizures *	☐ Yes	☐ No
Suicidal Attempt *	☐ Yes	☐ No
Thyroid Health Problems? *	☐ Yes	☐ No
Schizophrenia *	☐ Yes	☐ No

HOSPITALIZATION HISTORY

- surgeries, procedures or other: *

Family History

Family mental health history:

SUBSTANCE ABUSE HISTORY

Alcohol * ☐ Yes ☐ No

Amphetamines * ☐ Yes ☐ No

Benzodiazepines (Xanax, Klonopin, Valium, etc.) * ☐ Yes ☐ No

Cocaine * ☐ Yes ☐ No

Illegal Street Drugs * ☐ Yes ☐ No

Marijuana * ☐ Yes ☐ No

Opiates * ☐ Yes ☐ No

Current smoker? If yes, how many cigarettes a day? *

Vaping * ☐ Yes ☐ No

ABUSE HISTORY

Any past physical, sexual or verbal abuse history: *

HOME LIFE:

Who do you live with? *

Do you have any children? *

Are you on a diet? *

Do you exercise? *

Highest level of education: *

Employer and Occupation: *

By signing this form, you consent that all the information provided to Psychiatric Remedy PLLC statements provided are accurate and true.

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PATIENT/CAREGIVER SIGNATURE *