



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: *

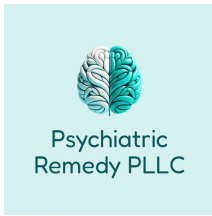
Pharmacy Number: *

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: *

MEDICATIONS 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.



Psychiatric Remedy PLLC FL
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PATIENT/CAREGIVER SIGNATURE *
