Psychiatric Remedy PLLC
20280 N. 59th Ave, Suite 115-643
Glendale, Arizona, US - 85308-6374

New Patient Intake Form

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

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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: *

LIST ANY CURRENT MEDICATIONS (if any): *

Are you currently pregnant? * ☐ Yes ☐ No

PHYSICAL AND MENTAL HEALTH HISTORY

ADD/ADHD health problems * ☐ Yes ☐ No

Anxiety Disorder * ☐ 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

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 (surgery, procedure(s), other): *

Family History

Family mental health history:

SUBSTANCE USE HISTORY

Alcohol * ☐ Yes ☐ No

Amphetamines * ☐ Yes ☐ No

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

Cocaine * ☐ Yes ☐ No

Illegal Street Drugs * ☐ Yes ☐ No

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Marijuana * ☐ Yes ☐ No

Opiates * ☐ Yes ☐ No

Vaping * ☐ Yes ☐ No

Any past physical, sexual or verbal abuse history: *

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

SOCIAL HISTORY

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: *

Occupation: *

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

PATIENT SIGNATURE * _____