Moonflower Psychiatry

Patient Name: ____

Date of Birth: ____

Date Service Provided: ____.

Primary Care Provider and number: ____

Pharmacy and phone number: ____

Emergency Contact name, number, and relationship: ____

How did you hear about Moonflower Psychiatry: ____

Reason for Visit:

Psychiatric History:

☐depressed
☐anxious
☐addictions
☐mood swings
☐disordered eating
☐sleep disorder
☐social isolation
☐ chronic pain
☐panic/trauma disorder
☐ personality disorder
☐ other

History of Psychosis: select an option

Hallucinations: ☐None ☐Auditory ☐visual ☐olfactory ☐gustatory

Delusions: ☐Bizarre ☐Grandiose ☐Jealousy ☐Nihilistic ☐Persecutory ☐Reference ☐Somatic

Additional Comments/Other Psychiatric conditions/concerns not listed (please list dates or ages of previous psychiatric diagnoses):

Have you ever had Suicidal or Homicidal thoughts, plans, or intentions?: Yes / No

If yes, please describe:

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Medical History:

☐Heart disease	☐Diabetes mellitus	☐ Dementia	☐Cancers
☐Cardiac arrhythmias	☐Hyperlipidemia	☐ Learning problems	☐ Obesity
☐Prior TIA / stroke	☐Seizure disorder	☐ Cognitive impairment	☐Fertility Issues
☐Hypertension	☐Sedentary lifestyle	☐ Memory Issues	☐Other
	☐Gastrointestinal problem		

Additional Comments/Other Medical Conditions not listed (please list dates or ages of previous medical diagnoses)

Current Medications:

Previous psychiatric testing performed and date/age:

Additional Comments/Other:

___________________________________ _______________
Patient Signature Date Signed

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