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