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| --- | --- | --- | --- |
| Patient Name: | | | Date of birth: |
| Primary Care Provider: | | | |
| Who referred you to see psychiatry: | | | |
| Why are you being sent to a psychiatric provider:   |  |  |  |  | | --- | --- | --- | --- | |  | Medication Management |  | Therapy/ Counseling/Psychological Evaluation |   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Medication Allergy: | | Response: | |
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| Previous *outpatient* Mental Health or Drug Treatment or Programs?  No or Yes (explain) | | | |
| Date(s): | | Reason/Treatment: | |
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|  | |  | |
| Previous *hospital stays* forMental Health or Drug Treatment Programs in the past year? No Yes (explain) | | | |
| Date(s): | | Reason/Treatment | |
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| Medical History (Check box and explain if applicable): | | | |
|  | Heart disease/Heart attacks | | |
|  | High blood pressure | | |
|  | Diabetes | | |
|  | Thyroid disease | | |
|  | Stroke | | |
|  | Neurological disorders | | |
|  | Dementia/ Neurocognitive Disorder | | |
|  | Stomach/Gastrointestinal disorders | | |
|  | Lung disease/Respiratory disorders | | |
|  | Other: | | |
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| --- | --- | --- |
| **Current Medications:** | | |
| Name of Medication: | Dose and Frequency | Reason for use: |
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| \*\*Please remember to bring all medication in the container given to you by pharmacy to your first appointment. \*\*  **\*\*It is your responsibility as a patient to give accurate medication information and notify the providers of medication changes at each appointment\*\*** | | |