GOODMAN PSYCHIATRIC GROUP, PLLC

NEW PATIENT INTAKE FORM

Patient Information Name: _____ Date of Birth: ___ **Address:** _____ ***City:*** ____ *State:* _ Zip Code: ___ **Phone:** ____ **Email:** _____ Emergency Contact: _____ ***Relationship:*** ___ Phone: _____

Current Concerns What brings you in today? (Please briefly describe your main symptoms or reasons for seeking care)

Psychiatric History Have you ever been diagnosed with a mental health condition? [ ] Yes [ ] No If yes, please list: _____

Have you ever been hospitalized for psychiatric reasons? [ ] Yes [ ] No If yes, when and where? _____

Medication History Current Psychiatric Medications: 1. _____ **Dosage:** _ ***Frequency:*** _ **2.** _____ **Dosage:** _ ***Frequency:*** _ 3. _____ **Dosage:** _ ***Frequency:*** ___

Past Psychiatric Medications (that you have tried):

Medical History Do you have any current medical conditions? [ ] High Blood Pressure [ ] Diabetes [ ] Thyroid Disorder [ ] Seizures [ ] Head Injury Other: _____

Current Non-Psychiatric Medications:

Substance Use History Alcohol: [ ] Never [ ] Occasional [ ] Daily - Amount per week: _ ***Tobacco/Nicotine: [ ] Never [ ] Current Smoker [ ] Former Smoker Cannabis: [ ] Never [ ] Occasional [ ] Daily Other Substances:*** _____

Family History Does anyone in your family have a history of mental illness? (e.g., Depression, Anxiety, Bipolar Disorder, Schizophrenia, Substance Use)

Goals for Treatment What are your primary goals for our work together?

Signature: _____ Date: _____