SHERBONDY'S

PSYCHIATRIC SERVICES

225 Adley Way – Greenville, SC 29607

(864) 987-9747 – fax (864-987-9770

PATIENT INTAKE

Name _____

Address _____

Phone (H) _____ (W) _____ (C) _____

Date of Birth_____ Age_____ Race _____ SS#_____

Do you have an Advance Directive or Power of Attorney □ Yes □ No If yes who? _____

Emergency Contact _____

Relationship to patient_____ Phone_____

Primary care physician_____ Phone_____ Date of last physical _____

Are you: □ Married □ Single □ Divorced □ Separated

Years Married? _____ Times Married? _____ Times Divorced? _____

Children? □ Yes □ No Current ages and gender: _____

Residing with you? □ Yes □ No If no, where? _____

Where are you living? _____

Do you have Family nearby? □ Yes □ No If no, where? _____

Education: □ College □ High School Grade _____ □ Professional or Vocational School

Are you currently employed? □ Yes □ No Where (if "no" where you were last employed?) _____

What type of work do / did you do? _____ How long have / did you work (ed) there? _____

Have you ever been arrested or convicted? □ Yes □ No □ DWI □ Drug-related □ Domestic violence □ Other

Have you ever been abused? □ Yes □No □ Physically □ Sexually (including rape or attempted rape) □ Verbally □ Emotionally

Have you ever attended? □ AA (□ Current □ Past) □ NA (□ Current □ Past)

If you are not currently attending meetings, what factors led you to stop? _____

Previous Psychiatric History:

• Have you ever been diagnosed with psychiatric or mental illness? □ Yes □ No (if yes) please lists diagnosis and dates:_____

_____

• Have you ever been hospitalized for psychiatric care? □ Yes □ No (if yes) Date(s)?_____

and where? _____

• Has a Psychiatrist(s) treated you in the past? □ Yes □ No (if yes please list)

Psychiatrist Name	Date(s) Seen	Reason Left?

Name: _____

• Have you ever been in counseling or therapy? □ Yes □ No (if yes) please give name(s) of Counselor /Therapist and dates:

Name(s)	Date(s)

Has a family member ever been diagnosed with psychiatric or mental illness? (Please describe) _____

_____

Current or past medical conditions **(√) all that apply)**

□ Asthma / Respiratory □ Cardiovascular (heart attack, high cholesterol, angina)
□ Hypertension □ Epilepsy or seizure disorder □ GI Disease □ STDs
□ Head Trauma □ Abnormal Pap Smear □ Diabetes □ HIV / AIDS
□ Liver Problems □ Pancreatic Problems □ Thyroid Disease □ Nutritional Deficiency
□ Other (Please describe) _____

If there is a family history of any of the illnesses listed above, (please list) _____

_____

Have you ever had surgery or been hospitalized? (Please describe)_____

_____

Please list all current prescription medications dosages and how often you take them:

Name of Prescribed Medication	Dosage	How often do you take it?
EXAMPLE: Dilantin	**EXAMPLE :** 50 mg	**EXAMPLE:** 1 tab 3 x a day

Name: _____

Please list Previous Psychiatric Medications and why you stopped them:

Medication	Why Stopped?
EXAMPLE: Dilantin	**EXAMPLE : It made me dizzy**

Please List all current herbal medicines, vitamin supplements, etc. and how often you take them:

Name	Dosage	How often do you take it?
EXAMPLE: VITAMIN – C	**EXAMPLE:** 500MG	**EXAMPLE:** 1- TWO TIMES A DAY

Please list any medication allergies you have _____

_____

Have you ever been treated for substance misuse? Y N (Please describe when, where and for how long) _____

_____

SUBSTANCE USE HISTORY:

DRUG	YES	NO	HOW LONG	HOW MUCH	HOW OFTEN	LAST USED
Alcohol						
Methamphetamine						
Caffeine						
Marijuana						
Cocaine						
Hallucinogen (LSD)						
Inhalant (gas, paint)						
Tobacco						
Sedative (Tranquilizer)						
Pain Medication						

Patient Full Name (Please Print): _____

Patient / Guardian Signature: _____ Date: _____