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______________________

Do you have a Primary care physician? □ Yes □ No □ I don't know □ May we contact your primary care physician?

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: ____________________