Vital Minds Psychiatry LLC.

PATIENT INFORMATION

First Name	Middle	Last
Address		
City	State	Zip
Cell Phone:	Alternative Phone:	County
Date of Birth	Sex	Social Security #
Race: African American ☐ White ☐ Hispanic ☐ Asian ☐ Other: _____		
Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐		
Referred By:		
Email Address:		

GUARDIAN (if applicable)

First Name	Middle	Last
Address		
City	State	Zip
Cell Phone:	Alternative Phone:	County
Client's Relationship ☐ Parent ☐ Spouse ☐ Child ☐ Other		

EMERGENCY CONTACT

First Name	Middle	Last
Address		
City	State	Zip
Cell Phone:	Alternative Phone:	County
Client's Relationship ☐ Parent ☐ Spouse ☐Child ☐Other		

PRIMARY CARE PHYSICIAN

First Name	Last	Office Phone
Address		
City	State	Zip
Last Primary Care Visit:		

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CURRENT MEDICATIONS (Please list ***ALL*** medications you are taking from all your doctors)

Current Medications	Dosage	Prescribing Physician

ALLERGIES TO MEDICATIONS (Please list ***ALL*** allergies to medications)

Medications	Allergic Reaction
1.	
2.	
3.	
4.	
5.	

PAST ***PSYCHIATRIC*** MEDICATIONS (Please list ***ALL*** your previous medications)

Name of Medication	Name of Medication
1.	*6.*
2.	*7.*
3.	*8.*
4.	*9.*
5.	*10.*

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PATIENT MEDICAL HISTORY

Reason for today's visit

Symptoms	Symptoms
1.	*4.*
2.	*5.*
3.	6.

CURRENT OR PAST MEDICAL CONDITION (Please check ***ALL*** that apply)

- ❑ Diabetes
- ❑ Asthma
- ❑ Cardiovascular (Heart Attack)
- ❑ Head Trauma
- ❑ Pancreatic Problems
- ❑ Epilepsy/Seizure
- ❑ Hypertension
- ❑ Liver Problems
- ❑ Abnormal Pap Smear
- ❑ HIV/AIDS
- ❑ High Cholesterol
- ❑ Thyroid Disease
- ❑ STDs

Pharmacy Address:

_____

Pharmacy Phone Number:

_____

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PAST PSYCHIATRIC HISTORY

Have you ever been admitted in an **IN-PATIENT** Psychiatric hospital/facility? Yes / No
Please enter ***inpatient*** information below:

Psychiatric hospital/facility	Reason for admission	How many times?
1.		
2.		
3.		
4.		
5.		

Have you ever received Psychiatric **OUT-PATIENT** treatment? Yes / No
Please enter ***outpatient*** information below:

Psychiatric hospital/facility	Reason for treatment
1.	
2.	
3.	
4.	
5.	

_____ _____
PATIENT/Guardian Name **Date**

_____ _____
PATIENT /Guardian Signature **Date**