Blue Umbrella Psychiatry
6100 Griffin Rd. 2nd Floor
Davie, FL - 33314-4416

**2027 New Patient Adult Intake

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Marital Status ☐ Single ☐ Married ☐ Others

Language(s)

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Marital Status ☐ Single ☐ Married

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone

Work Phone

Fax

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 *

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Address Line2

City *

Country *

State *

Zip code *

Postbox No

Emergency Contact Name

Emergency Contact Number

Extn

Caregiver(s) First Name

Caregiver(s) Last Name

Allergies

Allergies	Type	Severity	Reactions

Medications

Medication Name	Intake Details

What medications have you taken in the past? Please list names, approximate dosages and dates. *

Supplements

Supplement Name	Intake Details

Please list the name of your pharmacy with address below. *

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Emergency Contact Name _____

Emergency Contact Number _____

Context of Care Review

Successful heath care and preventive medicine are only possible when the physician has a complete understanding if the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your, time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Reason for office visit:

Why did you choose to come to this clinic?

What three expectations do you have from to our clinic?

Current Living Situation

Highest Education Level: _____

Occupation: _____

Marital status: _____

Total number of children: _____

Are there currently any significant marital stressors? ☐ Yes ☐ No

If yes, briefly explain:

Have you served in the military? ☐ Yes ☐ No

Have you ever been accused or convicted of any crime? ☐ Yes ☐ No

Personal History

Are you currently receiving any healthcare? ☐ Yes ☐ No

If yes, where and from whom?

General

Main interests and hobbies:

Have you ever been in treatment for alcohol or drug use? ☐ Yes ☐ No

If yes, please explain:

Do you use tobacco? ☐ Yes ☐ No

If yes, how much?

Do you drink alcohol? ☐ Yes ☐ No

If yes, please specify: ☐ Rarely ☐ Occasionally ☐ Daily ☐ Past

Adult Mental Health

Have you received previous counseling? ☐ Yes ☐ No

Are you currently under the care of a psychiatrist? ☐ Yes ☐ No

If yes, who is your current provider and for what are you being treated for?

Do you currently have a therapist? ☐ Yes ☐ No

If yes, what is the name of your therapist and for how long have you been seeing that person for therapy?

Have you ever taken psychiatric medications in the past? ☐ Yes ☐ No

If yes, please list (include problem, medication, dose, start/stop date, side effects and response):

Spiritual Orientation

Please list your spiritual orientation or religion:

How active are these beliefs in your life? ☐ Very active ☐ Somewhat active ☐ Not very active

How much do your beliefs help you when times are difficult?

Health History

For the following section, please read the question and select from the following responses: Yes, No, or In Past. If No, move on to the next question. If Yes or In past, please specify the severity in the "Others" box, choosing from the following: Mild, Moderate, or Severe.

Do you sleep well?	☐ Yes	☐ No	☐ In Past
Cannot stay asleep?	☐ Yes	☐ No	☐ In Past
Cannot fall asleep?	☐ Yes	☐ No	☐ In Past
Hyperthyroid/Hypothyroid?	☐ Yes	☐ No	☐ In Past

Neurologic

Seizures?	☐ Yes	☐ No	☐ In Past
Loss of memory	☐ Yes	☐ No	☐ In Past
Numbness or Tingling?	☐ Yes	☐ No	☐ In Past

Head?

Headaches?	☐ Yes	☐ No	☐ In Past
Migraines?	☐ Yes	☐ No	☐ In Past
Head injury?	☐ Yes	☐ No	☐ In Past
Jaw or TMJ problems?	☐ Yes	☐ No	☐ In Past

Respiratory/Cardiac

Shortness of breath?	☐ Yes	☐ No	☐ In Past
Asthma?	☐ Yes	☐ No	☐ In Past

Blood

Anemia?	☐ Yes	☐ No	☐ In Past
Easy bleeding or bruising?	☐ Yes	☐ No	☐ In Past

Gastrointestinal

Abdominal pain or cramps?	☐ Yes	☐ No	☐ In Past
Use antacids?	☐ Yes	☐ No	☐ In Past
Nausea/vomiting?	☐ Yes	☐ No	☐ In Past
Diarrhea?	☐ Yes	☐ No	☐ In Past
Constipation?	☐ Yes	☐ No	☐ In Past

Female Reproductive

Age of last menses? (if menopausal)	_____		
Pain and cramping during periods?	☐ Yes	☐ No	☐ In Past
Irritable and depressed during menses?	☐ Yes	☐ No	☐ In Past
Birth control? (if yes or in past, please specify in "other")	☐ Yes	☐ No	☐ In Past

Other

Do you have any current or past medical conditions that you have not already reported?	☐ No	☐ Yes	☐ Unsure
If yes, describe the condition and any relevant details.			
Have you had any surgeries or medical hospitalizations that you have not already reported? *	☐ No	☐ Yes	

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If yes, provide the reason and approximate date.

Have you received previous mental health treatment, psychological testing, or specialized treatment that you have not already reported? *

☐ No ☐ Yes

If yes, describe the type of treatment, approximate dates, and whether it was helpful.

Is there any additional medical or mental health history that you have not already shared and that you believe your provider should know before your appointment? *

I confirm that the information provided is accurate to the best of my knowledge.

I have reviewed my responses and confirm that the information provided is accurate to the best of my knowledge.

PATIENT SIGNATURE *

Today's Date *