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

** 2027 BUP First Visit Intake Form

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

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 *

Address Line2

City *

Country *

State *

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Zip code *

Postbox No

Emergency Contact Name

Emergency Contact Number

Extn

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

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.

Please list the name of your pharmacy with address below *

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? *

☐ Yes ☐ No

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 *