Silver Psychiatric Services

212 W. Matthews St.
Matthews NC, 28105
Tel: 704-847-0424 Fax: 704-847-0454
www.silverpsychiatric.com

## PATIENT INFORMATION

**Date of 1st Appointment:** _____ **Today's Date:** _____
**Patient Name:** _____ **Male** ☐ **Female** ☐
**Date of Birth:** _____ **Place of Birth :** _____ **Age:** ___ **Religious Affiliation:** _____
**Home Phone:** _____
**Address:** _____

**Employer:** _____ **Occupation:** _____
**Business Phone:** _____ **Cell Phone:** _____

**Education:** Years Completed: _____ Degrees Obtained: _____

**Marital Status:** Single Married Separated Divorced Widowed
Name of Spouse/Significant Other: _____
Date of Birth: _____ Occupation: _____
Education: Years Completed: _____ Degrees Obtained: _____
Date and place of Marriage: _____
Previous Marriages and Children: _____
If divorced, Custodial Parent: _____
Marital Problems? _____

List below all people residing in your home:

| Name | Relationship or Status in Home | Birthdate & Age | School Grade or Occupation |
|---|---|---|---|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ |

How were you referred? _____

What events or Circumstances prompted you to call at this time? _____
_____
Describes what you believe has caused the difficulties you are having? _____
_____
_____
What have you done to help these problems?_____
_____
_____
Have you sought professional help before? From whom and for what? Was it helpful? (Examples of professional help might be a social agency such as Family and Children's Service, a hospital, a psychologist, a social worker, a counselor, a psychiatrist.) _____
_____
Family or Personal history of Suicide Attempts? _____
_____

Describe any family difficulties or events which were upsetting (such as: illness or death of a family member or close relative, moves, financial problems, marital stress, sexual or physical abuse). _____
_____
_____

**Medical History**

Date of most Recent Physical Exam: _____ Results: _____
Please provide the name and address of your physician or medical clinic: _____
Name: _____ Phone: _____

Address: _____

_____

Are you now receiving treatment? _____

List below serious illnesses, accidents, or operations which you have had. Give the date of the illness or injury, and if you were hospitalized, give the name of the hospital, approximate length of stay, and the attending physician.

_____
_____
_____

Medications? (Please list current name dosage and frequency) Please include over the counter and herbal

_____
_____
_____
_____
_____
_____

Allergies?

_____

**Family History:**

Describe any medical or psychiatric conditions of your parents, siblings and children: _____
_____
_____
_____

| **Habits:** | **Amount currently using** | **Most ever used** |
|---|---|---|
| Coffee (cups/day) | _____ | _____ |
| Cigarettes (packs/day) | _____ | _____ |
| Alcohol | _____ | _____ |

**Psychiatric History**

Have you ever received psychiatric or psychological treatment of any kind before? Yes No

If you checked yes to the above question please answer the following:

What type of care did you receive? Inpatient (hospital) Outpatient Both

Where were you in treatment?

_____
_____

When were you in treatment? _____
How long were you in treatment? _____
Who was your therapist or doctor? _____
Did your doctor prescribe Medicine at that time? Yes No Not applicable
If yes what was prescribed (include dosage if know)? _____
_____
_____
_____

**Substance Use History**

Have you ever abused drugs or alcohol? Yes No

If yes please describe:

| Substances | Amount | Frequency | When? (First use; Last use) |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

If yes have you ever received substance abuse treatment of any kind? Yes No
Do you have a history of blackouts, seizures or withdrawal symptoms? _____
_____
Please describe anything else you would like your clinician to know? _____
_____
_____
_____
_____

**Insurance Information:** _____
Social Security#/ Insurance ID #: _____
Insurance Plan: _____
Main Policy Holder: _____
Pharmacy #: _____