NORTH RALEIGH PSYCHIATRY, P.A.

Medical Information Sheet

Date:_____ Patient Name:_____ Sex: ☐ Male ☐ Female

1) Primary Care Physician Name:_____ Phone#: (_____)_____
2) Did your PCP refer you to us? Yes ___ No ___ If no, were you referred by someone else? Yes ____ No _____ If yes, please provide the name and phone number of the person who referred you to us: _____
3) Briefly state the reason for your visit: _____

Below is a list of problems people sometimes have. Take each of these problems and decide how much each problem has distressed, worried or bothered you during the past week, including today. Circle only ONE number for each problem listed.

How much have you been bothered, distressed or worried by:	NOT AT ALL		MODERATELY		EXTREMELY
1. Headaches	1	2	3	4	5
2. Upset Stomach	1	2	3	4	5
3. Difficulty Sleeping	1	2	3	4	5
4. Not feeling like eating	1	2	3	4	5
5. Blaming, criticizing or condemning yourself	1	2	3	4	5
6. Feeling depressed or dejected	1	2	3	4	5
7. Suicidal thoughts	1	2	3	4	5
8. Being easily embarrassed	1	2	3	4	5
9. Being ill at ease with others	1	2	3	4	5
10. Trouble in keeping conversations going	1	2	3	4	5
11. Feeling shy with the opposite sex	1	2	3	4	5
12. Relationship problems	1	2	3	4	5
13. Sexual concerns	1	2	3	4	5
14. A lack of real friends	1	2	3	4	5
15. Problems with your parents	1	2	3	4	5
16. Financial problems	1	2	3	4	5
17. Feeling things around you seem unnatural or unreal	1	2	3	4	5
18. Staying by yourself a lot	1	2	3	4	5
19. Do you drink alcoholic beverages?	1	2	3	4	5
20. Do you smoke marijuana?	1	2	3	4	5
21. Do you use non-prescribed drugs? (i.e: amphetamines, tranquilizers, hallucinogens, etc.)	1	2	3	4	5

4) <u>If female:</u> a) Is there a possibility that you may be pregnant? Yes ____ No ____ b) Have you had any miscarriages? Yes ____ No _____

5) Do you have any allergies? Yes No If you answered yes, please specify: _____
6) Please list the names of any prescription medications, over-the-counter (OTC) medications, vitamins or supplements you are currently taking (include the strength and the frequency if known): _____
_____
7) Please provide the name and phone number of the pharmacy that you use most often:

Pharmacy Name:_____ Location: _____Phone #: (____)_____

8) Any other problems or concerns? _____

PATIENT/GUARDIAN CONSENT:

I certify that the above information is true and correct to the best of my knowledge. I hereby authorize the physician to provide any medical care that may be deemed necessary in order to diagnosis and treat the patient.

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

(if patient is under the age of 18, parent or guardian MUST sign form)