

Anna Flynn, M.D.
Board Certified Adult, Child & Adolescent Psychiatrist

— NEW PATIENT INFORMATION —

PATIENT

NAME: _____ BIRTHDATE: _____ SOC SEC # _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

REASON FOR SEEKING TREATMENT: _____

PERSON RESPONSIBLE FOR PAYMENT

NAME: _____ BIRTHDATE: _____ SOC SEC # _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ WORK PHONE: _____

THERAPIST OR OTHER MENTAL HEALTH PROVIDER

May we contact this person for the purposes of care coordination? YES NO

NAME: _____

OFFICE PHONE: _____ FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY CARE PHYSICIAN

May we contact this person for the purposes of care coordination? YES NO

NAME: _____

OFFICE PHONE: _____ FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)

MEDICATION NAME	DOSAGE	SCHEDULE (e.g. AM, PM)	REASON

ALLERGIES: _____

MEDICAL PROBLEMS:

DIAGNOSIS	TREATING PHYSICIAN	YEAR DIAGNOSED

DOES THE PATIENT HAVE ANY PRIOR HISTORY OF: (PLEASE DESCRIBE)

SEIZURE: YES NO _____

HEAD INJURY: YES NO _____

CARDIAC ARRHYTHMIA: YES NO _____

OTHER HEART PROBLEMS: YES NO _____

DEVELOPMENTAL DELAYS: YES NO _____

ALCHOLISM/SUBSTANCE ABUSE: YES NO _____

PSYCHIATRIC HOSPITALIZATION: YES NO _____

SELF-INJURY: YES NO _____

ATTEMPTED SUICIDE: YES NO _____

IS THERE ANY FAMILY HISTORY OF: (PLEASE NOTE RELATIONSHIP TO PATIENT)

DIABETES: YES NO _____

SEIZURE: YES NO _____

SUDDEN DEATH: YES NO _____

CARDIAC ARRHYTHMIA: YES NO _____

HIGH BLOOD PRESSURE: YES NO _____

OTHER HEART PROBLEMS: YES NO _____

DEPRESSION: YES NO _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: YES NO _____

ANXIETY: YES NO _____

AD/HD: YES NO _____

AUTISM: YES NO _____

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DEVELOPMENTAL DELAYS: YES NO _____

OTHER MENTAL ILLNESS: YES NO _____

ATTEMPTED/COMPLETED SUICIDE: YES NO _____

ALCHOLISM/SUBSTANCE ABUSE: YES NO _____

OTHER SIGNIFICANT FAMILY HISTORY: _____

-----FOR PATIENTS UNDER AGE 18-----

MOTHER

NAME: _____ BIRTHDATE: _____ OCCUPATION _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

FATHER

NAME: _____ BIRTHDATE: _____ OCCUPATION _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

ARE BIOLOGICAL PARENTS (CIRCLE ONE): MARRIED DIVORCED SEPARATED

DATE OF DIVORCE OR SEPARATION (WHERE APPLICABLE): _____

CUSTODIAL PARENT(S) AND AGREEMENT (WHERE APPLICABLE):

SIBLINGS:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

