1359 Milstead Road, Conyers, GA 30012
Ph: **678 562-2081** | Fax: **770-762-7899**
Email: atltelepsych@gmail.com : Website: www.atlantatelepsychiatry.com

PERSONAL INFORMATION - Please fill out this form as completely as you can. Please *print* your answers.

Date		Gender	
Full Name		Ethnicity	
Birth Date		Marital Status	
Social Security System		Occupation	

Contact Information - Please give your *home* address. Please check the appropriate letter letting me know if I can leave a full message (M), call-back number only (C), or no message (N).

Address		Home Phone		☐ M ☐ C ☐ N
City		Cell Phone		☐ M ☐ C ☐ N
State		Work Phone		☐ M ☐ C ☐ N
Zip		Email		☐ M ☐ C ☐ N

Emergency Contact - Please tell me the name of someone to contact in an emergency.

Name		Relationship	
Address		Home Phone	
City		Cell Phone	
State		Work Phone	
Zip		Email	

Referral Source - Please tell me who suggested that you see me.

Name	
Phone	
Relationship to you	

Pharmacy - Please provide contact information for the primary pharmacy you use for your prescriptions.

Pharmacy Name :	
Pharmacy street number and street	
address : Pharmacy city : Pharmacy	
State and Zip code :	

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TELE PSYCHIATRY
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Name conditions you are seeking treatment in the box below

Describe the duration of illness and the conditions as you experience them in the box below

Education and living condition concerns in the box below

Previous Psychiatric inpatient treatment: ☐ Yes or ☐ No

Psychiatric inpatient: List the name of hospital, city, date hospitalized, reason for hospitalization, and discharge diagnosis in the box below

Previous outpatient treatment: ☐ Yes or ☐ No

Previous outpatient experience in the box below: List diagnosis and when last seen by a Psychiatrist /PCP

Current Therapy: ☐ Yes or ☐ No

Describe in the box below: What type of therapy, for what condition and the date last seen by a therapist

Are there any suicidal ideations or gestures: ☐ Yes or ☐ No

Describe suicide ideation/Gesture in the box below: List name of hospital, city, date hospitalized, reason for hospitalization, and discharge diagnosis.

Is there any history of drinking of alcohol or abuse of street drugs or prescription medication: ☐ Yes or ☐ No

Describe in the box below: List the name of the drug of abuse, duration, of drug use, date of last use and any treatment

Any history of DUI /drug related charges or incarceration: ☐ Yes or ☐ No

Describe in the box below

Any history of mental illness in family members: ☐ Yes or ☐ No

Describe in the box below

Any history of drinking or illegal use of drugs by family members: ☐ Yes or ☐ No

Describe in the box below

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Any family history of DUI /drug related charges or incarceration: ☐ Yes or ☐ No

Describe below

Do you currently take any medications for any mental health concerns: ☐ Yes or ☐ No

Please list in the box below

Have you taken any psychiatric medications in the past: ☐ Yes or ☐ No

Please list the names in the box below

Describe Average Physical health ☐ Good ☐ Average ☐ Poor

Any diagnosed medical condition or notable medical symptoms: ☐ Yes or ☐ No

Describe in the box below: List the diagnosis and symptoms

Do you have any allergies or adverse reactions to any medication: ☐ Yes or ☐ No

In the box below list the name and what type of reaction

History of surgery: ☐ Yes or ☐ No

Describe in detail the name of the surgery, the conditions treated with surgery and the date

ATLANTA TELE-PSYCHIATRY

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☐ **Behavior influenced by Delusions or Hallucinations**

SOCIAL HISTORY:

Marital Status: Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed ☐

Number of Children: Age of Children:

Education: Current Occupation:

PSYCHIATRIC HISTORY

	Patient History		Family History		Specify Family Member (Mom, Dad, Sibling, etc.)
Depression	☑ YES	☐ NO	☐ YES	☐ NO	
Anxiety	☐ YES	☐ NO	☐ YES	☐ NO	
Bipolar Disorder	☐ YES	☐ NO	☐ YES	☐ NO	
Schizophrenia	☐ YES	☐ NO	☐ YES	☐ NO	
Suicide	☐ YES	☐ NO	☐ YES	☐ NO	
Other (Specify)					

PSYCHOSOCIAL RISK FACTORS

☐ Victim of Physical Abuse
☐ Victim of Sexual Abuse
☐ Trauma of Loss in Family
☐ Domestic Violence Victim D Perpetrator D
☐ History of Substance Abuse
☐ History of Assaultive Behavior
☐ History of Threatening Behavior
☐ History of Inappropriate Sexual Behavior
☐ History of Self- Injury
☐ History of Suicidal Behavior
☐ Access to Firearms (family, friends, self)
☐ Access to Other Means of Suicide
☐ Lack of Social Support
☐ History of Foster Care
☐ Homelessness
☐ Other

Name:

Signature:

Date :