Adamfopa Outpatient Psychiatry, PLLC

New Patient Intake Form

This form helps your provider understand your background, current concerns, and healthcare needs in order to provide safe and effective psychiatric care. Please complete all sections as accurately as possible.

1. Patient Information

Full Legal Name

Preferred Name

Date of Birth

Age

Sex at Birth

Gender Identity (optional)

Pronouns (optional)

Address

City

State

ZIP

Phone Number

Email Address

Preferred Method of Contact

2. Emergency Contact

Name

Relationship

Phone Number

3. Insurance Information

Insurance Provider

Member ID

Group Number

Policy Holder Name

Relationship to Policy Holder

4. Reason for Visit

What brings you in for care today? (brief description of concerns, symptoms, or goals)

When did these concerns begin?

Have these symptoms changed recently?

- [ ] Improved
- [ ] Worsened
- [ ] No change

5. Psychiatric History

Have you ever been diagnosed with a mental health condition?

- [ ] Yes
- [ ] No

If yes, list diagnoses and approximate dates:

Have you ever received psychiatric treatment?

- [ ] Therapy
- [ ] Medication
- [ ] Hospitalization

Any prior psychiatric hospitalizations or emergency visits?

- [ ] Yes
- [ ] No

If yes, please explain:

6. Current Medications

List all current medications, including psychiatric medications, supplements, and over-the-counter drugs.

Medication Name	Dose	Frequency	Prescribed By

7. Medical History

Current or past medical conditions (e.g., diabetes, asthma, thyroid disease):

Surgeries or major hospitalizations:

Allergies (medications, foods, environmental):

8. Substance Use History

Alcohol

- [ ] None
- [ ] Occasional
- [ ] Regular

Tobacco / Nicotine

- [ ] None
- [ ] Current
- [ ] Past

Cannabis

- [ ] None
- [ ] Occasional
- [ ] Regular

Other substances (please specify)

9. Safety Assessment

Have you ever had thoughts of harming yourself?

- [ ] Yes
- [ ] No

Have you ever attempted suicide?

- [ ] Yes
- [ ] No

Do you currently have thoughts of harming yourself or others?

- [ ] Yes
- [ ] No

If yes to any, please explain:

10. Family Psychiatric History

Have any family members been diagnosed with:

- [ ] Depression
- [ ] Anxiety
- [ ] Bipolar Disorder
- [ ] Schizophrenia
- [ ] Substance Use Disorder
- [ ] Other

Please specify relationship(s)

11. Social History

Marital Status

Living Situation

Employment / School Status

Primary Support System (family, friends, community)

12. Additional Information

Is there anything else you would like your provider to know that may help with your care?

13. Patient Acknowledgment

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that providing accurate information is necessary for appropriate psychiatric care.

Patient Signature

Date