AC4W Psychiatrist Intake Form for Dr. Dutta

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AC4Wbilling@gmail.com (404) 343-4162

Patient Name: ____Age______ DOB____________

Gender (at birth & identified) & preferred pronouns (he/she/them): _______________________

Pt. cell phone:____________________________ Email:________________________________

Parent(s) Names (if minor): ____

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If pt. is a minor and parents are divorced, who has custody/decision-making rights? __________

Patient Marital Status____

Patient Occupation: ____

Learning Concerns: ____

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What are the current struggles and stressors bringing you to treatment?

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Psychiatric/ Behavioral Symptoms and Concerns: _____________________________________

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Current Psychiatrist____

Therapist____

Dietician____

Physician______________________________ Practice:_________________________________

Phone number: ______________________________Email if known:______________________

Significant Medical History____

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Medical or Psychiatric Hospitalizations (including name of Res/PHP/IOP) with dates:

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Current Medications and prescribing doctor: ____

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Allergies: ____

Pertinent Family Medical/Psychiatric History:

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Printed name and signature of the person filling out this form and relationship to primary patient:

Printed Name:____________________________________ Relationship:__________________

Signature____ Date:_________________________

Who referred you to AC4W and/or Dr. Dutta?____