

Psychiatry Intake Form

PATIENT INFORMATION

Name:: _____ Date of birth:: _____ dd / mm / yyyy
Gender:: _____ Phone number:: _____
Address:: _____

EMERGENCY CONTACT

Name:: _____ Relationship:: _____
Contact details:: _____

Medical history:

Psychiatric history:

Stressors:

Treatment history:

Treatment goals:

CONSENT AND CONFIDENTIALITY AGREEMENT

I, _____, consent to receive psychiatric evaluation and treatment from [Psychiatrist's Full Name]. I understand and agree to the following:

Confidentiality: • All information shared will be kept confidential, except in cases of immediate harm, legal requirement, or court subpoenas. Treatment records: • I may maintain secure and confidential treatment records. Emergency situations: • In a mental health emergency, I am authorized to contact my designated emergency contact. Communication: • Electronic communication may be used for appointment reminders, but confidentiality cannot be guaranteed. Termination of services: • I can terminate services at any time, and may discuss referrals if necessary. Fees and insurance: • I agree to the fees and payment policies as outlined by _____.

I acknowledge my informed consent by signing below.

Patient's signature: _____

