Northeast Georgia
PHYSICIANS GROUP

NGPG Psychiatry
200 Wisteria Drive
Gainesville, GA 30501
770-219-5407 • fax 770-219-7102

Client Information Form

Patient Name ____DOB_______________________

Legal Guardian(s)_____________________________________Relationship______________

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Other family members living at home (children, stepchildren, and other relatives):

Name	Date of Birth	Age	Relationship to Patient
1.			
2.			
3.			
4.			

Primary Care Doctor

Name of Practice & Provider ____

Medical/Psychiatric History

Current Medical Illnesses: ____

Past Medical Illnesses: ____

Medication Allergies: ____

Food Allergies: ____

Surgeries: ____

List any prior **psychiatric** treatment (inpatient, outpatient, testing) includes names, locations, and dates:

____

____

____

____

Family history of **psychiatric** illnesses:

____

____

Social history:

Work/school:____

Hobbies: ____

Reason for Visit

Primary symptoms or problems that led to this visit:

1. ____
2. ____
3. ____

Are there any safety concerns (i.e. suicidal gestures/attempts, self-injury, cutting, etc…)

____

____

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CURRENT MEDICATIONS

Please list all medications that you are currently taking (please include over the counter medications, herbals and any nutritional supplements)

MEDICATION NAME AND STRENGTH	DATE STARTED	REASON FOR MEDICATION

PAST PSYCHIATRIC/MENTAL HEALTH MEDICATIONS

Please list ALL past Psychiatric/Mental Health medications you have tried in the past and why they did not work for you.

MEDICATION NAME AND STRENGTH	DATE STARTED	DATE STOPPED	Reason for Stopping Medication

IF YOU NEED MORE SPACE PLEASE USE THE BACK OF THIS FORM