MINDSPACE INTEGRATED CARE LLC

New Patient Intake Form

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Patient Information

Full name: _____

Date of birth: _____ Preferred pronouns: _____

Address: _____

Phone: _____ Email: _____

Emergency contact (name / relation / phone): _____

Reason for Visit

What brings you in today? _____

How long have you been experiencing these concerns? _____

Current stressors: _____

Medical & Psychiatric History

Current medications (name, dose, frequency): _____

Allergies: _____

Prior psychiatric diagnoses / treatment: _____

Primary care provider: _____

Social History

Living situation: _____

Occupation / school: _____

Substance use (alcohol, tobacco, other): _____

Signature: _____ Date: _____