dr. carrie poline
Child, Adolescent & Adult Psychiatry
Double Board Certified

Adult Patient Intake Form

This form requests information about you which will help us design a treatment plan geared specifically to your needs. Please take a few moments to complete the form carefully.

Patient Name: ________________________ Birthdate: _________________

Address: ____ Age:________

City, State, Zip: ____

Telephone: (________)____

Email address:____

Relationship Status:____

Gender/Pronouns:____

Occupation: ____

Primary Care Physician:____

Referring practitioner:____

Reason for referral:____

____

____

Please list other health care professionals involved in your care:

____

____

Please list current allergies or pertinent medical history:

____

____

Please list any history of psychiatric treatment or inpatient hospitalizations:____

____

____

Please list any family history or major medical or psychiatric illness:

____

____

Please list all current medications: _____________________________________

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