Psychiatry Intake Form

Patient Information
Name:
Date of Birth:
Gender: ◯ Male ◯ Female ◯ Other:
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 . I understand and agree to the following:

1. Confidentiality:

- All information shared will be kept confidential, except in cases of immediate harm, legal requirement, or court subpoenas.

2. Treatment records:

- may maintain secure and confidential treatment records.

3. Emergency situations:

- In a mental health emergency, is authorized to contact my designated emergency contact.

4. Communication:

- Electronic communication may be used for appointment reminders, but confidentiality cannot be guaranteed.

5. Termination of services:

- I can terminate services at any time, and may discuss referrals if necessary.

6. 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

Date: