HARSHAD PATEL MD PC

Initial Evaluation Questionnaire **Name:** _____

(1) **Reason** for Today's Visit: _____

(2) Who **referred** you to us? _____

(3) Any **Psychiatric Outpatient / Hospitalization / Drug / Alcohol** Treatment ? Yes: _____, No: _____

Outpatient: _____

Any **Hospitalization**: _____

Any **Drug / Alcohol** Problem: _____

Any **Legal** Problem: _____

(4) List Of All **Psychiatric Medications: Current Medications / Dosage** (Including Herbal and Over The Counter): _____

_____

_____

_____

Past Medications and Response: _____

_____

_____

(5) Any **Medical** Problems: _____

_____

_____

Any Current **Physical Complains**: _____

Date Of Last **Physical Examination**: _____

Date Of Last **Lab** Work-Up: _____

Any Medication **Allergies**: _____

(6) Name of **Primary Care Physician:** _____
Telephone No: _____, Fax No: _____

(7) Name Of Current **Therapist/Counselor:** _____
Telephone No: _____, Fax No: _____

(8) Any **Family Members** With Psychiatric / Drug / Alcohol Problems ? _____

_____

(9) Do you **Authorize** Dr. Harshad Patel to **exchange** clinical information to **Primary Care Physician** And / Or **Therapist** for

Co-ordination of care ? (If necessary): Yes: _____, No: _____

_____ _____

Signature Of Patient Or Legal Representative Date