Psychiatry Intake Form

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Gender: _____ 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 [Psychiatrist's Full Name]. I understand and agree to the following:

Confidentiality: • All information shared will be kept confidential, except in cases of immediate harm, legal requirement, or court subpoenas. Treatment records: • may maintain secure and confidential treatment records. Emergency situations: • In a mental health emergency, is authorized to contact my designated emergency contact. Communication: • Electronic communication may be used for appointment reminders, but confidentiality cannot be guaranteed. Termination of services: • I can terminate services at any time, and may discuss referrals if necessary. 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: _____ dd / mm / yyyy