766 Hartness Road, Suite A
Statesville, NC 28677
Phone: (704) 380-3620 ◆ Fax: (704) 380-3623

Welcome to Iredell Psychiatry. Please complete your new patient packet and return it to our office.
As a new patient at Iredell Psychiatry, we require the completed paperwork ahead of time so that our office may prepare your chart in advance and verify your insurance coverage prior to your new patient intake assessment.

Please bring your ID, Insurance Card and a current list of all medications you are currently taking to your new patient intake assessment. *We ask that you arrive a minimum of 30 minutes prior to your scheduled appointment time in order to complete the final intake process. If you arrive later than 30 minutes prior to your appointment you may be asked to reschedule.* At the time of your arrival for your new patient intake appointment, you will be expected to pay your insurance co-pay in full.

If you need to change your new patient appointment for any reason, please contact the office at least 24 hours in advance at (704) 380-3620 so that we may assist you with rescheduling your appointment.

Please call your insurance provider to verify benefits for mental/behavior health prior to your appointment.

We strive to provide the best possible patient care. If you have any questions or concerns, please call our office at (704) 380-3620 so we may assist you. We look forward to meeting you, and we welcome you to our practice.

Thanks,
Iredell Psychiatry

Clinical Intake Form

Patient Name: _____DOB: _____

MRN: _____ Date Paperwork Completed: _____

Chief Concern:

What issues or symptoms bring you to this practice?

_____

When did these symptoms start?

_____

Past Treatment History:

List any previous mental/ behavioral health conditions you have been diagnosed with:

_____

_____

Name of previous psychiatrist(s) and years seen: _____

_____

Name of current or previous counselor(s)/ therapist(s) and years seen: _____

_____

_____

List of previous psychiatric hospitalization(s) with dates and reasons for admission(s): _____

_____

_____

Have you ever attempted suicide and if so, when and how? _____

Have you ever received ECT (shock treatment) or Transmagnetic Stimulation (TMS)? If so, when and where?

_____

Have you ever been in a Partial Hospitalization Program (PHP) or Intensive Outpatient Program (IOP)? If so, when and where?

_____

Have you ever had an eating disorder (binge, purge, food restricting)? _____

Have you ever had issues with cutting or self-mutilation? _____

Medical Information:

Did you have any developmental delays in childhood? _____

Did your mother have exposure to drugs/trauma while pregnant with you? _____

Med Allergies: _____

Current Meds and Doses (Including Over-the-Counter and Herbal Medications): _____

_____

_____

Females Only: Is there any chance you are currently pregnant? _____

Clinical Intake Form

Patient Name: _____DOB: _____

MRN: _____ Date Paperwork Completed: _____

Past Surgery:	Reason for Surgery:	Year:

Patient and Family Medical History:

MEDICAL ILLNESS:	**PATIENT**:	FAMILY MEMBER(S):	COMMENTS/SPECIFICS:
Anemia/Blood Disorders			
Cancer			
Diabetes			
Migraines			
Hepatitis/Liver Disorder			
Heart Disease			
Hypertension			
Lung Disease			
HIV			
Seizures/Neurologic Illnesses			
Serious Head Injury/Concussion			
Thyroid Disease			
Other			

Family Psychiatric History: Check all that apply and identify any family members with the disorders below:

PSYCHIATRIC ILLNESS:	YES	FAMILY MEMBER(S):	COMMENTS/SPECIFICS:
Depression			
Bipolar Disorder (Manic Depression)			
Post-Traumatic Stress Disorder			
Anxiety Disorders			
Obsessive Compulsive Disorder			
Schizophrenia			
Substance Abuse/Alcohol Abuse			
Autism			
Suicide Attempt/Completion			
Other			

Clinical Intake Form

Patient Name: _____DOB: _____

MRN: _____ Date Paperwork Completed: _____

Background:

Where were you born and raised? _____

Who raised you? _____

Have you lived in a group home or in foster care? _____

Number of siblings and their ages: _____

Do you have a guardian or a payee? _____

What is your relationship status? _____

List previous relationships/marriages and their lengths: _____

Number of pregnancies: _____ Number of children and their age: _____

What are your current living arrangements? _____

Highest education level you completed: _____

Did you have learning disabilities or need remediation?_____

Current employer/position: _____

List any previous employment: _____

Are you on Social Security Disability or have you filed for SSI? _____

What is your Faith? _____

Have you ever been a victim of any form of abuse? _____If so, what type?_____

Have you ever had any legal problems? If so, what type/when? _____

Do you have a history of violent behavior? _____

Do you have access to firearms? _____

Describe any recent significant life changes or stressors: _____

_____

Have you served in the Military? _____ If so, what Branch and Years of Service? _____

What do you enjoy doing for fun or to relax? _____

Who do you consider as part of your social support system? _____

Substance Use History:

Are you a **current** or a **former** tobacco product user (please circle)?_____For how long?_____

Types of tobacco/vape products?_____

Have you ever abused or been dependent on any of the following: **Illicit** drugs-_____ **Prescription** drugs-_____ **alcohol-**_____

If yes, which drug(s)? _____

First Used? _____ Last Used? _____

Highest Amount Used? _____

Current Amount Used? _____

History of rehab/detox: _____

Have you had withdrawal, seizures, DTs, blackouts, or medical hospitalization due to drug use? _____

Previous social/legal consequences to substance use: _____

Clinical Intake Form

Patient Name: _____DOB: _____

MRN: _____ Date Paperwork Completed: _____

Please list any additional information below that you feel would be helpful for the physician to know as part of your assessment: