MICHELLE FLOWERS, MD

DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

NEW PATIENT INFORMATION SHEET

PATIENT:

NAME: _____ AGE: _____ BIRTHDATE:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP:_____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

FOR PATIENTS UNDER AGE 18:

MOTHER'S NAME: _____ AGE: _____ FATHER'S NAME: _____ AGE: _____

MOTHER'S OCCUPATION _____ FATHER'S OCCUPATION _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP:_____

HOME PHONE: _____

EMAIL: (M) _____ (D) _____

CELL: (M) _____ (D) _____

MARITAL STATUS OF PARENTS: (Circle One) Married Separated **Divorced*** Widowed

---

***If Divorced:** Custody: _____

Visitation: _____

Child's Main Residence: _____

SIBLINGS:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

DOES THE PATIENT HAVE HISTORY OF…OR IS THERE ANY FAMILY HISTORY OF? (PLEASE NOTE RELATIONSHIP TO THE PATIENT IF THERE IS A FAMILY HISTORY):

DEPRESSION: YES NO _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: YES NO _____

ANXIETY: YES NO _____

ADHD: YES NO _____

AUTISM: YES NO _____

DEVELOPMENTAL DELAYS: YES NO _____

SELF-INJURY: YES NO _____

ATTEMPTED/COMPLETED SUICIDE: YES NO _____

ALCOHOLISM/SUBSTANCE ABUSE: YES NO _____

LEARNING DISABILITIES: YES NO _____

PSYCHIATRIC HOSPITALIZATION: YES NO _____

HEAD INJURY: YES NO _____

CARDIAC ARRHYTHMIA: YES NO _____

OTHER HEART PROBLEMS: YES NO _____

DIABETES: YES NO _____

SEIZURE: YES NO _____

SUDDEN DEATH: YES NO _____

HIGH BLOOD PRESSURE: YES NO _____

OTHER SIGNIFICANT FAMILY HISTORY: _____

_____

_____

_____

_____

_____

MEDICAL:

1) OTHER THERAPIST OR OTHER MENTAL HEALTH PROVIDER OUTSIDE DRS. GF&A
May we contact this person for the purposes of care coordination? YES NO

NAME: _____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

2) PRIMARY CARE PHYSICIAN/PEDIATRICIAN
May we contact this person for the purposes of care coordination? YES NO

NAME:_____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

3) CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)

MEDICATION NAME	DOSAGE	SCHEDULE (e.g AM, PM)	REASON

4) ALLERGIES: _____

CURRENT SCHOOL:

SCHOOL: _____ GRADE: _____ PHONE: _____

TEACHER'S NAME: _____DEAN'S NAME: _____

IS THERE A 504 PLAN IN PLACE? YES NO IS THERE AN IEP IN PLACE? YES NO

HAS YOUR CHILD EVER HAD PSYCHOLOGICAL OR PSYCHOEDUCATIONAL TESTING? YES NO

REFERRAL SOURCE/HOW DID YOU HEAR OF OUR PRACTICE?:

REFERRAL SOURCE:_____PHONE:_____