JCE Health
Psychiatry & Functional Medicine
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New Patient Intake Form

1. Full Name: _____

2. Date of Birth: _____/_____/_____

3. Phone Number: _____

4. Email address: _____

5. Address: (Please include full address with city, state and zip

_____

6. Height (Ft ' in) _____ Current Weight (In lbs)_____

7. Sex: ☐Female ☐ Male ☐ Other
If "Other" please list here: (Please also include Sex at Birth)

_____

8. Marital Status:
☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

9. Number of Children: (include sex and ages)

_____

10. Highest Education Level completed:

☐ Elementary School ☐Middle School ☐High School ☐GED
☐Some College ☐Associates Degree ☐Bachelor's Degree
☐Master's Degree ☐Doctorate Degree / PHD

11. Primary Care Doctor Name and Phone Number:

_____

12. Emergency Contact Name and Phone Number:

_____

13. Allergies: _____

14. Check the reasons why you are you here today:

☐Medication Management ☐Anxiety ☐Depression ☐Stress
☐ Lack of Focus ☐Panic Attacks ☐OCD ☐Bipolar Disorder
☐ Schizophrenia ☐Insomnia ☐Drug / Alcohol addiction
☐Other _____

15. Past Medical History: (Your personal history)
☐High Blood Pressure ☐Diabetes ☐Thyroid disorder
☐History of Cancer ☐High Cholesterol / Triglycerides
☐Chronic pain ☐Headaches/Migraines ☐Renal Disease
☐Lung Disease ☐Other_____

16. Past Surgical History:
☐Tonsillectomy ☐ Appendectomy ☐ Hysterectomy
☐ Gallbladder Removal (Cholecystectomy ☐ Prostate Surgery
☐ Breast Augmentation ☐ Liposuction ☐ Tummy Tuck
☐ Other Cosmetic Surgery _____
☐ Gastric Bypass ☐ Cancer Related Surgery ☐ Heart Surgery
☐ None ☐ Other_____

17. Family Medical History (mom, dad, grandparents, etc.)
☐ Anxiety ☐ Depression ☐ Addictions (Drugs or Alcohol)
☐ Hypertension ☐ Diabetes ☐ Thyroid Disorder ☐ History of Cancer
☐ High Cholesterol ☐ Chronic Pain ☐ Headaches / Migraines
☐ Other _____

18. List of all Medications you are currently taking: (Include the mg if known)
_____
_____
_____

19. Have you ever been Baker Acted?
☐NO ☐ YES If YES, please explain why, and when the Baker Act occurred: (List all, if more than one)
_____

_____

20. Past Substance Use:
☐ Smoking (tobacco use) ☐ Alcohol ☐Marijuana ☐Crack ☐Cocaine
☐Heroin ☐Opioids ☐Meth ☐Acid ☐LSD ☐None
☐Other _____

21. Have you ever received Psychiatric Treatment before?

☐NO ☐ YES, If yes, please list where and when was the last time you were seen. _____

22. Preferred Pharmacy: _____

23. Optional: List any additional information below you believe is important for us to know:

_____
_____
_____

Acknowledgement:
By signing below, I confirm that the above information, including medical history, is correct and accurate to the best of my knowledge. If anything changes regarding my health status, and / or medications current health conditions outside of Psychiatry, I understand that it is my responsibility to inform my Psychiatric provider.

_____ _____/_____/_____
Name Date

_____
Signature