Dr. Marc Schwartz, DO

The ARIZONA SCHWARTZ GROUP
Child, Adolescent, Adult Psychiatry

Fax 866-831-1158
Tel 480-899-4077
www.azSchwartzGroup.com

Adult Intake Form

Referred By

Name	Phone
Address	☐ Pediatrician ☐ Primary Care Physician ☐ Psychologist ☐ Counselor ☐ Friend

Patient Information

Name	Gender ☐ Male ☐ Female	Date
Address	DOB	Age
Home Phone	Mobile Phone	
Work Phone	Email	

Emergency Contact Information

Person	Age	Person	Age
Address		Address *(if different)*	
Relation		Relation	
Home Phone		Home Phone	
Mobile Phone		Mobile Phone	
Work Phone		Work Phone	
Email		Email	

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School Information

Name	
Address	
Guidance	Phone
Psychologist	Phone
Social Worker	Phone

Work Information

Occupation
Company
Address
Phone
Email

Family members residing in the home

Name	DOB	Age	Gender	Relationship
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	

Mental Health History

Psychiatric Hospitalizations ☐ *Yes* ☐ *No* If yes, how many? _____

Hospitals	Date	Reason

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Mental Health History *(Continued)*

Psychotherapy – *(Current and Past)*

Clinician Name: _____ Dates _____ to _____

Phone: Fax: Email:

Clinician Name: _____ Dates _____ to _____

Phone: Fax: Email:

Clinician Name: _____ Dates _____ to _____

Phone: Fax: Email:

Prescriber – Physician or Nurse Practitioner *(Current and Past)*

Clinician Name: _____Dates _____ to _____

Type: Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: Fax: Email:

Clinician Name: _____Dates _____ to _____

Type: Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: Fax: Email:

Psychiatric Medication History

Current Psychiatric Medications: ☐ *Yes* ☐ *No*

Medication	Dose	Start Date	Side Effects

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Previous Psychiatric Medications: ☐ *Yes* ☐ *None*

Medication	Dose	Start Date	Stop Date	Reason for stopping

Medical History

Primary Care Doctor

Name	Phone
Address	Fax

Medical or Surgical History

Medical Diagnosis or Surgery	Date Diagnosed	Treating Physician Name	Phone

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Current Medical Medications *(other than psychiatric)*

Medication	Dose	Start Date	Treating Diagnosis	Side Effects

Allergies ☐ *None* ☐ *Yes (see below)*

Medication Allergies

Name	Reaction

Food Allergies

Name	Reaction

Other Allergies

Name	Reaction

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Family History of Mental Health Disorders *(Leave blank if not applicable)*

Diagnosis	Relationship to Patient	Treated or Untreated
Alcohol Abuse/Dependence		
Anger Problems		
Anxiety *(Generalized or Panic Disorder)*		
Attention Deficit Hyperactivity		
Autism		
Behavior/Conduct Problems		
Bipolar Disorder		
Depression		
Eating Disorders		
Gambling Problems		
Learning Disorders		
Intellectual Disability		
Obsessive Compulsive (OCD)		
Schizophrenia		
Suicide - Attempts		
Suicide - Completed		
Substance Abuse		
Tic Disorder		
Other		

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Reason for seeking treatment *(In Brief)*

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Thank you for your time in completing this form. All of the information will help Dr. Schwartz provide a thorough and comprehensive assessment. Any additional information not covered in this form that you think is helpful and important information, please feel free to detail it below.

Additional Information *(If applicable)*