Shalini Varma, M.D.

Board Certified Psychiatrist - American Board of Psychiatry and Neurology

Patient Information Form

Thank you for selecting me to be your psychiatrist. Please fill out this form completely and to the best of your knowledge as this information is needed for optimal treatment. If you have any concerns or questions regarding this form ask for assistance. Please print clearly.

Please present a Driver's License or other government issued photo ID when turning in these forms

Payment of Services is handled PRIOR to your session

Please fill in all blanks, write NO if not applicable

Name: _____ Birth Date: _____Age:____ Gender: *M F*
(First) (Middle) (Last)

Home Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Soc. Sec. #: _____

Employer/School: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ ZIP:_____

Spouse/Guardian Name: _____ Spouse/Guardian Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Email: _____

*By providing your email address you are consenting to allow Dr. Varma to contact you by email regarding appointments and nonurgent treatment.

We are always grateful for a referral. How did you hear about this office? _____

Responsible Party for this account (if different from above)

Name:_____ Relationship: _____ Phone:_____

Home Address: _____ City: _____ State: ____ ZIP: _____

- **MEDICAL HISTORY:**

Primary Physician: _____ Date of Last Exam: ____/____/_____

Physician's Phone:_____Address:_____

	Yes	No
Height_____ inches Weight _____ pounds		
Are you currently under a physician's care for any reason? ……	☐	☐
Reason(s): _____		
Have you been medically hospitalized in the last two years for any reason? ……	☐	☐
please explain:_____		

- **Do you have any drug/substance allergies?** (list) _____

- **Please list ALL current medications**:

Medication Name	Dose	How Often?	Reason/Treatment of?

Additional Medications or medical conditions: _____

_____

Preferred Pharmacy: _____ Phone: _____

- **<u>MEDICAL & PSYCHIATRIC HISTORY</u>: (Have you ever been diagnosed or treated for the following)**

	You	Family		You	Family		You	Family
Heart Disease	☐	☐	Alzheimer's	☐	☐	Emphysema/Asthma	☐	☐
Irregular Heartbeat	☐	☐	Anemia	☐	☐	Rheumatic Fever	☐	☐
Angina/Chest Pains	☐	☐	Obsessive Compulsive	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Parkinson's	☐	☐	Migraine Headaches	☐	☐
Thyroid	☐	☐	Blood Disorder	☐	☐	Depression	☐	☐
Cardiac Pace Maker	☐	☐	Alcoholism	☐	☐	ADD/ADHD	☐	☐
Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐	Head injury, serious	☐	☐
High Blood Pressure	☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐
Kidney Disease	☐	☐	Shortness of Breath	☐	☐	Anxiety/Panic Disorder	☐	☐
HIV	☐	☐	Bipolar Disorder	☐	☐	Liver Disease	☐	☐
Drug Addiction/Abuse	☐	☐	Schizophrenia	☐	☐	Hepatitis A, B, or C	☐	☐
Stroke	☐	☐	Epilepsy or Seizures	☐	☐	Meningitis	☐	☐

WOMAN ONLY: Oral contraceptive: Y N **Breastfeeding:** Y N **Pregnant:** Y N **Last period or Due Date**: _____

Are you presently having thoughts of suicide? No Yes Explain: _____

Have you ever made a suicide attempt? No Yes When and how? _____

Psychiatric Medications that have been used in the past	Any side effects?	How did they work for you?

Psychiatric treatment history (Psychiatrist name, IOP, drug treatment, inpatient care, ALL inpatient and outpatient)	Reason (depression, alcohol dependence)	Dates (start and end- ie 9/04-10/06)

Nonprescription Drug use (include alcohol, marijuana, cocaine, caffeine, tobacco, supplements, etc)	Age begun	Frequency/Amount	Last time used	Would you like help cutting down/quitting

1.				
2.				
3.				
4.				
5.				

Background information

Religious preference-_____Any beliefs that may affect your treatment?_____

Current Marital status (circle one): married, divorced, separated, single, widowed / Number of marriages _____

Years in current marriage?_____Is spouse supportive? ___explain_____

Child's Name	Age	Biological, step, adopted, foster
1.		
2.		
3.		
4.		

Describe who lives in household (husband, wife, children, mother, father, siblings, pets, etc)

_____

_____

Education, major, skills _____

Limitations in daily living situations and learning problems_____

Legal concerns_____Military History_____

Work History of Patient: (current job, how long at job, do you enjoy your, work stressors?)

_____

_____

_____

Family of origin			Number brothers
Parents stayed married	Yes	No	Number of sisters
Parents divorced at what age?			History of physical abuse at the hands of_____
Patient lived with:			History of sexual abuse at hands of _____
Close family relationships	Yes	No	History of emotional abuse at hands of _____

I have answered every question to the best of my knowledge. I understand inaccurate information can negatively affect my treatment. I consent to psychiatric evaluation.

Patient or Guardian Signature: _____ Date: _____

Printed name: _____

Dr. Shalini Varma signature_____ Date:_____