Monisha Vasa, M.D.
General and Addiction Psychiatrist

New Patient Information Form

Name : _____

Age/Date of Birth : _____

1. Phone Numbers where you can be reached (in order of preference):

1. _____
2. _____
3. _____ **2. Is it ok to leave a message at the above numbers?** (PleaseTick) **Yes** **No**

Address : _____

_____

Email Address : _____

3. Is it ok to contact you via email? Please note that e-mail communication may not be secure.

4. Emergency contact name/relationship/phone number: _____

5. Do you have any acute or chronic medical problems? _____

6. Name and phone number of Primary Care physician:

_____

7. Please list all medications, including prescription and over the counter medications, herbal preparations, supplements, etc.

_____

_____

Pharmacy phone number: _____

Do you have any allergies? _____

8. Please describe briefly your reasons for seeking mental health treatment:

_____

_____

_____

9. Do you have a therapist? If so, please list name and contact information:

_____

10. Please list psychiatric medications that you have taken in the past:

_____

11. Highest Level of Education and Occupation:

_____

12. Are you working or in school currently? If not, when was the last time?

_____

13. Are you in a committed relationship?

_____

14. Do you have children?

_____

15. Please briefly describe any history of alcohol or drug problems:

_____

_____

_____