

Logan Graddy M.D. PLLC
909 Broad Street
Durham, NC 27705
Cellular: (919) 672-1299

New Patient Intake Form

Name: _____ **Date:** _____

Mailing Address:

Physical Address (if different):

_____	_____
_____	_____
_____	_____

May I send mail to the above address? **Y / N**

Telephone Numbers (Please provide only numbers at which you give me permission to call)

Home: _____ May leave a detailed message? ___yes ___*no

Work: _____ May leave a detailed message? ___yes ___*no

Cell: _____ May leave a detailed message? ___yes ___*no

Date of Birth/Age: _____ **Relationship Status:** _____

Occupation/Employer: _____

Contact Person in case of emergency: _____

Relationship: _____ **Telephone #:** _____

Primary Care Physician: _____ **Telephone #:** _____

Therapist: _____ **Telephone #:** _____

MEDICAL HISTORY

List any medical problems:

List any medical hospitalizations:

Please list all medications you are prescribed for medical reasons:

Name of medicine	Dose	Reason prescribed	Prescribed by	Date began
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Known Food or Drug Allergies: _____

PSYCHIATRIC HISTORY

Have you ever been given a psychiatric diagnosis?

No _____ Yes (describe) _____

Have you ever had psychotherapy or counseling in the past?

No _____ Yes (describe) _____

Have you ever seen a psychiatrist before?

No _____ Yes (describe) _____

Have you ever attempted suicide or had serious suicidal thoughts?

No _____ Yes (describe) _____

Please list all medications you are prescribed for psychiatric reasons:

Name of medicine	Dose	Reason prescribed	Prescribed by	Date began
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Hospitalizations (Psychiatric or Substance abuse- give place and year):

Have you ever been the victim of mental, physical, or sexual abuse?

No _____ Yes _____

FAMILY HISTORY

Mental illness? No _____ Yes (who, describe) _____

Substance abuse? No _____ Yes (who, describe) _____

Suicide? No _____ Yes (who, describe) _____

SUBSTANCE USE

Have ever had a problem with alcohol or drugs? No _____ Yes _____

(describe) _____

How often do you?

Smoke _____ never _____ monthly _____ weekly _____ daily

Drink alcohol _____ never _____ monthly _____ weekly _____ daily

Use drugs _____ never _____ monthly _____ weekly _____ daily

WHAT ARE YOUR GOALS FOR TREATMENT?

CONSENT FOR TREATMENT:

Your signature below indicates that you have read the practice policies and procedures and agree to its terms and also serves as an acknowledgement that you have received the HIPAA information.

Signature of Patient (or Guardian if under 18)

Date

Printed Name

Dr. Graddy's Signature

RECORD RELEASE AUTHORIZATION

I hereby authorize Dr. Graddy to furnish information to insurance carriers concerning my illness/ treatment.

Signature of Patient (or Guardian if under 18)

Date

HEALTH INSURANCE INFORMATION

Name of the policy holder: _____

Address of the policy holder: _____

Employer of the policy holder: _____

Insurance plan name: _____

Insurance plan group number: _____

Insurance policy number: _____

Copayment amount: _____