315 Meigs Rd. Suite A404, Santa Barbara, CA, 93109 / tel: 805.898.2288

www.mortonsacksmd.com

PATIENT INTAKE

Name______________________________________ **Date**_______________________________

Date of Birth________________**Email**____

Weight____________**Height**___________**Occupation**____________________________________

Chief Medical Complaint____

Name of Primary Care Physician____

Name of Psychiatrist or other Mental Health Care Provider(s):

____

____

When was your last visit with above-listed provider(s)?_________________________________

Are you taking any medications? Yes_____ No_____ If yes, list medications and dosage:

____

____

Do you have any side effects from any of these medications? Yes_____No_____ If yes, please list here:____

Do you have any allergies to medications? Yes___No___ If yes, please describe:

____

Have you had a medical condition that required hospitalization or long term care?

Yes_____No______If yes, please list details and dates _____________________________________

____

Have you ever had surgery? Yes______No______ If yes, please provide details and dates:

____

Have you been diagnosed with any of the following psychiatric conditions? If yes, circle any that apply: Anxiety / Depression / ADHD / OCD / Bipolar Disorder / Schizophrenia / Suicide Ideation / PTSD / Other ____

Do you have a history of the following? If yes, circle any that apply, and provide details in the space below: High Blood Pressure / Heart Disease / Glaucoma / General Anesthesia / Ketamine Use / Psychedelic Use (LSD, psilocybin, MDMA) / Excessive Alcohol Intake / Alcohol Addiction / Opiate Use / Opiate Addiction / Family History of Psychiatric Condition: ____________________________________

____

____