COASTLINE PSYCHIATRIC LIAISONS
950 48th Ave N, Suite 202
Myrtle Beach, SC 29577

Phone: (843)-992-0853
Fax: (843) 839-9855
Email: office@coastlinepsychiatric.com

PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _________________

Address: ____

Home #: _____________________ Cell #: __________________________

Work #: ______________________ Email: __________________________

Social Security #: __________________________ DOB: _____/______/_______

Allergies:____

Age: ____________ Status: Single Married Widowed Divorced Separated

Emergency Contact Person: ____

Relationship to you: ______________________ Contact #: ____________________________

Employer: ______________________________ Occupation: __________________________

Employer Address: ____

Primary Care Physician: ___________________________ Telephone: ___________________

How did you hear about my office? ____

1. How often do you experience your symptoms?
   □ Constantly (76-100% of the time)
   □ Occasionally (26-50% of the time)
   □ Frequently (51-75% of the time)
   □ Intermittently (1-25% of the time)

2. How are your symptoms changing with time?
   □ Getting Worse □ Staying the Same □ Getting Better

3. Using a scale from 0-10 (10 being the worst), how would you rate your mood?
   0 1 2 3 4 5 6 7 8 9 10 (Please circle)

4. How much has the problem interfered with your work?
   □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

5. How much has the problem interfered with your social activities?
   □ Not at all □ A little bit □ Moderately □Quite a bit □ Extremely

6. Do you consider this problem to be severe?
   □ Yes □ Yes, at times □ No