MARYLAND PSYCHIATRIC CARE
Hope. Help. Health. Healing.

Date: _____

Maryland Psychiatric Care
Confidential New Patient/Medical Checklist

Welcome to MPC! We strive to provide the best quality of care. In order to do so, we need to have your medical history to ensure we are providing the safest and most comprehensive treatment. In accordance with HIPAA*, we may need your permission to request medical records. Please fill out the following information to the best of your knowledge. Your intake therapist will help you complete what you cannot. We will obtain your signature electronically. Releases of information can be revoked at any time per your request.

Name/Date of Birth: _____ /_____

Emergency Contact:	
Name	
Phone / Fax Numbers	
Relationship to Patient	
Referred From:	
Name	
Phone / Fax Numbers	
Primary Care Physician:	
Name	
Phone / Fax Numbers	
Most Recent Hospitalization: (if applicable)	
Hospital Name	
Phone / Fax Numbers	
Probation/Parole Officer: (if applicable)	
Name	
Phone / Fax Numbers	

Marital Status:	_____Single _____ Married _____ Divorced
Sexual Orientation:	_____ Heterosexual _____ Gay or Lesbian _____ Bisexual _____ Questioning

Charles County
3050 Crain Highway
Waldorf, MD 20601

Charles County
4470 Southern Business Park Drive
2nd Floor
White Plains, MD 20695

Medications:

What medications are your currently taking (prescription and over-the-counter):	*Taken for:*	*How often?*	*Prescribed by?*

Allergies:

Are you allergic to any medications, foods, or other substance?	*Reaction*

Smoking Status:

Do you smoke or chew tobacco?	*Yes No (circle one) How much?*
Do you drink alcohol?	*Yes No (circle one) How much?*
Are you currently pregnant/could you be pregnant/trying for a pregnancy?	*Yes No (circle one)*

Health History:

Do you have or had any of the following conditions?	*If yes, please provide details:*
Bowel/intestinal problems	
Breathing problems	
Cancer/tumors	
Diabetes	
Headaches	
Heart condition/irregular beats	
Hepatitis	
HIV/AIDS	
Kidney/bladder infections	
Seizures	
Sexually transmitted diseases	
Thyroid problems	
Weight – recent gain or loss	

Surgeries/Hospitalizations:

When:	*Reason:*

Additional information:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____

*HIPAA stands for the Health Insurance Portability and Accountability Act, a U.S. law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. These standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country.

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