Anna Flynn, M.D.
Board Certified Adult, Child & Adolescent Psychiatrist

— NEW PATIENT INFORMATION —

PATIENT

NAME:_____BIRTHDATE: _____SOC SEC #_____

STREET ADDRESS: _____

CITY:_____STATE: _____ZIP:_____

HOME PHONE: _____CELL PHONE:_____

EMAIL: _____

EMERGENCY CONTACT: _____RELATIONSHIP:_____

HOME PHONE: _____CELL PHONE:_____

REASON FOR SEEKING TREATMENT: _____

PERSON RESPONSIBLE FOR PAYMENT

NAME:_____BIRTHDATE: _____SOC SEC #_____

STREET ADDRESS: _____

CITY:_____STATE: _____ZIP:_____

HOME PHONE: _____CELL PHONE:_____

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(847) 212-1909 Fax: (312) 275-7884
181 Waukegan Road Suite 105 Northfield, IL 60093

EMAIL: _____RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____WORK PHONE:_____

THERAPIST OR OTHER MENTAL HEALTH PROVIDER
May we contact this person for the purposes of care coordination? □ YES □NO

NAME: _____

OFFICE PHONE: _____ FAX: _____

ADDRESS: _____CITY:_____STATE: ____ZIP:_____

PRIMARY CARE PHYSICIAN
May we contact this person for the purposes of care coordination? □ YES □NO

NAME: _____

OFFICE PHONE:_____ FAX: _____

ADDRESS: _____CITY:_____STATE: ____ZIP:_____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)

MEDICATION NAME	DOSAGE	SCHEDULE (e.g. AM, PM)	REASON

ALLERGIES:_____

_____

MEDICAL PROBLEMS:

DIAGNOSIS	TREATING PHYSICIAN	YEAR DIAGNOSED

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DOES THE PATIENT HAVE ANY PRIOR HISTORY OF: (PLEASE DESCRIBE)

SEIZURE: □ YES □NO _____

HEAD INJURY: □ YES □NO _____

CARDIAC ARRHYTHMIA: □ YES □NO _____

OTHER HEART PROBLEMS: □ YES □NO _____

DEVELOPMENTAL DELAYS: □ YES □NO _____

ALCHOLISM/SUBSTANCE ABUSE: □ YES □NO _____

PSYCHIATRIC HOSPITALIZATION: □ YES □NO _____

SELF-INJURY: □ YES □NO _____

ATTEMPTED SUICIDE: □ YES □NO _____

IS THERE ANY FAMILY HISTORY OF: (PLEASE NOTE RELATIONSHIP TO PATIENT)

DIABETES: □ YES □NO _____

SEIZURE: □ YES □NO _____

SUDDEN DEATH: □ YES □NO _____

CARDIAC ARRHYTHMIA: □ YES □NO _____

HIGH BLOOD PRESSURE: □ YES □NO _____

OTHER HEART PROBLEMS: □ YES □NO _____

DEPRESSION: □ YES □NO _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: □ YES □NO _____

ANXIETY: □ YES □NO _____

AD/HD: □ YES □NO _____

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AUTISM: □ YES □NO _____

DEVELOPMENTAL DELAYS: □ YES □NO _____

OTHER MENTAL ILLNESS: □ YES □NO_____

ATTEMPTED/COMPLETED SUICIDE: □YES □NO _____

ALCHOLISM/SUBSTANCE ABUSE: □ YES □NO _____

OTHER SIGNIFICANT FAMILY HISTORY: _____

_____

_____

_____

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----------FOR PATIENTS UNDER AGE 18----------

MOTHER

NAME:_____BIRTHDATE: _____OCCUPATION_____

STREET ADDRESS: _____

CITY:_____STATE: _____ZIP:_____

HOME PHONE: _____CELL PHONE:_____

FATHER

NAME:_____BIRTHDATE: _____OCCUPATION_____

STREET ADDRESS: _____

CITY:_____STATE: _____ZIP:_____

HOME PHONE: _____CELL PHONE:_____

ARE BIOLOGICAL PARENTS (CIRCLE ONE): MARRIED DIVORCED SEPARATED

DATE OF DIVORCE OR SEPARATION (WHERE APPLICABLE): _____

CUSTODIAL PARENT(S) AND AGREEMENT (WHERE APPLICABLE):

_____

SIBLINGS:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

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PATIENT'S CURRENT SCHOOL

NAME:_____ PHONE:_____

ADDRESS: _____CITY:_____STATE: ____ZIP:_____

TEACHER'S NAME:_____ GRADE:_____

DOES CHILD CURRENTLY HAVE AN IEP OR 504 PLAN? YES NO

DATE OF LAST IEP MEETING: _____

CURRENT EDUCATIONAL CONCERNS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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