Greg Berman *MD*

PSYCHIATRY

4039 N. Mississippi Ave.
Suite 207
Portland, OR 97227
503.227.7555
gregbermanmd.com

NEW CLIENT INFORMATION

Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please let me know which of these are ok to leave messages on. _____

Address: _____

Email: _____

Would you like appointment reminders emailed to you. YES NO

Primary Care Provider: _____ Phone: _____

Pharmacy _____ Phone: _____

Current Medications *(If applicable)*: _____

_____

_____

Please list any outside mental health providers that you currently see and their phone numbers.

Name: _____ Phone: _____

Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Insurance Company *(If applicable)*: _____

Please provide additional information or comments on the back. Thank You.

Briefly list or describe reason(s) for coming: _____

_____

_____

Past mental health treatment: _____

_____

_____

List any prior psychiatric medications: _____

_____

_____

List any allergies or medication reactions: _____

_____

_____

Current and Past Medical Problems: _____

_____

_____

List current school, grade, past schools and locations *(If client is a minor)*: _____

_____

_____

Current job and employer *(If applicable)*: _____

_____

Please provide additional information or comments on the back. Thank You.