Gregory Narron M.D.
AND ASSOCIATES

Appointment Date & Time _____

Intake Date _____ Approved ☐ YES ☐ NO

Doctor Requested _____

Referred by _____

Patient _____ Date of Birth _____

Parent _____

Phone _____

Address _____

Email _____

Insurance _____ Policy # _____

Group # _____ Subscriber _____

Date of Birth _____ Insurance Phone _____

Copay _____ Co-Insurance _____

Self Pay _____ Agrees to fees _____

What are the problem(s) for which you are seeking help?

1. _____

2. _____

3. _____

List ALL current prescription medications and how often you take them (if none, write none).
Medication Name / Total Daily Dosage / Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever experienced any of the following?

Extreme depressed mood	☐ Yes ☐ No	Unexplained losses of time	☐ Yes ☐ No
Dramatic mood swings	☐ Yes ☐ No	Unexplained memory lapses	☐ Yes ☐ No
Rapid speech	☐ Yes ☐ No	Alcohol/substance abuse	☐ Yes ☐ No
Extreme anxiety	☐ Yes ☐ No	Frequent body complaints	☐ Yes ☐ No
Panic attacks	☐ Yes ☐ No	Eating disorder	☐ Yes ☐ No
Phobias	☐ Yes ☐ No	Body image problems	☐ Yes ☐ No
Sleep disturbances	☐ Yes ☐ No	Repetitive thoughts (e.g. obsessions)	☐ Yes ☐ No
Hallucinations	☐ Yes ☐ No	Repetitive behaviors (e.g. frequent checking, hand washing)	☐ Yes ☐ No

Check if you have ever tried the following
****If yes, how long and when did you last use?***

Methamphetamine	☐ Yes ☐ No	Pain Killers	☐ Yes ☐ No
Cocaine	☐ Yes ☐ No	Methadone	☐ Yes ☐ No
Stimulants (pills)	☐ Yes ☐ No	Tranquilizer/Sleeping Pills	☐ Yes ☐ No
Heroin	☐ Yes ☐ No	Ecstasy	☐ Yes ☐ No
LSD or Hallucinogens	☐ Yes ☐ No	Alcohol	☐ Yes ☐ No
Marijuana	☐ Yes ☐ No		

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.) ***Please circle and list family member.***

Alcohol/Substance Abuse	☐ Yes ☐ No	Eating Disorders	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Obsessive Compulsive Behavior	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Schizophrenia	☐ Yes ☐ No
Domestic Violence	☐ Yes ☐ No	Suicide Attempts	☐ Yes ☐ No