SHAWN BARNES M.D.

700 GARDEN VIEW
SUITE 201-C
ENCINITAS, CA 92024

NEW PATIENT FORM

Name: ____ Date of Birth: __________ Age: _______

Address: _________________________________ City, State, Zip: ________________________________

E-mail: ____ Phone: ___________________________

Name you prefer to be called: ____________________________

Primary Care Doctor (if any):

Name: ___________________________________

Telephone Number: ________________________

Ok to contact this person? **Yes** **No**

Psychiatrist or therapist (if any):

Name: ___________________________________

Telephone Number: ________________________

Ok to contact this person if needed? **Yes** **No**

Preferred Pharmacy (if any):

Name: ___________________________________

Address: _________________________________

Telephone Number: ________________________

Emergency contact:

Name: ___________________________________

Telephone Number: ________________________

Ok to contact this person if needed? **Yes** **No**

Personal Information:

Are you married? **Yes** **No** *If so, what is your spouse's name?*_____________________________

Do you have children? **Yes** **No** *If so, what are their names and ages?* ______________________

____

What is your occupation? ____

Do you identify with any religious or spiritual affiliation? **Yes** **No**

If yes, please tell me more ____

Do you exercise regularly? **Yes** **No** *If yes, please tell me more* ______________________________

Do you follow a particular diet or philosophy of eating? **Yes** **No**

If yes, please tell me more ____

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Medical and Psychiatric History:

What psychiatric conditions (if any) have you been treated for?

☐ I am not aware of any prior psychiatric conditions

_______________ _______________ _______________

_______________ _______________ _______________

Have you ever been admitted to a psychiatric hospital? **Yes** **No**

If yes, please tell me more ______________________________________

What medical conditions do you have?

☐ I am not aware of any ongoing medical issues

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

What medications, herbals, or supplements you are currently taking? Please list all:

Medication or supplement	Daily dosage	Medication or supplement	Daily dosage