

D. David Mu M.D.
28 Allegheny Avenue, #1202
Towson, MD 21204
Phone: (443) 470-9065 / Fax: (410) 825-2979
Email: doctordavidmu@gmail.com

PATIENT INTAKE QUESTIONNAIRE (Please use additional blank pages if needed)

Patient Name: _____

Date of Birth: ____/____/____

1. REASONS FOR SEEKING TREATMENT:

Please describe your primary concern(s) that have led you to treatment.

2. PAST TREATMENTS:

Please describe any previous treatments that you have had with respect to above concerns. Include names of health care professionals, dates of treatment, medications/therapies performed, etc. Please be as specific as you can with reference to medication dose, duration, side-effects and response.

3. FAMILY INFORMATION:

Has anyone on either side of the family ever been diagnosed with a mental illness such as depression, bipolar disorder, dementia, schizophrenia, or attention deficit hyperactivity disorder? If so, please explain.

4. SOCIAL HISTORY

Please describe any significant personal relationships, current or past employment, education background, recent changes in living situation, or any other personal details that may be relevant to your seeking care.

5. MEDICAL HISTORY:

Please list any medical problems you have including time of diagnosis and any ongoing treatments.

Please list ALL medications you are currently taking including dosage. Please include any over the counter medications or supplements.

Please list any drug allergies/intolerances

6. GOALS OF TREATMENT:

Please describe your goals for treatment. Additionally, are there specific personal, social or work-related goals you would like to attain that may be helped with treatment?

Thank you for your thoughtful responses. I look forward to discussing them with you in person.

Patient/Guardian Signature

Date