New Patient Information

Patient Name:________________________________ DOB: _____________ Marital Status:____________________

Address: _______________________________________ City:_____________________State: _____ Zip:_________

Sex: M __ F__ Home Phone: (____)______________Work Phone: (___)____________Cell: (___)________________

SS#: ____________________Drivers License #: _____________Employer: _________________________________

Occupation: ____Years at work: ______________

Spouses Name:____________________________________ DOB: ______________ SS#: ____________________

Address: _________________________ City: _____________State: _____ Zip: ______ Home Phone: (___)__________

Employer Name: ____________________ Occupation: _______________________ Work Phone: (___)____________

Responsible Party

Name: _________________________________ Relationship to patient: __________________ DOB: ______________

Address: _______________________________________ City:_____________________State: _____ Zip:_________

Person To Contact In Case Of an Emergency (Not residing with you):

Name: _________________________________ Relationship:________________ Telephone #: (___)____________

Insurance

Primary Insurance Co: ___________________________ Member ID#: ____________________Group #: ___________

Phone #: (_) ____________ I have additional coverage: Yes __ No.__ If Yes carrier name:_

Primary Care Physician (PCP): _________________________ Address: _____________________________________

City: _________________________State: _____ Zip: ________ Telephone #: (____)___________________________

Person/Agency that Referred You:

Name/ Agency: _________________________________ Address: ____

City: _________________________State: _____ Zip: ________ Telephone #: (____)___________________________

Reason (s) you were referred. ____

____

____

____

____

____

____

New Patient History Questionnaire

Please complete the following information for your permanent record. Please return to the receptionist for your clinician to review at the beginning of your session.

Name:_________________________________ DOB:__________________ Today's Date: ____________________________

Rating of Health:	Poor	Fair	Satisfactory	Good	Excellent
Physical:	1	2	3	4	5
Emotional:	1	2	3	4	5

Goals for Treatment:

What problems do you want to work on? ____

____

____

____

Current Symptoms:
What emotional, behavioral and physical symptoms have you experienced recently? Please give the frequency (Example ~rarely / occasionally / frequently)
Symptom#1: ____

____

____

Symptom #2____

____

____

Symptom #3.____

____

____

Personal History:

Educational Level: ________________ Occupation: _______________________ Time at Job:________________________

Other Past or Current Concerns or emotional Issues:____

____

Medical History: Date of last physical exam________________significant findings (if any)_____________________________

Current & Previous Medical Illnesses (Including Surgeries):____

____

Medication Allergies: Yes _______ No _______ Known Allergies: ____

Name of medication(s) taken – Current & Past	Dosage (mg)	Current	Past	Last time taken

Hospitalizations: ( ) Past ( ) Recent Hospital Name __________________________ Date of Discharge ___________

New Patient History Questionnaire

Name:_________________________________ DOB: __________________ Today's Date:_____________________________

Self harm Behavior: History of Prior Suicide: No ________Yes _____ If Yes, When____________________________________

Other Self Harmful Symptoms (Self Cuttings / induced Vomiting etc.): No ________ Yes__If Yes, When.________________________

____

Family History: does anyone in your immediate family have a history of serious illness? If yes please explain

____

____

Please list any medical, psychological, or chemical dependency, suicide or homicide attempts in your family history:

____

____

____

Describe any abuse/victimization to yourself or any person in your family:

____

____

____

Chemical Abuse & Dependency History: (if not applicable, please check box [ ])

Substance	**Amounts/Frequency**	**Time period used**	**Date last used**
________________	__________________	________________	_____________
________________	__________________	________________	_____________
________________	__________________	________________	_____________
________________	__________________	________________	_____________
________________	__________________	________________	_____________

Legal problems / Arrests:____

____

Please list previous Therapist/Psychiatrist or programs with type of treatment and dates:

____

____

Please list any other issue(s), which you think might be helpful for your Therapist / Psychiatrist in this evaluation:

____

____

____