New Patient Information

Contact Information

Client Name: ______________________ **Date:** __________ **Date of Birth:** __________ **Age:** __________

Gender: ❐ Male ❐ Female **Marital Status:** ____________________ **Occupation:** ____________________

Street Address: ____ **Apt:** __________

City: ____ **State:**__________ **Zip:** __________

Home Phone: ______________________________ **Is it OK to leave a message?** ❐ Yes ❐ No

Cell Phone: ______________________________ **Is it OK to leave a message?** ❐ Yes ❐ No

Work Phone: ______________________________ **Is it OK to leave a message?** ❐ Yes ❐ No

Email Address: ______________________________ **Is it OK to send a message?** ❐ Yes ❐ No

Emergency Contact Name: ________________ **Relationship:** ________________ **Phone:** ________________

Living Situation

Please identify those living in your household currently.

Name **Age** **Relation**

1. ____
2. ____
3. ____
4. ____
5. ____

Do you have any adult or minor children that are not currently living in your household? If yes please describe.

❐ Yes ❐ No ____

Medical Background

Primary Care Doctor (PCP): ____

Date if your last physical exam? ______________ **By Whom?** ______________________________

Please name any medical specialists currently involved in your health care other than your PCP:

Name **Medical Specialty**

1. ____
2. ____
3. ____

Who referred you for therapy? ____

If self referred, how did you hear about this practice?______________________________

Are you currently being treated for any medical conditions? If yes please describe.

❐ Yes ❐ No ____

Are you currently taking any prescription medication? If yes please describe.

❐ Yes ❐ No ____

Have you ever experienced any of the following? If yes, please describe.

❒ **Chronic pain condition(s):** ____________________

❒ **Difficulty maintaining a healthy weight:** ____________________

❒ **A head injury/TBI:** ____________________

❒ **A seizure disorder:** ____________________

❒ **Childhood developmental issues:** ____________________

❒ **Childhood learning problems:** ____________________

Psychiatric History

Have you ever seen a psychiatrist, therapist, counselor, psychiatric nurse practitioner or social worker in the past?

❒ Yes ❒ No If yes, please list the name of the provider and the dates of treatment:

Name of provider: ____________________ **Dates of treatment:** (i.e., May 2000 – May 2001) ____________________

Have you ever been given a mental health diagnosis in the past from a mental health professional? If yes please describe.

❒ Yes ❒ No ____________________

Have you ever been prescribed psychotropic (antidepressants, anti-anxiety, sleep aids) medications in the past?

❒ Yes ❒ No If yes please describe.

Name of medication: __________ **Dates prescribed:** __________ **Did you find it helpful:** __________

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Have you ever been hospitalized for psychiatric reasons? If yes please describe.

❒ Yes ❒ No ____________________

Have you ever attended a partial hospitalization program? If yes, list dates.

❒ Yes ❒ No ____________________

Have you ever experienced any of the following? If yes please describe.

❒ **Suicidal thoughts or attempts in the past** ____________________

❒ **Homicidal thoughts or actions in the past** ____________________

❒ **Been in a violent relationship** ____________________

❒ **Been the recipient of physical abuse** ____________________

❒ **Been the recipient of verbal or emotional abuse** ____________________

❒ **Been the recipient of sexual abuse as a child** ____________________

❒ **Been the recipient of unwanted sexual advances as an adult** ____________________

❒ **Been the witness of a traumatic event** ____________________

❒ **Known someone who has committed suicide** ____________________

Substance Abuse History

Have you ever used (currently or in the past)? If yes please describe.

❒ **Cigarettes** ____________________

❒ **Alcohol** ____________________

❒ **Marijuana** ____________________

❒ **Cocaine** ____________________

❒ **Opioids** ____________________

❒ **Other street drugs** ____________________

❒ **Prescription drugs recreationally** ____________________

Have you ever wondered if you have a problem with drugs or alcohol? ❒ Yes ❒ No

Have anyone suggested to you that you might have a problem with drugs or alcohol? ❒ Yes ❒ No

Have you ever been formally treated for a drug or alcohol problem? If yes, list dates of treatment.

❒ Yes ❒ No ____

Current Concerns

Please describe your main reason for seeking therapy at this time: ____

____

Have you had therapy in the past for this same issue? ❒ Yes ❒ No

Related to the issue that you described above, please check any of the following symptoms that you are currently experiencing:

- ❒ **Anger/Rage**
- ❒ **Anxiety**
- ❒ **Alcohol use**
- ❒ **Appetite changes**
- ❒ **Arguing**
- ❒ **Compulsive behaviors**
- ❒ **Depression/sadness**
- ❒ **Distractibility**
- ❒ **Fatigue**
- ❒ **Financial problems**
- ❒ **Hypersomnia (too much sleep)**
- ❒ **Insomnia**
- ❒ **Job loss**
- ❒ **Legal issues**
- ❒ **Loneliness**
- ❒ **Low motivation**
- ❒ **Low self esteem**
- ❒ **Marital infidelity**
- ❒ **Marital conflict**
- ❒ **Mood swings**
- ❒ **Nightmares**
- ❒ **Obsessive thoughts**
- ❒ **Panic attacks**
- ❒ **Physical symptoms/discomfort**
- ❒ **Restlessness**
- ❒ **Self harming behaviors**
- ❒ **Sexual dysfunction**
- ❒ **Social withdrawal**
- ❒ **Stress**
- ❒ **Suicidal thoughts/behaviors**

Other: ____

For Women Only

Gynecologist's Name: ________________________________ **Phone Number:** ________________________

Date of Last Gyn Exam: ______________ **Number of Pregnancies:** ___________ **Number of Live Births:** __________

Are you currently pregnant? ❒ Yes ❒ No If yes, number of weeks: ___________

Have you ever experienced a miscarriage? ❒ Yes ❒ No If yes, list dates: ________________________________

Have you ever had a termination/ abortion? ❒ Yes ❒ No If yes, list dates: ________________________________

Have you ever had a fetal death in utero? ❒ Yes ❒ No If yes, list dates: ________________________________

Are you currently or have you had difficulty conceiving / infertility? ❒ Yes ❒ No

Do you suffer from painful or heavy periods? ❒ Yes ❒ No

Do you suffer from moderate to severe mood swings related to your menstrual cycle? ❒ Yes ❒ No

Do you have concerns about urinary incontinence? ❒ Yes ❒ No

Do you have concerns about your sexual functioning? ❒ Yes ❒ No

Personal Statements

Please comment on any other details that may be important to know when working with you. This may include sexual orientation, religious convictions or spirituality, ethnicity, cultural background, sensitivities, disabilities, or anything else important to your sense of identity.

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I have completed this form and believe the information that I have provided is truthful to the best of my knowledge.

Print Name: ______________________ **Signature:** ______________________ **Date:** ________________