NEW PATIENT INFORMATION FORM - ADULT

(Please fill out and return at or prior to first appointment)

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DEMOGRAPHIC INFORMATION

Patient Legal Name	Preferred Name		Date
Date of Birth	Age		Sex
Address	City	State	Zip
Phone 1 ◯ Home ◯ Cell ◯ Work	Phone 2 ◯ Home ◯ Cell ◯ Work		
Email Address	Appointment reminders? ◯ Email ◯ Text ◯ Both		
Occupation	Employer	Highest Education	Religion
Emergency Contact	Relationship to you	Phone	
Referred by?	May we acknowledge the referral?		

CHIEF COMPLAINT

Briefly describe your reason for seeking treatment?

Describe main symptoms.

Please check any areas below which have been worsened due to your current problems.

- ◯ My school/work performance
- ◯ My relationship with my family
- ◯ My interest in keeping up my apprearance
- ◯ My ability to control my temper
- ◯ My ability to carry out my usual leisure interests/hobbies
- ◯ My ability to plan for my future and set goals for myself
- ◯ My relationship with my friends
- ◯ My ability to manage my usual chores at home
- ◯ My ability to get along with my parents/children
- ◯ My ability to control my behavior
- ◯ My relationship with my employer or co-workers
- ◯ My relationship with legal authorities

PATIENT PSYCHIATRIC AND MEDICAL HISTORY

HISTORY OF PRESENTING ILLNESS

When did these symptoms begin?

Did something occur to precipitate them?

Have there been symptom-free periods?

PAST PSYCHIATRIC HISTORY

Have you been treated for problem in the past?

When did treatment first begin?

What kind of treatment occurred?

Individual psychotherapy? If yes, when and with whom?

Group/Family/Couples psychotherapy? If yes, when and with whom?

Have you ever been psychiatrially hospitalized? If yes, when how, and under what circumstances?

Have you ever hurt yourself in any way? For example, cutting or burning self. If yes, when, how, and under what circumstances?

Have you ever thought of or attempted to commit suicide? If yes, when, how, and under what circumstances?

MEDICAL HISTORY

Current and prior medical problems:

Medical hospitalizations / surgeries:

Known drug allergies:

Primary Care Physician	Last physical exam:

Address/Phone:

Immunizations current? ◯ Yes ◯ No

Describe current eating habits:

Describe current sleeping habits (How many hours per night? How many times do you wake up per night? How long to fall asleep?)

Describe current exercise habits:

PAST MEDICATIONS

NAME OF MEDICATION	*DOSAGE*	*WHY PRESCRIBED*	*WHO PRESCRIBED*	*COMMENTS (HELPFULNESS/SIDE EFFECTS)*

CURRENT MEDICATIONS

NAME OF MEDICATION	*DOSAGE*	*WHY PRESCRIBED*	*WHO PRESCRIBED*	*COMMENTS (HELPFULNESS/SIDE EFFECTS)*

Please comment on any substance abuse (drugs/alcohol).

What?	*When did you start?*	*How much did you use?*	*Last use?*	*What did it do for you?*

Please mark any that the patient has or has had and include dates as best you can.

- ◯ Head injury/Loss of consciousness
- ◯ Seizures/Convulsions
- ◯ Other neurological problems
- ◯ Ear, Nose, or Throat problems
- ◯ Dental problems
- ◯ Asthma
- ◯ Chest problems
- ◯ Stomach or bowel problems/soiling
- ◯ Urinary or bladder/wetting
- ◯ Heart problems
- ◯ Rheumatic fever/strep infections
- ◯ Liver/Kidney problems
- ◯ Skin problems
- ◯ Joint/limb problems
- ◯ Hearing/vision problems
- ◯ Growth/endocrine problems
- ◯ Gynecological/menstrual problems
- ◯ Childhood measles/mumps

FAMILY HISTORY

Please give the names, ages, and relationships of people living in the home:

Who are family other immediate family members not living in the home:

FAMILY PSYCHIATRIC HISTORY

Has any family member had any of the following? Please indicate which family member.

- ◯ Depression
- ◯ Mania/Bipolar Disorder
- ◯ Suicidal thoughts/Urges/Behaviors
- ◯ Anxiety
- ◯ Panic
- ◯ Obsessions/Compulsions
- ◯ Rituals
- ◯ Movement Disorders
- ◯ Tics
- ◯ Unusual noises/vocalizations
- ◯ ADHD
- ◯ Eating Disorder
- ◯ Learning Disability
- ◯ Coordination problems
- ◯ Mental Retardation
- ◯ Autism/Asperger's disorder/PDD
- ◯ Sleep Disorder
- ◯ Drug Use
- ◯ Alcohol Use
- ◯ Psychosis
- ◯ Legal Problems
- ◯ Psychiatric hospitalizations
- ◯ Other _____

Please elaborate on above as needed:

Please provide information about significant medical issues on the FATHER'S side:
Please provide information about significant medical issues on the MOTHER'S side:
Please use the remaining space to describe any other comments, questions, or concerns.

Problem Behavior Checklist: Do you have any of the following problems? Please check all that apply.

	In the past	Occasionally	Often	Very Often
Short attention span				
Impulsivity (acts before thinking)				
Won't follow rules/directions				
Irritable, poor fustration tolerance				
Easily riled up				
Picks on others, bullies				
Feels picked on				
Teases others unmercifully				
Deliberately tries to annoy people				
Easily angered, bad temper				
Frequent accidents				
Gets out of control				
Gets violent and aggressive				
Cruel to animals				
Fire setting				
Steals				
Cries easily				
Gets giddy and silly				
Tiredness/listlessness				
Lack of interest in activities				
Isolates self from others				
Sadness				
Poor appetite				
Problems getting to sleep				
Early morning awakening				
Self-injurious/abusive behaviors				
Excessive sleepiness				
Weight gain/loss				
Worries a lot				
Fear of the dark				
Other specific fears (heights, etc)				
Catastrophic fears				
Reluctance to go to school/work				
Repeated unwanted thoughts				
Compulsive behaviors				
Rituals (has to repeat the same action)				
Hair pulling				
Excessive concerns: body defects				