New Patient Information

This form is designed to give me background information that will help me better understand and treat the problems you are dealing with. Please fill out this form as completely as you can. Thank you.

Today's Date: _____ Name: _____ DOB/Age: _____

Who referred you? _____ Who is your family doctor? _____

Please tell me about your current family and household.

Marital Status: _____ Number of years in current relationship: _____

Please list all members currently living in your household, their relationship to you and their ages, including children and stepchildren:

_____

_____

Past Marriages for Yourself:

Duration	Divorced/Widowed/Separated?

Past Marriages for Your Significant Other:

Duration	Divorced/Widowed/Separated?

Family History:

Father's Age (if deceased, what year and how old were you? _____

Occupation: _____

Please describe your father in about 10 words:

_____

_____

Family History Continued:

Mother's Age (if deceased, what year and how old were you? _____

Occupation: _____

Please describe your mother in about 10 words:

_____

_____

Did your parents get divorced, and if so, how old were you? _____

Who did you live with after the divorce? _____

Who was in your household growing up?

_____

_____

Has anyone in your **biological** family been diagnosed with Anxiety, Depression, Bipolar Disorder, ADHD, or any other mental health problems? _____YES _____NO
If yes, please describe below:

Relative	Mental Health Diagnosis	Alcohol or Substance Abuse

Medical History:

Please describe your current health problems:

_____

_____

Do you have problems with pain? _____ What is your diagnosis? _____

_____

Are you receiving treatment for your pain? _____ What kind of treatment? _____

What is your average pain level on a scale of 0-10 (10 being the worst)? _____

Medical History Continued:

Have you ever had a head injury that left you unconscious, even briefly, or resulted in a concussion? If so, when?

_____

_____

Do you have any of the following? Please check all that apply.

_____ Allergies - _____

_____ Dental Issues or Tooth Pain _____Vision Problems

_____ Speech Problems _____Hearing Problems

Employment and Education History:

Disability: Yes: _____ No: _____

Current Employment(s): _____

Full-Time: _____ Part-Time: _____ Duration: _____

Last Grade Level Completed: _____ Are you currently in school? _____

Did you have any problems when you were in school? If so, what problems?

_____

_____

Did/Do you serve in the military? _____ When and where? _____

Background information about your current problem(s):

Briefly describe your problems or reason for seeking services:

_____

_____

When did these problems begin? If they have been going on for a long while, what made them worsen?

_____

_____

Background Information Continued:

Please mark all of the problems or stressors that apply to you and/or your significant other.

_____Work or Job Difficulties
_____Memory Issues
_____Relationship Problems
_____Parents/In-Laws
_____Children or Step Children
_____Health Problems
_____Legal Problems
_____Past Legal Problems
_____Current Trauma/Abuse
_____Past Trauma/Abuse
_____Finance
_____Grief
_____Loss

Suicide History:

	Past	Recent	Never
Suicidal Thoughts			
Suicide Attempt			
Homicidal Thoughts			
Family Member Attempt/Die By Suicide			

Addictive Behavior History:

	Past	Recent	Never
Alcohol Use			
Substance Use			
Tobacco Use			
Gambling			
Shopping			
Phone/Computer/ Internet/Social Media			

Have you ever assaulted or abused another person?

_____

_____

Sleeping and Eating Habits and Patterns:

Usual Bedtime: _____ Usual Wake Up Time: _____ Hours per Night: _____

Do you struggle with any of the following issues? Please check all that apply.

_____Difficulty Falling Asleep
_____Awaken Frequently
_____Wake up Early and Can't Fall Back Asleep
_____Unusual Behaviors when Sleeping
_____Cravings
_____ Binge Eating
_____Emotional Eating
_____Purging
_____Other: _____

_____Shift Work
_____Snore
_____Fall Asleep During the Day
_____Poor or Extreme Appetite
_____Yo-Yo Dieting
_____ Food Restriction
_____ Excessive Exercise

Past Treatment and Current Goals:

Please provide information about your past treatment (if applicable). Include the type of treatment and the nature of the problem at that time:

_____

_____

If you did have past treatment, do you feel that it was helpful? Why or why not?

_____

_____

Do you see a health care provider for mental health medications? If so, what are you taking and who is prescribing them?

_____

_____

What other mental health medications have you tried in the past and why were they discontinued?

_____

_____

Have you ever been hospitalized for psychiatric problems? If so, when and for what problem?

_____

_____

Please tell me what you hope to get out of your appointments with me. What are your current treatment goals? How do you want your life to look one year from now?

Coping Strategies and Support System:

What hobbies, activities, or interests do you have or are you involved in?

Please list some things that are going well for you, your strengths, and some aspects of your life that you do NOT want to change:

Who/Where do you turn for help or support? Please check all that apply.

_____ Family
_____ Friends
_____ Neighbors
_____ Caregivers
_____ Other: _____

_____ People I work with
_____ Church or spiritual community
_____ People I play sports or exercise with
_____ People in my book club or other social interest group

In the past, what has helped you overcome problems, cope with stress, or deal with difficult feelings or a crisis?

Is there any more information that you feel would be important for me to know?