Roz Davidovich, PsyD
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New Patient Information Form

Please take the time to complete the following questions in as much detail as possible, as it will help me determine the best treatment plan for you. I realize that some of these questions are quite personal, but please be assured that this document is treated with the same degree of confidentiality as all other documents in your chart.

Name: _____ Date: _____

Date of Birth: _____ Place of Birth: _____ Sex: M / F

Address: _____

Insurance Information

Primary Health Insurance: _____ ID number: _____

Subscriber Name: _____ Relationship to Subscriber: _____

Subscriber Date of Birth: _____

Contact Telephone Numbers

	Phone Messages okay?	Primary Contact Number?
CELL: (___) _____	☐ Yes ☐ No	☐
HOME: (___) _____	☐ Yes ☐ No	☐
WORK: (___) _____	☐ Yes ☐ No	☐

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____ Phone # _____

Name of Primary Care Physician: _____ Phone**:** _____

Address: _____

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Marital Status

☐ Single ☐ Married (____ years) ☐ Divorced (___ years) ☐ Other _____

Spouse's/Partner's Name: _____

If I can't reach you, is it okay to contact your spouse/partner? ☐ Yes ☐ No ☐ N/A

If yes, spouse/partner's phone number: (___) _____

Household composition

Name	Relationship	Age

Do you have any school-age children who do not live with you? ☐ No ☐ Yes → If yes, what are their names, ages, and circumstances that that led to this arrangement?

_____

_____

_____

Do you have any adult children who live outside your home? ☐ No ☐ Yes → If yes, what are their names, ages, place of residence and your relationship with them?

Name	Age	Place of residence	Relationship

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How many of years of school did you complete?

HS _____College_____Graduate_____Post-Graduate_____

Employment Status:

Are you employed? ☐ No ☐ Yes → **Occupation:** _____

If unemployed, for how long? _____

Are you unemployed due to a disability? ☐ No ☐ Yes →_____

_____

_____

Do you have any current physical illnesses or medical problems? ☐ No ☐ Yes ⇩

_____

_____

_____

_____

Please describe the primary concern that led to this appointment:_____

_____

_____

_____

_____

_____

To the best of your ability, please describe your mental health history, starting with when you first remember a mood disturbance (e.g., anxiety, depression, suicidal ideation, etc): ___

_____

_____

_____

_____

_____

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Have you ever received psychological services before? ☐ No ☐ Yes ⇩

When (approx.)?	For What?	With What Results?

Have you ever taken medications for mood/anxiety/emotional difficulties? ☐ No ☐ Yes ⇩

Name of Medication	When (approx.)?	For What?	With What Result?

In the past few weeks, have you wished you were dead? ☐ No ☐ Yes

In the past few weeks, have you felt that you or your family would be better off if you were dead:

☐ No ☐ Yes

In the past week, have you been having thoughts about killing yourself? ☐ No ☐ Yes

Have you ever tried to kill yourself? ☐ No ☐ Yes

In the space below please enter the scores from the Burns Depression Checklist and the Burns Anxiety Inventory (which I collectively titled Mood Checklists) and asked you to complete in conjunction with this Patient Information Form.

Burns Depression Checklist: _____

Burns Anxiety Inventory: _____

Substance Use:

1. Have you ever felt the need to cut down on your drinking (or other substance)? ☐ No ☐ Yes
2. Have you ever felt annoyed by criticisms of your drinking (or other substance)? ☐ No ☐ Yes
3. Have you ever felt guilty about your drinking (or other substance)? ☐ No ☐ Yes
4. Have you ever taken a morning "eye-opener?" ☐ No ☐ Yes

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5. How much beer, wine, or hard liquor do you consume each week, on average?_____
6. How much tobacco do you smoke each week, on average_____
7. What drugs (**not** medications prescribed for you) have your used?

What Substance?	Current or past use?	Age(s)?	How often?

Please indicate if you've ever had:

☐ Blackouts ☐ Withdrawal symptoms ☐ An overdose(s) ☐ Detox (in hospital)

☐ Rehab (in hospital/outpatient setting) ☐ None of these

Family Mental Health History

The following questions are about your family history of mental illness. If you answered yes, please indicate the family member affected, age (if known), and length of illness (if known).

Depression Yes No _____

Suicide Yes No _____

Anxiety Disorders Yes No _____

Bipolar Disorder Yes No _____

Panic Attacks Yes No _____

Alcohol/Substance Abuse Yes No _____

Eating Disorder Yes No _____

PTSD/Trauma Yes No _____

Sexual Abuse Yes No _____

Obsessive Compulsive Behavior Yes No _____

Schizophrenia Yes No _____

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Please describe/answer the following:

- Your parents' relationship with each other when you were a child (verbal/physical fights, etc):
- Your parents' physical health, substance use or emotional difficulties when you were a child:
- Your relationship with your parents when you were a child:
- Your current relationship with each parent:
- Your relationship with your siblings in the past and present:
- Were you raised by anyone other than your parents? If yes, please elaborate:
- Is there anything significant that I need to know about your childhood that may be related to current or past mental health concerns: