NEW PATIENT INFORMATION & HISTORY (ADULT)

TODAY'S DATE: _____

PATIENT NAME: _____

BIRTH DATE: _____

HOME ADDRESS: _____CITY:_____ZIP:_____

HOME PHONE:_____CELL:_____WORK PHONE:_____

EMERGENCY CONTACT: _____

Relationship:_____ Telephone: ( )_____

Please tell me your MOST SIGNIFICANT problems or symptoms in order of importance,

1. _____
2. _____
3. _____
4. _____
5. _____

Briefly describe when and how the problems started?

_____

_____

_____

_____

_____

Patient Name_____

Please CIRCLE all symptoms that you experience FREQUENTLY.

Agitation	Sleep disturbances	Appetite Disturbances
Angry Outbursts	Insomnia	Eating Too Much or Too Often
Crying Spells	Excessive Sleeping	Lack of Appetite
Low Self-Esteem	Frequent Awakening	Other _____
	Nightmares	

Suicide Attempt: No Yes If Yes: how many:_____ When:_____

Why: _____

How: _____

Have you hurt others: No Yes If Yes: Who:_____When:_____

Why:_____

_____

Problems with parents? No Yes N/A
Problems with spouse/boyfriend/girlfriend? No Yes N/A
Hearing Voices? No Yes Describe: _____

Seeing things that are not there? No Yes Describe:_____

HISTORY OF PSYCHIATRIC TREATMENT

Outpatient: No Yes Since when:_____How often:_____
Therapist and or Psychiatrist Name/Phone #: _____
_____
Medications prescribed? No Yes If yes, list names:_____

_____

Inpatient No Yes If yes: Dates: _____

Psychiatrist Name/Phone#: _____
Medications prescribed? No Yes if yes, list names:_____

_____

_____

PERSONAL HISTORY

Born where:_____

Grade completed in school: _____

History of child abuse No Yes who and when:_____

Patient Name_____

Brothers: No Yes Names /age_____

Sisters: No Yes Names/age_____

Are any family or extended family with psychiatric disorders : No Yes Who and
Diagnosis:_____

_____

Martial history:

Single, never married No Yes

Presently married No Yes If yes, how long _____

Divorced: No Yes If yes: how long and how many times: _____

Do you have children? No Yes How many? _____ Ages: _____

Work history:

Presently working No Yes If yes, where: _____

Longest job that you ever had: Where:_____How long:_____

When:_____Why did you leave:_____

Last job you had: Where:_____Why did you leave:_____

Problems with the law:

Have you been in jail: No Yes Number of Times:_____

Prison: No Yes Total time incarcerated:_____

Reasons: Theft, Armed Robbery, B&E, Assault

Domestic Violence, DUI, Fraud, Drug Related

Are you currently on probation? No Yes If yes, for what_____

Drug Use/Abuse History:

Check all that been have used:	Date Last Used	Frequency of Current Use	Amount of Current Use
___ Alcohol			
___ Cocaine			
___ Crack			
___ Marijuana			

Patient Name _____

Patient Name_____

Check all that you have used:	Date Last Used	Frequency of current Use	Amount of Current Use
___ Heroin (IV)			
___ Heroin (snort)			
___ Other opiates			
___ Nicotine			
___ Caffeine			
Any other, please Identify:			

MEDICAL HISTORY
Check all that apply Provide additional information as indicated:

___ Anemia
___ Arthritis
___ Asthma
___ Cancer
___ Diabetes, Type 1
___ Diabetes, Type 2
___ Hypoglycemia
___ Eczema
___ Seizures
___ Gastrointestinal Disturbances
___ High Blood Pressure
___ Peptic Ulcer
___ Heart Disease
___ Heart Attack
___ Stroke
___ Cardiac Arrhythmia
___ Kidney Disease
___ Migraine Headaches
___ Thyroid Disorder
___ Tuberculosis
___ Lupus
___ Liver problems
___ Emphysema
___ HIV+
___ other, describe,

_____

_____

Patient Name_____

Do you have any allergies or reactions to medications, foods, or other agents? Please describe:

_____

_____

Please list all serious illnesses, injuries and surgeries with the dates:

1. _____
2. _____
3. _____
4. _____

Please list all of the medication that you are currently taking and for what reason

_____

_____

_____

_____

Who is your family doctor or Primary Care Physician (PCP)?_____

Name/Phone:_____

Fax #, Email: _____

Address: _____

When did you last have a physical examination?_____