BRIDGEWAY
HEALTH SERVICES

New Patient Information

Patient Name:_____ DOB:_____

PH:_____ Address:_____

City:_____ St:____ Zip:_____ Cell Ph:_____ SS#: ____-____-____

Email Address:	**YES**	**NO**
Reminder Text Messages (Appointments)	☐	☐
Access Patient Portal (Effective July 1st, 2015)	☐	☐

Primary Language: _____

What is your: Height_____ Weight _____ What is your Race / Ethnicity?

☐	Non-Hispanic Black alone
☐	Hispanic or Latino
☐	Non-Hispanic White alone
☐	Non-Hispanic Asian or Native Hawaiian and Other Pacific Islander alone
☐	Non-Hispanic American Indian and Alaskan Native alone
☐	Decline to Answer

Referring Physician: _____ Ph: _____

Parent (if Patient is a Minor) / Spouse Info:

Mother/Wife:_____ SS#:_____-_____-_____ DOB:_____
Ph:_____ Cell:_____ Employer:_____
Father/Husband:_____ SS#:_____-_____-_____ DOB:_____
Ph:_____ Cell:_____ Employer: _____

Emergency Contact/Relationship to Patient:

Name: _____ Relation: _____

Home Ph:_____ Cell: _____ Consent on file?: YES / NO

Health History

Caffeine Use: YES / NO # _____ Cups per day of Coffee, Tea, or Soda?

Alcohol Use: YES / NO # _____ Drinks per Day, Week, or Month?

Tobacco Use: YES / NO # _____ Packs per Day?

Smokeless Tobacco Use? YES / NO

Are you currently taking any medications? YES / NO (Prescribed or Over the Counter)
If yes, Name of medication, dosage, how often? _____
_____

Do you have any current or ongoing medical problems? YES / NO
If yes, what is the problem and duration? _____
_____

Previous Medical Hospitalizations and/or Surgeries?: _____
_____

Prior Therapy/Counseling?: YES / NO If yes, name of therapist, when and duration?:
_____
_____

Prior Psychiatric Hospitalization? YES / NO If yes, where, where, duration, diagnosis, and medication given? _____
_____

Family History of Mental Illness? YES / NO If yes, who? Mother, Father, Sister, brother, Aunt, Uncle, Grandparents? _____
_____

Current or Prior Substance Use? Alcohol / Drugs / Both:
_____

Family History of Substance/Alcohol Abuse?: YES / NO If yes, who?
_____
_____

Allergies to Medications?:
_____

Please explain why you are here today:_____
_____
_____

Patient Signature: _____ Date: _____
(Parent / Guardian if patient is a minor child)