NEW PATIENT INFORMATION

Patient: _____ **DOB:** _____ **Today's Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Sex: ❑ **Male** ❑ **Female** **Age:** _____ **Marital Status:** _____

Emergency Contact: _____ **Relationship:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Referred By: _____

PRIMARY INSURANCE INFORMATION (Please complete information for policy holder)

Insured: _____ **DOB:** _____ **Relationship:** _____

Insurance Company: _____

Group Number: _____ **Insured ID:** _____ **Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Employer Name: _____
Phone: _____

SECONDARY INSURANCE INFORMATION (Please complete information for policy holder)

Insured: _____ **DOB:** _____ **Relationship:** _____

Insurance Company: _____

Group Number: _____ **Insured ID:** _____ **Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Employer Name: _____
Phone: _____

COORDINATION OF CARE

It is important for your health care providers to speak to each other so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.

Primary Care Physician: _____ **Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

May we contact your physician: ❑ **YES** ❑ **NO** ❑ **I DO NOT HAVE A PHYSICIAN**

Psychiatrist/Therapist: _____ **Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

May we contact your psychiatrist/therapist: ❑ **YES** ❑ **NO** ❑ **I DO NOT HAVE A PSYCHIATRIST/THERAPIST**

Name:_____

CURRENT INFORMATION

Reason for appointment:

Appetite issues or changes:

Concentration issues or changes:

Sleep issues or changes:

Losses in past few years: (Deaths, relationships, job, etc):

MEDICAL HISTORY

Allergies: ❑ None ❑ Allergic to:

Date of last physical exam:

Surgeries:

Medical conditions:

CURRENT MEDICATIONS (Dosage, frequency - include supplements and over-the-counter medications)

PSYCHIATRIC HISTORY (Include treatment dates, name of provider[s])

Psychiatric admissions: ❑ No ❑ Yes Where & dates?

Chemical dependency admissions: ❑ No ❑ Yes Where & dates?

Outpatient treatment: ❑ No ❑ Yes Where & dates?

Suicide attempts: ❑ No ❑ Yes How & when?

Past psychiatric medications: ❑ No ❑ Yes What meds & response?

FAMILY MEDICAL & PSYCHIATRIC HISTORY (Include substance abuse, hospitalizations, suicide attempts)

Name:_____

SUBSTANCE USE PAST & PRESENT (Include alcohol, illicit, prescribed and OTC abuse)

Substance	Amount	Frequency	Duration	First Use	Last Use
Tobacco					
Caffeine					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Other					
Other					

Longest sobriety:

SOCIAL HISTORY

Support system:

Legal:

School:

Marital history:

Spiritual beliefs:

Financial issues: ❑ No ❑ Yes

Who lives with you?

EMPLOYMENT STATUS & HISTORY ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Disability

HISTORY OF ABUSE ❑ Verbal ❑ Physical ❑ Sexual ❑ Emotional

Please explain:

ADDITIONAL INFORMATION

Have you felt down, depressed or hopeless in the past two weeks? ❑ No ❑ Yes
Have you felt little interest or pleasure in the things you used to enjoy in the past two weeks? ❑ No ❑ Yes