NEW PATIENT INFORMATION

Preferred name: _____

Legal Name: _____

Date of Birth: _____

Gender: _____

Preferred Pronoun: _____

Marital status: __single __married __divorced
__widowed __separated __ Partner

Phone Number(s): _____

Address:

_____

_____

Please describe who lives in your household:

_____

_____

Emergency Contact Name and Phone Number:

_____

_____

Insurance Information:

Insurance company: _____

Insurance ID: _____

Insurance phone number: _____

Name of insured: _____

Date of birth of insured: _____

Relationship to patient: _____

Medical Information:

Primary care physician name and phone number:

_____

Psychiatrist name and phone number:

_____

Current medications (medical and/ or psychiatric):

_____

_____

Current medical history:

_____

_____

Immediate family members' medical issues:

_____

_____

Clinical Information:

Current assessment – what brings you here today?

Please check all that apply and add in any symptoms not listed

__Depressed mood __Decreased energy
__Grief __Hopelessness
__Worthlessness __Thoughts of suicide
__Self-harm __Guilt
__Anxiety __Hyperactivity
__Loneliness __Emotional/ physical/ sexual trauma
__Domestic violence __Paranoia
__Addiction/ substance use; please describe which substances are being used, amount and frequency, or if in recovery, how long have you been sober:

_____

_____

__Dissociative states __Sexuality issues
__Gender issues; If transitioning, describe where you are currently in this process:

_____

_____

__Oppositionalism __Panic attacks
__Somatic complaints __Obsessions/ compulsions
__Elevated mood __Impulsivity
Other:

_____

_____

How long have you been experiencing the symptoms noted above?

_____

Please describe any recent events out of the ordinary that have contributed to or triggered these symptoms:

_____

_____

Any past events that you feel are relevant to the current symptoms:

_____

_____

Family history of mental health issues, substance dependence, suicide, violence, physical/ sexual abuse:

_____

_____

Past treatment for self:

_____

_____

Past treatment for family:

_____

_____

Goals for therapy:

_____

_____

Signature: _____

Date: _____