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### New Patient Information Form

Name: \_\_\_\_\_ Please call me: \_\_\_\_\_ Date: \_\_\_\_\_

Birthday: \_\_\_\_\_ Age \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship Status: \_\_\_\_\_

Street Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_ OK to leave a message? \_\_\_\_\_

Email Address: \_\_\_\_\_ Preferred contact? \_\_\_\_\_

Emergency Contact Person & information \_\_\_\_\_

Relationship to you? \_\_\_\_\_

Will you be using insurance? \_\_\_\_\_

Have you ever been given a Mental Health Diagnosis? If so, what was it? \_\_\_\_\_

Please list any prior mental health providers and/or facilities:

Please list any Current relevant treating physicians (e.g. Primary care MD/PA/NP, psychiatrist, specialist for medical condition which affects presenting problem)

Please list any medications (prescription or Over-the-counter) or herbal supplements you take; list purpose, dose, frequency if you know them:

What is your primary reason for seeking help at this time?

Please circle if any of these issues have been a problem/concern now or in the past:

Issue	Current/ Past	Severity	Issue	Current/ Past	Severity
Abuse (Physical, Emotional, Sexual)	C P	L M H	Impulsivity	C P	L M H
Academic or Work Problems	C P	L M H	Legal Action or school/work discipline	C P	L M H
Addictive/Compulsive Behaviors (e.g. gambling, gaming, spending, etc)	C P	L M H	Mania/Hypomania	C P	L M H
Alcohol use	C P	L M H	Medical Illness/Injury	C P	L M H
Anger	C P	L M H	Relationship Problems (family, friends, peers, romantic, etc)	C P	L M H
Anxiety	C P	L M H	Self-injury	C P	L M H
Assault	C P	L M H	Sexual Preference concerns	C P	L M H
Attention problems	C P	L M H	Sleep difficulty	C P	L M H
Body Image	C P	L M H	Suicidal Ideation	C P	L M H
Death of someone close to you	C P	L M H	Suicide attempt	C P	L M H
Depression	C P	L M H	Other trauma (major accident, natural disaster, combat, victim/witness to crime, etc.)	C P	L M H
Domestic Violence	C P	L M H	Unusual thoughts/perceptions	C P	L M H
Drug use (unprescribed/misuse of drugs or medications)	C P	L M H	Workplace stress	C P	L M H
Eating problems (restriction, binging, purging)	C P	L M H	Violent behavior/thoughts	C P	L M H
Family Conflict	C P	L M H	Other:	C P	L M H
Gender Identity concerns	C P	L M H	Other:	C P	L M H

Who do you consider members of your current family?

Name	Age (d=deceased)	Relationship to you	Living with you currently?
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Who do you consider members of your childhood family?

Name	Age (d=deceased)	Relationship to you	Lived with you?
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Have any of your family members had a mental health issue/diagnosis? If so, please