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New Patient History

I. Identifying Information

Name:____ Date:____________________

Date of Birth:_____________ Age:____________ Gender: ☐Female ☐Male ☐Transgendered

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed
☐Committed Relationship ☐Domestic Partnership/Civil Union
Spouses Name (if applicable):____

Address:____

City:___________________________ State:______________ Zip:_____________________

Home #:_________________ Cell #:______________________ Work #:____________________

Is it OK to leave a message at your: ☐Home # ☐Cell # ☐Work # ☐Other # ___________________

Currently Employed? ☐Yes ☐No Employer:____

Emergency Contact Name:_________________________________ Relationship:_________________

Emergency Contact #(s):____

Who referred you to my practice or how did you hear about my practice?_________________________

Is it OK to contact the above to say thank you for the referral? ☐Yes ☐No

Primary Care Doctor (PCP):__________________________ Phone#:_________________________

PCP Address: ____

Other Mental Health Provider (if any):_______________________ Phone: ____________________

II. Presenting Problem and Psychiatric History

Please describe your main reasons for seeking help at this time:__________________________________

____

____

How long has this been a significant problem for you (be as specific as possible):____________________

____

____

What would like to work on or see change as a result of psychotherapy?__________________________

____

____

What symptoms or issues are related to the above problem? Please check all that apply for you **now**.

☐ Abortion / termination of pregnancy	☐ Anger / Irritable / Temper	☐ Alcohol/Drug use	☐ Anxiety/ Nervousness
☐ Appetite/ eating concerns/ restricting food/ overeating	☐ Arguing / fighting	☐ Chronic pain	☐ Compulsive behaviors
☐ Concentration problems	☐ Depression	☐ Difficulty making decisions	☐ Difficulty with assertiveness
☐ Fatigue / lack of energy	☐ Fears / worries	☐ Feeling moody	☐ Financial problems
☐ Health problems/ adjustment to illness	☐ Impulsivity/ acting before thinking	☐ Infertility	☐ Job loss
☐ Loneliness	☐ Loss of a loved one/ grief	☐ Low motivation / apathy	☐ Low self-esteem
☐ Marital problems	☐ Marital Infidelity	☐ Nightmares	☐ Obsessive thoughts
☐ Panic attacks	☐ Pregnancy loss/ miscarriage	☐ Premenstrual tension	☐ Rape/ sexual assault
☐ Relationship problems	☐ Restlessness	☐ Self-harm	☐ Sexual concerns
☐ Sleep difficulties	☐ Social withdrawal	☐ Stress	☐ Suicidal thoughts/ behavior
☐ Traumatic experience	☐ Weight concerns	☐ Work/ school	☐ Other:
☐ Other:	☐ Other:	☐ Other:	☐ Other:

Have you ever been given a mental health diagnosis in the past from a mental health or health professional? ☐ Yes ☐ No If yes, as you understand it, what is/was the diagnosis?

Have you ever had treatment by, or are you currently seeing, a mental health or substance abuse professional or program, including a psychiatrist, psychologist, therapist, or counselor?
☐ Yes ☐ No If yes, please list the year(s), provider name(s), and reasons for treatment:

Have you ever been hospitalized for a mental health or psychiatric issue?
☐ Yes ☐ No If yes, please list the year(s), hospital name(s), and reasons for hospitalization:

Have you ever experienced any of the following?

Experienced unwanted sexual attention or activity? Yes____ No____

Experienced a violent or otherwise traumatic event? Yes____ No____

Been the victim of physical, sexual, verbal, or emotional abuse? Yes____ No____

Experienced suicidal thoughts or made a suicide attempt? Yes____ No____

If you answered “Yes” to any of the above, please describe briefly:________________________________

____

____

III. Medical History

Date of last physical exam:____________________________ By whom?_________________________

Do you have any medical or physical problems? ☐ Yes ☐ No If yes, please describe:____________

____

____

Medical Specialists (other than your PCP):

Name Specialty Phone #

____

____

____

For Women

Gynecologist’s Name________________________________Phone #: ____________________

Date of last gynecological exam: ______________________Number of pregnancies_________

Are you currently pregnant? ☐ Yes ☐ No

Have you ever experienced a pregnancy loss (e.g. miscarriage)? ☐Yes ☐No Date(s):______________

Have you ever had a pregnancy termination/abortion? ☐ Yes ☐ No Date(s) _____________________

Are you or have you had difficulties conceiving / infertility? ☐ Yes ☐ No

Do you have any particular difficulties associated with menstruation or ovulation? ☐ Yes ☐ No

If yes, please describe (include mood swings, headaches, pelvic pain, etc.):_________________________

____

Please list your current medications and dosages (including prescription, non-prescription, and herbal/alternative/supplements):

Medication	Dosage	Purpose	Prescribed by	When started	Benefits/Problems

Past medications, including prescription, non-prescription, and herbal/alternative/supplements:

Medication	Dosage	Purpose	Prescribed by	When started/ stopped	Benefits/Problems

Are you allergic to any medications? ____

1. How many hours of sleep do you average per night?_____________________
2. Do you exercise? ☐ Yes ☐ No If so, what type of exercise and how often?____________________
3. Do you use products with caffeine (i.e., coffee, caffeine/energy drinks)? ☐ Yes ☐ No
   If yes, specify type and amount/frequency ____
4. Would you consider that you engage in "high risk" sexual behaviors? ☐ Yes ☐ No
   If yes, explain ____
5. Do you diet? ☐ Yes ☐ No How frequently? ______________________________________
6. Do you consider yourself to have a weight problem? ☐ Yes ☐ No
7. Have you experienced any of the following?
   - Childhood medical, developmental, or learning problems? ☐ Yes ☐ No
   - History of significant illnesses, injuries, surgeries, or hospitalizations? ☐ Yes ☐ No
   - A head injury? ☐ Yes ☐ No
   - History of seizures? ☐ Yes ☐ No
   - Significant current medical illnesses or conditions? ☐ Yes ☐ No

   If yes to any of the above, please describe:____

   ____

8. Do you currently smoke cigarettes? ☐ Yes ☐ No If yes, how many/day? ___________________
9. Did you previously smoke cigarettes? ☐ Yes ☐ No When did you quit? _____________________
10. Do you currently smoke marijuana? ☐ Yes ☐ No If yes, how often? ______________________
11. Did you previously smoke marijuana? ☐ Yes ☐ No When did you quit? _____________________
12. Have you ever used cocaine? ☐ Yes ☐ No Last time used? ________________________
13. Have you ever used other drugs? ☐ Yes ☐ No Last time used? ________________________
14. Do you drink beer, wine, liquor, or other alcoholic beverages? ☐ Yes ☐ No

    How many days per week?_____________________

    On the days you drink, how much do you drink?____
15. Have you ever wondered if you had a problem with drugs or alcohol? ☐ Yes ☐ No

    If yes, why? ____
16. Has anyone ever suggested that you may have a problem with drugs or alcohol? ☐Yes ☐No

IV. Family and Social History

Did you finish high school? ☐ Yes ☐ No

Did you attend college? ☐ Yes ☐ No If yes, please list all:________________________________

____

Highest degree earned:________________________________

Have you ever been in any legal difficulty? ☐ Yes ☐ No When?______________________________

Circumstances:____

Has anyone close to you ever died? ☐ Yes ☐ No If so, who and when? _______________________

____

Has anyone close to you ever committed suicide? ☐ Yes ☐ No If so, who and when?___________

____

Has a family member ever been treated for emotional difficulties, mental health or psychiatric issues?

☐ Yes ☐ No If yes, please explain:____

Have you ever had concerns about the use of alcohol or drugs by someone close to you?

☐ Yes ☐ No If yes, please explain:____

Who lives with you in your current household?

First name	Age	Relationship to you

Other family members (i.e., spouse, children) who do not currently live with you:

First name	Age	Relationship to you

Your family of origin (i.e., parents, step-parents, siblings)

First name	Age	Relationship to you

Please provide any other information you feel may be relevant to an understanding of you as a person. This may include past or current family or social situations, cultural background, language, ethnicity, sexual orientation, spirituality or religion, or anything else important to a sense of your identity and view of the world.

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Print Name	Signature	Date