New Patient Intake form

Date: ______/________/_______

Basic Information

Name: Last______________First______________MI___________ Birthdate: ____/_____/____

Age: ________ Sex: Female ___ Male___ Other_____

How did you hear about our clinic?

- ☐ Primary Care or Other Provider: __________________________
- ☐ Friend/Family member
- ☐ Insurance Company
- ☐ Facebook
- ☐ Psychology Today or another internet provider search
- ☐ Other _______________________

Ethnicity:

___ White/Caucasian ___ Asian ___ Native American/Alaskan Native

____ Black/African American ____ Hispanic ____Native Hawaiian/Pacific Islander

Other: _____________________________

Contact Information:

Primary Phone ______________________________ Cell __ Home __ Work ___ Other: __

Secondary Phone____________________________ Cell __ Home __ Work ___ Other: __

Email Address ____

Address: ____

City: ________________________________ State: ___________ Zip: _______________________

Contact Person_________________________ Contact in emergency only? __ Yes __ No

Relationship: _______________________

Primary Phone __________________________ Secondary Phone ____________________

Physician Information:

Do you have a Primary Care Provider (PCP)? Yes ____ No ____

Name of primary care provider (PCP) : ____

Address _______________________ Phone ____________________ Fax ___________________

Do you see any specialist providers? (i.e. cardiologist, therapist, etc)? Yes ____ No ____

If yes, please list below:

1) Provider Name/Location: _______________________ Specialty:________________________
2) Provider Name/Location: _______________________ Specialty:________________________
3) Provider Name/Location: _______________________ Specialty:________________________
4) Provider Name/Location: _______________________ Specialty:________________________

Pharmacy: ____

Pharmacy Address: ____

Pharmacy Phone Number: ______________________ Fax Number: _____________________

Guarantor/ Person Financially Responsible For the Payment If Other Than The Patient:
Name: __________________________ Sex: __ Male __ Female Date of Birth: ___/___/___
Relationship to Patient: ___________________________Address: ___________________________
City: _________________ State: _______ Zip: _______________ Home: ( ) _____-________
Cell: ( ) _____-_________ Work: ( ) _____-_________

Primary Insurance

Insurance Company: ____

Policyholder Name: _______________________ Relationship to Patient: _________________

Member/Policyholder ID # _______________ Policyholder Date of Birth: _______________
Insurance Co. Phone # _______________________ Group #_______________________

Secondary Insurance

Insurance Company: ____

Policyholder Name: _______________________ Relationship to Patient: _________________

Member/Policyholder ID # _______________ Policyholder Date of Birth: _______________
Insurance Co. Phone # _______________________ Group #_______________________

Briefly describe your main symptoms/reason for treatment:

Please list the names of other therapists/counselors, psychiatrists, psychologists, or psychiatric nurse practitioners you have seen for this problem:

Please list any psychiatric hospitalizations in the past. Include age/year, reason for hospitalization, and name of facility (to the best of your ability):

Have you ever had: Comments: ____________________________________

- ☐ ECT? ____
- ☐ TMS? ____
- ☐ Psychotherapy ____
- ☐ DBT Therapy ____

History of suicide attempts? ___ Yes ___ No Comments: _______________

History of cutting or other non-suicidal self-injury? ___ Yes ___ No ___________________________

ALLERGIES
Allergies to medication/foods and type of reaction:
1.
2.
3.
4.
3.

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

CURRENT MEDICATIONS

Name of drug	Dose (strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		

Please list any PAST medications that you have taken for this problem or other psychiatric problems, including sleep, depression, anxiety, focus/concentration, anger, hallucinations.

Name of drug: Highest dose taken: Length of Trial: How long ago: Problems/Benefits of med?
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

PAST MEDICAL HISTORY		
Do you now or have you ever had:		
❑ Brain injury/head trauma		❑ Kidney stones
❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _______________	❑ Stroke	❑ Stomach or peptic ulcer
❑ Arrhythmias (abnormal heart rhythm)	❑ Epilepsy (seizures)	❑ Syncope (passing out)
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	❑ Syncope (passing out)

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause of death
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

PREVIOUS SURGERIES

Surgery:	Number of times:	Ages or Approximate Dates:
Tonsillectomy		
Adenoidectomy		
Cesarean Section		
Bariatric Surgery (Type:________)		
Sinus Surgery		
Appendectomy		
Gall Bladder Removal		
Hysterectomy		

PERSONAL HISTORY

Were there problems with your mother's pregnancy or with your birth? If so, please specify:

Length of gestation (pregnancy)?

Did you meet developmental milestones on time? (Walking, talking, etc.)

Where were you born & raised?

What is your highest education? ❑High school ❑Some college ❑ College graduate ❑Advanced degree

What is your current or past occupation? ____

Are you currently working? ❑Yes ❑No Hours/week _____ **If no, are you** ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No **If yes, for what disability & how long?** ______________________

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

❑ Partnered/significant other

Number of marriages: ________

Identify as: ❑ Male ❑ Female ❑ Non-Binary

❑ Other: _______ **Sexual Orientation**: ________

Religion: _________________ **How important is your religion to you?** ____________

Please describe your primary source of emotional support (i.e. family, friends, church group, etc):

____

Legal History:

Incident ("DUI," "assault," etc)	Approx date	Result of action and length(probation, jail, etc)
1.		
2.		
3.		
4.		
5.		

History of abuse	**Age**
❑Physical	
❑Sexual	
❑Emotional/verbal	
❑Witnessed or been a part of traumatic event	

Regular Exercise? ❑ Type: ____________________ Frequency: _________________________

Usual diet habits/Restrictions: ❑ Frequent fast food/restaurant ❑Home meals ❑Low Fat ❑Low salt ❑Diabetic ❑Other: ___________

Daily water intake: ❑ Very little/none ❑ Less than 6 glasses/day ❑ Greater than 6 glasses/day

Caffeine intake (coffee, tea, soda): Type ____________________ Amount per day: ____________________

Tobacco use: Type _________________________ Amount per day: ______________

Type _________________________ Amount per day: ______________

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- ❑ Recent weight gain; how much___
- ❑ Recent weight loss: how much___
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES

- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS

- ❑ Ringing in ears
- ❑ Loss of hearing

EYES

- ❑ Pain
- ❑ Dryness
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision

NERVOUS SYSTEM

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES

- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN

- ❑ Redness
- ❑ Color changes of hands or feet
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss

PSYCHIATRIC

- ❑ Depression
- ❑ Excessive worries
- ❑ Stress
- ❑ Difficulties with sexual arousal
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Binge Eating
- ❑ Purging/Restricting Food
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Anxiety
- ❑ Thoughts of suicide / attempts
- ❑ Self-Injury
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Frequent nightmares/bothersome dreams
- ❑ Risky behavior
- ❑ Repetitive thoughts or behaviors that seem out of your control

OTHER PROBLEMS:

THROAT

- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS

- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

BLOOD

- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER

- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:

- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

WOMENS REPRODUCTIVE HISTORY:

Age of first period: ___________________

Pregnancies: ___ Have you reached menopause? Y / N At what age? ____

Miscarriages: ____ ❑ Hysterectomy ❑Tubal Ligation

Abortions: ____

Living Children ___

Do you have regular periods? Y / N

Type of birth control currently used? ________________

Substance Use History					
DRUG CATEGORY Circle each substance used	Age when you first used this	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL Beer, liquor, wine, other___					
CANNABIS: Marijuana, hashish, hash oil					
STIMULANTS: Cocaine, crack					
STIMULANTS: Methamphetamine—speed, ice, crank					
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Dexedrine, Adderall, Vyvanse					
Benzodiazepines/Tranquilizers: Xanax, Klonopin, Valium, Librium, Ativan, Halcion, "Roofies"					
Sedatives/Hypnotics/Barbiturates: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					
Heroin					
Street or Illicit Methadone					
Other Opioids: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid, Hydrocodone					
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					
Inhalants: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					
Other: Specify: _______________					