Adult New Patient Information

Name (First, MI, Last, Suffix): ______________________________

Address: ______________________________

City: ______________ State: __________ Zip: __________

Mobile Phone (main): ______________ Consent to leave a message? ☐Yes ☐No

Alt Phone: ______________ Consent to leave a message? ☐Yes ☐No

Primary Email: ______________ Please note that email is not considered to be a confidential medium of communication

May we email you? ☐Yes ☐No Contact Preference: cell, home phone, email? (circle one)

Spouse/Emergency Contact: ______________ Relationship: __________

Address: ☐ (check if same as patient) ______________________________

City: ______________ State: __________ Zip: __________

Patient Demographics:

DOB:(mm/dd/yyyy): ______________ Age: __________

Race: __________ Ethnicity: __________ Sexual Orientation __________

Gender Identity __________ Assigned sex at birth: __________ Pronouns: __________

Guarantor Demographics (who is Primary on Insurance)

Guarantor name: ______________ DOB:(mm/dd/yyyy): __________

Mobile Phone (main): ______________ Consent to leave a message? ☐Yes ☐No

SSN: ______________ Email: ______________

Employer: ______________ Patient's relationship to guarantor: __________

Guarantor's Mailing Address: ☐ (check if same as patient)

Address: ______________________________

City: ______________ State: __________ Zip: __________

Primary Insurance:

Company Name: ______________ Phone: ______________

Address (may be a PO Box): ______________________________

City: ______________ State: __________ Zip: __________

ID#: ______________ Group #: ______________

Subscriber (Primary on Insurance): ______________ Relationship: __________

Secondary Insurance (if applicable): ☐None

Company Name: ______________ Phone: ______________

Address (may be a PO Box): ______________________________

City: ______________ State: __________ Zip: __________

ID#: ______________ Group #: ______________

Subscriber (Primary on Insurance): ______________ Relationship: __________

Visit Information

What events or circumstances prompted you to contact us at this time? ____

____

____

Please describe what you believe has caused the difficulties you are experiencing. ______________________________

____

____

What have you done to help these challenges?____

____

____

List any family difficulties or upsetting events (ex. Illness or death of a family member or close relative, moves, financial challenges, marital stress, abuse (emotional/sexual/physical)?________________________________

____

____

What would you like to gain from working with us? What are your goals? ______________________________

____

____

____

List all <u>Current</u> psychiatric and non-psychiatric medications including over the counter, herbal medications and vitamins.

Name of Medication	**How many milligrams (mg)?**	**When is it taken? (am, pm, twice a day, etc.)**	**Reason for medicine?**
1			
2			
3			
4			
5			
6			
7			

Preferred Pharmacy Name: ________________________________ Location: ____________________

Mail Order Pharmacy: ☐ None ________________________________

Previous Psychiatric/Psychological Treatment

Prior Psychiatric diagnoses: ☐None ____

Suicide Attempts? ☐No ☐Yes (when/what age?) ____

____

Self-Harm? (eg. Cutting, burning) ☐No ☐Yes (how often?)______________________________

Violent behavior? ☐No ☐Yes (when/where?) ____

Have you had any suicidal thoughts recently? ☐Frequently ☐Sometimes ☐Rarely ☐Never

Have you ever engaging in talk therapy before? ☐Yes ☐No

Have you ever worked with a Psychiatrist before? ☐Yes ☐No

Psychiatrist or Therapists name(s). Please indicate when and how long were you were in treatment?

____

____

____

Any guns or weapons at home? ☐No ☐Yes If yes, how/where are they stored? ____________________

Previous Psychiatric Medication trials:

Medication	Dose	Frequency	Duration of treatment (ex. days, weeks, months, years)	Side Effect(s)
1				
2				
3				
4				
5				

Psychiatric Hospitalizations and/or Residential Treatment:

Dates	Hospital	Reason

Social History:

Family Members at home (spouse, parents, children, siblings and/or other relatives):

1. Name ______________________________ Relationship to the patient: ______________
2. Name ______________________________ Relationship to the patient: ______________

3. Name ____ Relationship to the patient: _______________

4. Name ____ Relationship to the patient: _______________

5. Name ____ Relationship to the patient: _______________

6. Name ____ Relationship to the patient: _______________

Are you Married/Single/Separated/Divorced? (circle one) Past Marriages? ☐No ☐Yes (how many?) _______

Children? ☐No ☐Yes (how many?) _______ If divorced, who is the custodial parent?_________________

Occupation: Currently Working? ☐Yes ☐No ☐On Disability ☐Retired

If currently working, where: __________________________________ How Long: ______________

Education: Years completed: ____________ Degree(s) obtained:_____________________________

Religious/Spiritual Information:

Do you consider yourself to be religious? ☐No ☐Yes If yes, what is your faith? ______________________

If no, do you consider yourself to be spiritual? ☐No ☐Yes

Thank you for completing this form.

Who may we thank for your referral (Physician, Nurse, Teacher, Counselor, Family, Friend): ______________________

Signature Acknowledgement

Your signature serves as a comprehensive signature acknowledgement for the following forms and policies. Please access the patient portal to review and print your documents, or they can be printed for you upon request. You further acknowledge that you have read, understand and accept each policy in its entirety.

- ✓ **HIPPA Form**
- ✓ **Controlled Substance Agreement**
- ✓ **Payment Policy**
- ✓ **Treatment Consent**

Patient/Guardian Signature: ____ Date:_______________

Print name: ____