New Patient Information Form

Patient Name First Middle Last

Date of Birth _____ **Referred by**_____

Today's Date_____ **Age** _____ **SSN** _____

Sex: Male Female **Highest Level of Education** _____ **Email** _____

Mailing Address_____

City, State, Zip Code: _____

Insurance Company Name_____ **Plan Number**_____

Policy Holder Name: _____ **Group Number:** _____

Policy Holder's DOB _____**Policy Holder's Employer:** _____

Phone: Home_____**Work** _____**Cell** _____
Please circle preferred contact number

Can I leave a message at each number above? Y or N If not, please describe special instructions regarding leaving voice mails at any of the above numbers_____

_____

Occupation and Employer_____

Ethnic Identity/Race_____**Religion**_____

If a student, where do you attend school? _____

List any major physical illness, hospitalizations, accidents that you have had and at what age they occurred.

_____

_____

Previous Therapy experience, including name of prior provider and year of treatment:

_____

_____

_____

Have you had past psychiatric hospitalizations? Y or N **If yes, list where & reason for hospitalization.**

_____

_____

_____

Please list all prescribed medications and dosage.

_____

_____

_____

Please list the name of Primary Care Physician, Psychiatrist and/or Neurologist.

_____

_____

_____

Do you consider substance use to be a problem? Y or N **If yes, please describe.**

_____

_____

_____

Do you have difficulties with sleep? Y or N **If yes, please describe.**

_____

_____

Do you have difficulties with eating habits? Y or N **If yes, please describe.**

_____

_____

What activities do you enjoy in your free time?

_____

_____

_____

Who provides you with support and encouragement?

_____

_____

_____

Which of the following applies to you?

☐ **Single** ☐ **Married** ☐ **Partnered** ☐ **Divorced** ☐ **Widowed** ☐ **Other**_____

Are you currently in a romantic relationship? **Y or N** Do you live with your partner or spouse? **Y or N**

Name of spouse or partner:_____

What is your partner or spouse's occupation?_____ _____

Please list the names and ages of your children, if any.

Name *Age* *Relationship to you (biological, adopted child, stepchild)*

_____

_____

_____

Please list all individuals that live in your current home? _____

_____

_____

Please check any past or impending issues that apply to you, your parent, siblings, or partner.

	Self	Mother	Father	Sibling	Partner
Alcohol Abuse					
Drug Abuse					
Psychiatric Hospitalization					
Anxiety					
Depression					
Bipolar Disorder					
Other Mental Illness					
Psychosis					
Serious Physical Illness					
Weight/eating problems					
Anorexia					
Bulimia					
Insomnia					
Attempted Suicide					
Epilepsy					
Physical Abuse					
Sexual Abuse					
Learning Problems					
Death					
Divorce					
Financial Crisis					
Legal Problems					

Are your parents married or divorced?_____

How much emotional support does your immediate family provide for you? Please Circle**.**

None Little Somewhat Substantial Very strong

What issue or problem is your main reason for starting therapy?

_____

_____

_____

_____

How long this issue has persisted?_____

Can you describe a goal you would like to work on? _____

_____

APPOINTMENT REMINDER CONSENT

Appointment reminders can be sent via text, phone or email. Please note that voicemails, email and text messages are never fully secure or confidential. Thus, if you prefer to opt out of appointment reminders due to privacy concerns, or for any other reason, please leave this form blank.

PATIENT NAME: _____

Please check the method/s you prefer your appointment reminder:

❑ **Email** Preferred Email Address:_____

❑ **Text Message** Mobile Number: _____

❑ **Phone Call** Preferred Number for Reminder: _____

IN SIGNING THIS FORM YOU ARE AGREEING TO RECEIVE APPOINTMENT REMINDERS VIA EMAIL, PHONE OR TEXT.

_____

Patient Signature Date