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New Patient Evaluation Form

Please fill out the following intake form to the best of your ability. Use the back of the page if you need more space. If you are not comfortable answering certain questions, we can discuss them in person. Thank you.

PATIENT IDENTIFICATION

Name _____ Birth Date _____ Age _____

Occupation _____Marital Status _____ Email address _____

Address _____ City _____ State ____ Zip_____

Home Phone # _____ Work # _____ Cell # _____

Referred here by whom: _____

Primary Care Physician: _____Phone:_____

Other doctors seen regularly: _____

MAIN PURPOSE OF THE CONSULTATION (Why did you seek the evaluation at this time? What are your goals in being here?)

_____

_____

_____

Most Prominent Problems **How Long**

1._____

2._____

3._____

4._____

5._____

Previous emotional, psychological, or behavioral difficulties throughout your life:

_____

_____

_____

_____

_____

Current medications for these problems, dosages, reasons for taking them, and their effects on you:

_____

_____

_____

_____

PRIOR PSYCHOTHERAPY/PSYCHIATRIC TREATMENT

(Please include contact with other professionals, medications tried, types of treatment, hospitalizations, etc.)

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Present Height _____ Present Weight _____ Most you ever weighed? _____ Least? _____

Current medical problems and medications: _____

_____

_____

_____

Current supplements, vitamins, herbs: _____

_____

History of head trauma**?** (if yes, please describe):_____

_____

Any history of seizures?_____

Prior hospitalizations or surgery: _____

_____

Prior abnormal lab tests, X-rays, MRI, EEG, etc:_____

_____

Allergies/drug intolerances (describe): _____

For women: How many pregnancies have you had? _____ any abortions, miscarriages, or stillbirths? ____
Do you use contraception regularly?_____If so, what kind? _____

Sleep behavior**:** insomnia (past or present), sleepwalking, nightmares, recurrent dreams:

_____

_____

CURRENT LIFE STRESSES (e.g. stresses in relationships, job, school, finances, with children)

_____

_____

_____

_____

Any Legal Problems past or present**?** _____

_____

Any problems with gambling (please describe)? _____

_____

Any history of eating disorder (bingeing, bulimia, anorexia, disturbed body image?) _____

_____

Alcohol and Drug History: Please list age started and types of substances used, past and present. Describe how each of these substances made you feel; what benefit you got from them. Include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids), cocaine or crack, PCP, amphetamines, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinogens (LSD, mescaline, mushrooms): _____

_____

_____

_____

_____

_____

Have you ever experienced withdrawal symptoms from alcohol or drugs?_____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____
Have you ever used drugs or alcohol first thing in the morning?_____
Caffeine use per day (e.g. coffee, tea, sodas, chocolate) _____
Nicotine use per day, past and present_____

Please describe any sexual problems, past or present:_____

_____

_____

Any history of physical or sexual abuse? (if yes, please describe)**:**_____

_____

FAMILY HISTORY

Family structure (who lives in your current household, please give relationship to each):

_____

_____

Current marital or relationship satisfaction:_____

_____

Significant developmental events (e.g. marriages, divorces, deaths, traumatic events, losses, illness, etc.)

_____

_____

_____

Has your **mother** or any of her blood relatives had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

Has your **father** or any of his blood relatives had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

Siblings (names, ages, any history of psychiatric problems?)_____

_____

_____

Children (names, ages, problems, strengths) _____

_____

_____

_____	_____	_____
Patient Signature	**Patient name printed**	**Date**