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New Patient Evaluation Form

Please fill out this form to the best of your ability. If you are not comfortable answering certain questions then we can discuss them in person. Thank you.

PATIENT IDENTIFICATION

Name _____ Birth Date _____ Age _____

Occupation _____ Marital Status _____Email address _____

Address _____ City _____ State ____ Zip _____

Cell Phone # _____ Work # _____ Home # _____

Emergency contact name and phone no. _____

May I leave messages on your voicemail, including information such as appointments or lab results? _____

E-mail is not a secure communication but can add convenience. May I contact you by e-mail? _____

How were you referred here? _____

Primary Care Physician: _____ Phone:_____

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._____

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

_____

_____

_____

_____

PRIOR PSYCHIATRIC TREATMENT, PSYCHOTHERAPY, and MEDICATION TREATMENTS
(Include medications tried, the reasons for taking them, and their effects upon you)

_____

_____

_____

_____

_____

_____

Have you ever been hospitalized for mental health reasons? If so, please describe _____

_____

Is your sleep disturbed? Please describe: _____

_____

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

_____

Have you ever attempted suicide or ever engaged in deliberate self-harm behavior? Please explain:

_____

_____

MEDICAL HISTORY

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

Current medical problems and medications: _____

_____

_____

_____

Current supplements, vitamins, herbs: _____

_____

Other doctors/clinics seen regularly: _____

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

_____

Any history of seizures?_____

Prior hospitalizations or surgery: _____

_____

Allergies/drug intolerances (describe): _____

For women: Is there a chance you may be pregnant? _____ Are you trying to conceive? _____
How many pregnancies have you had? _____
Have you had any abortions, miscarriages, or stillbirths? _____
Do you use contraception regularly? _____ If so, what kind? _____

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 problems with internet addiction?_____

With pornography?_____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage.). Include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

_____

_____

_____

_____

_____

Do you believe your alcohol or drug use have caused you any problems? Please explain. _____

_____

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 tried to cut back from your drug or alcohol use? _____

Have you ever used drugs or alcohol first thing in the morning?_____

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____

Nicotine use per day, past and present_____

Please describe any sexual problems, past or present: _____

_____

_____

Any history of being physically or sexually abused (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, separations, divorces, deaths, traumatic events, losses, etc)

_____

_____

_____

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

_____

_____

Siblings (names, ages, quality of relationship):_____

_____

Children (names, ages, problems, strengths) _____

_____

_____

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