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NEW PATIENT INFORMATION (Adult)

Name: ______________________________________ Today's Date: ____________________

Date of Birth: ______________________ Age:_______________

Home Address: ____

City, State, Zip:____

Home Phone:____________________________ Cell Phone:____________________________

Emergency Contact (relationship):___________________________________

Emergency Contact Phone Number: __________________________________

Occupation: ____

Employer: ____

Marital Status (Single/Married/Divorced/Other)?____________________________________

Who were you referred by?: ____

Why are you seeking treatment at this time?: _______________________________________

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Have you sought treatment for this in the past? If so, were you happy with your progress?

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Who is your physician? ____

Address/Phone of physician: ____

Approximate date of last physical: ____

Do you have any medical issues currently, or have you had any medical issues in the past?

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Are you currently taking any medications (prescribed or over-the-counter)? If yes, please list:

Medication Dosage Reason

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____

Who prescribes the medications? ____

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Emotional Health History:

Are any of the following present(or were they present in the past) in the **child** or **family** members (including aunts, uncles, and grandparents on both sides of the family)?

	Please Specify Who
___ Alcohol Use/Abuse	______________________
___ Anxiety	______________________
___ Autism/Asperger's	______________________
___ Bipolar Disorder	______________________
___ Cutting/Self Harm	______________________
___ Depression	______________________
___ Drug Use/Abuse *	______________________
___ Fire Setting	______________________
___ Hair Pulling	______________________
___ Homicide	______________________
___ Hospitalization (Mental)	______________________
___ Obsessive-compulsive Disorder	______________________
___ Panic Attacks	______________________
___ Undiagnosed Mental Health Issues	______________________
___ Schizophrenia	______________________
___ Skin Picking	______________________
___ Suicide Attempts/Completions	______________________
___ Other Emotional Issues	______________________

* (including prescription and over-the-counter medications)