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NEW PATIENT INFORMATION (Adult)

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Name you prefer to be called by: _____ Gender: _____

Home Address: _____

City, State, Zip: _____

Email Address (ONLY if I have permission to contact you here. I will also give you access to my client portal this way): _____

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?: _____

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

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?

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

<u>Medication</u>	<u>Dosage</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who prescribes the medications? _____

Emotional Health History:

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

	<u>Please Specify Who</u>
___ 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)