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New Patient Information

The following information will provide me with a fuller understanding of your situation and will reduce the amount of session time spent on your history and administrative issues. Therapy records are confidential. If you prefer not to answer certain questions, however, leave them blank.

Date of first appointment: _____

Name:_____ Sex: M / F Birthdate: _____ Age:____

Home address: _____

_____

Home phone: _____ □ please check if I am able to leave a message

Cell phone: _____ □ please check if I am able to leave a message/text

Work phone: _____ □ please check if I am able to leave a message

Occupation: _____Employer: _____ Work hours: _____

Email: _____

Primary health ins.: _____ Subscriber id # _____ Group # _____ Co-pay: $_____

Relationship Status: single / married / committed partner / separated /
divorced / widowed / remarried

Religious affliation:_____ how important: very / some / little / none

Primary Care Physician: _____ Phone: _____

In case of emergency: (not living at home)

Name: _____

Home phone _____ Work phone _____ Phone _____

Address _____ City _____ State ____ Zip _____

How were you referred: _____

Please list any health problems which you are currently or recently receiving treatment:_____

_____

_____

Allergies: _____

List any medications, including dose, child takes currently or regularly:

_____

_____

List any hospitalizations or emergency room visits you have had:

_____

_____

Briefly describe the reason for seeking psychological services: _____

_____

_____

_____

How severe do you feel your current difficulties are:

Mild / Moderate / Severe / Critical

If therapy is effective, how will your life be different:_____

_____

_____

Have you ever received psychological services before? If so, when? For how long? With whom? Why?

_____

_____

If you have had previous therapy, what was best about it? _____

_____

_____

What was worst, or least helpful? _____

_____

_____

Current Household:

Name	Age	Relationship to you	Occupation, if student school and grade

Other Significant Family (parents, siblings, children out of home, etc.)

Name	Age	Relationship to you	Occupation, if student school and grade

Please mark with the following letters (M=mother, F=father, S=sister, B=brother, A=aunt, U=uncle, GM=grandmother, GF=grandfather, O=other) if family members had a history of:

depression___ anxiety___ alcohol abuse___ drug abuse___ aggression___

learning disability___ hyperactivity___ seizures or tics___ schizophrenia___

emotional abuse___ physical abuse___ sexual abuse___ attempted suicide___

completed suicide____ psychiatric hospitalization___ thyroid problems___

Additional information?

_____

_____

How stressful are these areas of your life? (scale of 0-10 = maximum)

family___ friends___ school___ leisure time___ money___ living situation___

legal situation___ health___ other, please specify_____

Finish the following sentences:

1. I am a person who _____
2. What I need now is _____
3. I could help myself by_____

Circle any of the following that apply to you:

headaches	dizziness	palpitations	anxiety	fears
fatigue	nightmares	depression	confusion	insomnia
sleep too much	no appetite	eat too much	can't relax	tiredness
forgetfulness	sex problems	no ambition	over-ambitious	alcohol use
drug use	suicidal thoughts	lack self control	under-educated	
no hobbies	job too easy	job too hard	work absences	can't drive
legal charges	on probation	apathetic	argue too much	laziness
pessimistic	impulsiveness	worrying	messiness	being dishonest
suspiciousness	agitation	unable to have a good time		can't do anything right
bowel trouble	trouble concentrating		trouble making decisions	
stomach troubles	trouble finishing tasks		don't stand up for self	

Circle the following feelings that are common for you (child):

anger	discouraged	sadness	panicky	tense
lonely	unhappy	stressed	helpless	ashamed
unloved	irritable	stupid	moody	misunderstood
abandoned	bored	unattractive	anxious	nervous
shy	frustrated	inferior	betrayed	worthless
guilty	persecuted	restless		

Have you ever thought you should cut down on your drinking or other drug use? Yes / No

Have you ever been annoyed by other people's reaction to your drinking or drug use? Yes / No

Have you ever felt guilty about your drinking or drug use? Yes / No

THERAPIST NOTES:

Substance abuse an issue? Other risk factors:

_____

_____

_____

Crises plan: _____

_____

_____