**New Patient Health History Form**

***Instructions****: Welcome! I look forward to working together. Please take some time to fill out this form as accurately and completely as possible. I will review what you write carefully before our first session. Gathering this information in advance helps ensure that we maximize the time spent in your session.*

**FORM COMPLETED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GENERAL INFORMATION:**

Full Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I leave confidential messages on your voicemail? ☐Yes ☐No

May I text message you on your phone? ☐Yes ☐No

Do you wish to communicate by email (recognizing that email may not be completely secure)? ☐Yes ☐No

Financially Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact 1 (Name, Relationship, and Phone Number):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact 2 (Name, Relationship, and Phone Number):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy (Name and Phone Number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASONS FOR VISIT:** Please describe the reasons why you are seeking treatment. Include the nature of the problem, and timing or duration of your symptoms / challenges. We will discuss these in greater detail during your session.

**PERSONAL HISTORY:**

|  |  |  |  |
| --- | --- | --- | --- |
| Birth place: | | Have you served in the military? **☐ Yes ☐ No** | |
| Marital status: ☐Single ☐Married ☐Domestic Partnership ☐Divorced (date: ) ☐ Widowed (date: ) | | | |
| Highest level of education: ☐ Grade school ☐ High School ☐College ☐ Graduate School | | | |
| Employment history: ☐ Currently employed | | | Occupation: |
| ☐ Unemployed (date): | Last worked (date): | | Prior Occupation: |
| ☐ Retired (date): | ☐ Disabled (date): | | Disability Diagnosis: |
| Do you live with anyone else? | | | |
| Number of children and ages (if applicable): | | | |
| Do you presently have a source of income and housing? (please describe) | | | |
| Have you ever attended a rehabilitation program for alcohol or drug use? ☐ No ☐ Yes - list dates below | | | |
| Do you smoke tobacco? ☐No ☐Yes - please quantify; if prior smoker, report pattern of use and quit date | | | |
| Are you religious? ☐ No ☐ Yes - please describe | | | |
| Do you have any current or past legal problems? ☐None ☐Arrest ☐Incarceration ☐Conviction  ☐Probation ☐Parole  Describe: | | | |
| What are your hobbies? | | | |
| What are your goals for the future? | | | |

**CONTACT INFORMATION:** Please list the contact information for those involved in your care whom I may contact.

|  |  |  |
| --- | --- | --- |
| Prior Psychiatrist | Name | Tel # |
| Therapist | Name | Tel # |
| Primary Care Physician | Name | Tel # |
| Cardiologist / Endocrinologist (if applicable) | Name | Tel # |
| Family member  or friend | Name | Tel # |

**PSYCHIATRIC HISTORY:**

Have you previously received psychiatric treatment? ☐ Yes ☐No

At what age did your symptoms first start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What prior diagnoses, if any, have you received, and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you understand and agree with these diagnoses? ☐Yes ☐No

Have you been hospitalized in the past for a psychiatric illness? ☐Yes ☐No

If yes, how many times have you been hospitalized for a psychiatric illness?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your first hospitalization?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was your most recent hospitalization?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever participated in psychotherapy (“talk therapy”)? ☐Yes ☐No

If yes, please list dates, type of psychotherapy, and whether it was helpful:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide? ☐Yes ☐No If yes, please describe details:

Have you ever been severely underweight, or engaged in activities such as excessive food restriction or induced vomiting / use of laxatives to lose weight?

☐Yes ☐No If yes, please describe details:

**CURRENT PSYCHIATRIC AND NON-PSYCHIATRIC MEDICATIONS:**

Please list ALL medications you are currently taking or being prescribed, including over

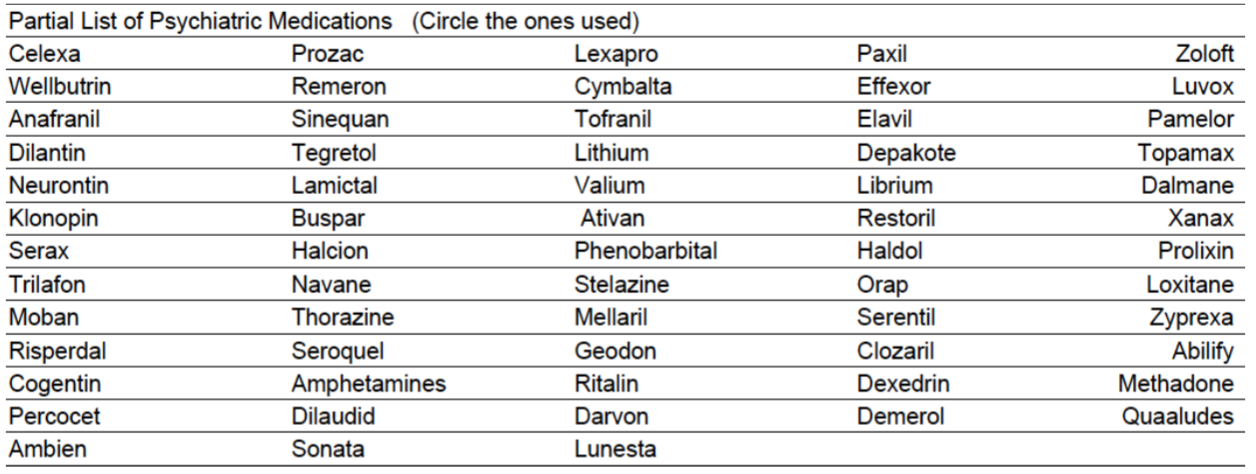
the counter medications, herbal supplements, or vitamins. Please attach a list of additional medications if they exceed the space provided.

☐ I am NOT taking ANY medications currently.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Dose** | **How often?**  **(example: twice daily)** | **How long have you been taking/prescribed this medication?** | **Last time taken** |
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**PRIOR PSYCHIATRIC MEDICATIONS:** List all psychiatric medication that you have taken in the past (**This information is particularly helpful in providing the best care possible**; please fill out this table as completely as possible, and refer to your prior records if needed)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Dose** | **Length of time** | **Did it help?** | **Side Effects** |
|  |  |  |  |  |
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☐ Psychotherapy

Type (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ECT (Electroconvulsive Therapy)

Dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Partial hospitalization programs, intensive outpatient treatment programs, residential treatment programs, group therapy

Dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Substance abuse, dual diagnosis, AA/NA/SAA groups

Dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Other Treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION/FOOD ALLERGIES:**

☐ I have NO known food or drug allergies

Please list ALL allergies and reactions to medications and food:

|  |  |
| --- | --- |
| MEDICATION/FOOD | REACTION |
|  |  |
|  |  |

**MEDICAL HISTORY:**

What is your current weight (estimate if you do not know exactly)?

Have you ever had any of the following conditions?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **YES** | **NO** | **Condition** | **YES** | **NO** |
| Heart attack |  |  | Liver disease/cirrhosis |  |  |
| Heart failure |  |  | Gynecologic illness or condition |  |  |
| Abnormal heart rhythm |  |  | HIV |  |  |
| High blood pressure |  |  | Blood clots/DVT |  |  |
| Diabetes/high blood sugar |  |  | Excessive bleeding |  |  |
| Stroke |  |  | Bone loss/osteoporosis |  |  |
| Asthma |  |  | Cancer |  |  |
| Emphysema/COPD |  |  | Thyroid problem |  |  |
| Stroke |  |  | Dementia |  |  |
| Kidney Disease/Dialysis |  |  | Parkinson’s Disease |  |  |
| Kidney Stones |  |  | Glaucoma |  |  |

**Please list any other medical problems that your doctors have diagnosed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR WOMEN ONLY:**

Are you currently pregnant?                    ☐ Yes ☐ No ☐ Unsure

Do you plan on getting pregnant within the next year?       ☐ Yes ☐No  ☐ Unsure

Are you using a form of birth control if sexually active?    ☐ Yes ☐No   If so, what type:

What age did you begin menstruating: \_\_\_\_         Are your periods regular?   ☐ Yes ☐ No

How many days between menstrual periods?\_\_\_\_\_    Has this recently changed? ☐ Yes ☐ No

When was your last menstrual period?\_\_\_\_\_\_\_        Do you have hot flashes ?   ☐ Yes ☐ No

Have you ever been pregnant:  ☐Yes ☐No       If so, number of pregnancies: \_\_\_\_\_\_

How many children have you delivered?  \_\_\_\_\_    Are you breastfeeding?  ☐ Yes ☐ No

Have you had a hysterectomy?     ☐ Yes ☐ No

If you have had any other gynecological surgeries, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBSTANCE, ALCOHOL AND CIGARETTES:**

Do you drink coffee? ☐ Yes       ☐No     If yes, how many cups per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes? ☐ Yes       ☐No     If yes, how many per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol: do you drink? ☐ Yes        ☐No

If yes, please describe typical use.

Do you use drugs?  ☐ Yes        ☐No

If yes, please describe the nature of the drugs you use, and frequency of use.

Do you worry about your alcohol or drug use? ☐ Yes      ☐No

Have friends or family commented about your alcohol or drug use? ☐ Yes       ☐No

Is there a *past history* of substance use or abuse? ☐ Yes        ☐No

**FAMILY HISTORY:** Has anyone in your family been diagnosed with any of the following conditions?

**Condition Relative affected**

|  |  |
| --- | --- |
| Depression |  |
| Bipolar disorder |  |
| Schizophrenia / schizoaffective disorder |  |
| Post traumatic stress disorder |  |
| Anxiety disorder |  |
| Borderline personality disorder |  |
| Alcohol abuse |  |
| Illicit drug abuse |  |
| Dementia |  |
| Attempted suicide, or died by suicide |  |
| Other (please specify) |  |

**MEDICAL SCREENING:** Please indicate if you have recently experienced any of the following symptoms

(Check all that apply):

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| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | □ | Fever | □ | Stiff neck | □ | Increased frequency of urination | | □ | Chills | □ | Neck swelling | □ | Incontinence of urine/stool | | □ | Night sweats | □ | Chest pain | □ | Swelling of legs or hands | | □ | Weight gain #lbs\_\_\_\_\_\_\_\_\_\_\_\_ | □ | Palpitations | □ | Rash | | □ | Weight loss #lbs\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ | Vomiting | □ | Numbness/tingling of hands or feet | | □ | Memory problems/disorientation | □ | Diarrhea | □ | Difficulty walking | | □ | Fatigue | □ | Shortness of breath | □ | Weakness of muscles | | □ | Malaise | □ | Nausea | □ | Sinus congestion | | □ | Vision changes | □ | Constipation | □ | Increased thirst | | □ | Hearing changes | □ | Blood in stool | □ | Intolerance to heat/cold | | □ | Headache | □ | Change in stool color | □ | Runny nose | | □ | Cough | □ | Pain with urination | □ | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ | Sore throat | □ | Blood in urine |  |  | |  |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Patient or Patient Representative) (Date and Time signed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed Name)