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New Patient Information

Name: _____

Best Phone to Reach You: _____

Address: _____

Birthdate: _____

Reason for your visit: Psychotherapy Pain Management Other

Who referred you? _____

Please describe the problem briefly: _____

_____

_____

Current Symptoms and complaints related to the reason you are here. **Please circle or list all that apply**.

PHYSICAL

Dizziness	Fatigue	Weakness	Nausea/Vomiting
Coordination	Pain	Headaches	Seizures
Sleep Difficulties	Changes in Eating	Balance problems	Tremor/Shakiness
Ringing Ears	Tingling/Numbness		

Other (please specify): _____

COGNITIVE

Word Finding Problems	Lose Train of Thought Easily
Forgetting Easily	Problems Doing Things I Should Do Automatically

Other (please specify): _____

BEHAVIORAL/EMOTIONAL

Energy Level	Bad Temper	Anxiety	Depression
Patience	Job Difficulties	Hallucinations	Obsessions
Mood Swings	Impulsive	Suicide Thoughts	Suicide Attempts
Worthlessness	Bad Dreams	Easily Overwhelmed	Easily Frustrated
Feel I don't care	More Emotional	Less inhibited	Doing things automatically
Feel on top or the world			

Other (please specify): _____

Have others commented to you about changes in your thinking, behavior, personality, or mood?
YES NO If yes, who and what have they said?

Overall, have your symptoms developed SLOWLY or QUICKLY? (**please circle**)

My symptoms occur: OCCASIONALLY or OFTEN? (**please circle**)

Other the past six months, have your symptoms IMPROVED STAYED THE SAME or GOTTEN WORSE? (**please circle**)

What seems to make the problem worse?

Are you still able to participate in social and recreational activities? YES NO

Please list all treatments you have had for the current injuries/accident or condition. Use the back of this page if you need more room to explain.

Treatment **Date** **Helped/Not Helped/Made Worse**

_____

_____

_____

_____

Please provide any other information about your symptoms that you feel is important:

What are your goals for this therapy, and how will you know you are benefitting from this work?

SOCIAL HISTORY

Relationship status (check all that apply): _____Single _____Engaged _____Married/Civil union

_____Separated _____Divorced _____Widowed _____Co-habitating/Partnered

With whom do you live? (check all that apply): _____Alone _____Parents _____Spouse/partner

_____Roommate _____Children _____Friend(s) _____Others (specify):_____

Have you been the victim or perpetrator of domestic violence? YES NO

Do you have friends that you talk with on a regular basis? YES NO

Do you have a religious/spiritual affiliation? YES NO _____

DEVELOPMENTAL HISTORY

Mother's name: _____ Age: _____
Occupation: _____ Education completed: _____
Medical problems?: (describe) _____
Psychiatric/psychological history? (describe): _____

Father's name: _____ Age: _____
Occupation: _____ Education completed: _____
Medical problems?: (describe) _____
Psychiatric/psychological history? (describe): _____

Stepparent's name: _____ Age: _____
Occupation: _____ Education completed: _____
Medical problems?: (describe) _____
Psychiatric/psychological history? (describe): _____

How many brothers do you have?: _____ Sisters?: _____
Academic, medical, or psychiatric/psychological problems? _____
_____

Was your birth normal? YES NO

Did you have any major diseases, illness, accidents, surgeries or hospitalizations as a child (before 16 years old)? If so, please list these:

Has **anyone** in your family experienced the following: (please circle all that apply)

Alcoholism	Learning Disabilities	Attention Deficit Disorder
Depression	Anxiety	Alzheimer's Disease
Suicide	Drug abuse or addiction	

Do **you** have or have you ever experienced or been diagnosed with the following: (please circle all that apply)

Alcoholism	Learning Disabilities	Attention Deficit Disorder
Depression	Anxiety	Alzheimer's Disease
Suicidal Tendencies		Drug abuse or addiction

Was you childhood home happy? _____
Did you experience any abuse as a child? _____

HEALTH HISTORY

Please list any major diseases or other medical conditions you have or have had.

Please list all hospitalizations (after age 16) for any reason

Approximate Date Reason

_____
_____
_____

Please list all operations or surgeries you have had.

Approximate Date Reason

_____
_____

Have you ever been in any kind of counseling or psychotherapy for any reason? YES NO
If yes, please explain.

Current Medications

Name of Medicine	Dose	Reason for Taking	How long been taking?

Do you smoke or use tobacco products? YES NO If so, how much? _____

How much caffeine do you use each day? _____

I drink alcohol: _____rarely or never _____1-2 days/week
_____3-5 days/week _____daily

Usual number of drinks I have at one time: _____

My last drink was: _____less than 24 hours ago _____24-48 hours ago
_____over 48 hours ago

Please check all that apply:
_____I can drink more than most people my age and size before I get drunk.
_____I sometimes get into trouble (fights, work problems, legal issues) after drinking.
_____I sometimes blackout after drinking.

Please check all the drugs you are now using or have used in the past. **Please circle any you consider yourself dependent on.**

	Presently using	*Used in past*
Amphetamines	_____	_____
Barbiturates (downers, etc.)	_____	_____
Cocaine or crack	_____	_____
Hallucinogens	_____	_____
Inhalants (glue, etc.)	_____	_____
Marijuana	_____	_____
Opiate Narcotics	_____	_____
PCP	_____	_____
Others (list)	_____	_____

Do you consider yourself dependent on any **prescription** drugs? YES NO
If yes, which one(s)?:
Check all that apply:
____I have gone through drug withdrawal.
____I have used IV drugs.
____I have been in drug treatment.

Has use of alcohol or drugs ever affected your work performance? YES NO

Has use of alcohol or drugs ever affected your driving ability? YES NO

Have you had any alcohol or drug-related driving offenses? YES NO

LEGAL HISTORY

Have you ever been in jail or arrested? YES NO
If yes, what was it for? What length?

Do you have an attorney now? YES NO If yes, attorney's name: _____
Are you suing anyone at this time? YES NO
Have you ever sued anyone? YES NO

EDUCATION HISTORY

Did you complete high school? YES NO If no, what grade did you complete? _____
Do you have a GED? YES NO

Did you go to college? YES NO
If yes, what degree(s) do you have? _____

Please list any other education or training, such as vocational school, trade school or any other education.

Have you ever been told that you have a learning disability, ADD/ADHD or were placed in special classes at school? YES NO If yes, please explain:

Did you do any of the following before the age of 16? (circle all that apply)
Shoplifting Stealing Fighting Truancy

VOCATIONAL/WORK HISTORY

Are you presently employed? YES NO If yes, where?_____
How many hours do you work? _____

Please list other jobs you have had, starting from most recent:
Place of Employment Your Position Year Began/Ended Reason for Leaving

_____
_____
_____
_____

Have you ever been fired from a job? YES NO If yes, how many times, and why?

Were in the military? YES NO
Branch_____ When?_____
Discharge status_____

Thank you for taking time to fill out this questionnaire.