CONFIDENTIAL New Client History Form

Please bring completed form to consultation Name_____

Name_____ Age: ____ Date of Birth _____ Gender ☐ M ☐ F
Address_____ City _____ Zip _____
Phone (____)_____ Email_____Preferred Contact? ☐ Phone ☐Email
Primary Care Physician _____Primary Care Physician Phone:_____
Current Therapist_____ Therapist's Phone_____

Purpose for visit

What issues(s) are you seeking help for?
1._____
2._____
3._____

What are your treatment goals?
_____
_____
_____

Current Symptoms: Please indicate how the following symptoms/problems are affecting you (Please rate):
0) No effect **1**)Little effect **2**) Some effect **3**) Much effect **4**) Significant effect

__ **Eating** Appetite: ☐more or ☐less, ☐binging or ☐purging. ☐Weight change _____lbs in _____(time)
__ **Sleep** Average # Hrs_____ Difficulty: ☐falling asleep ☐staying asleep ☐waking up early, # Naps _____
__ Low or Depressed Mood, Tearfulness
__ Decreased Energy/Fatigue
__ Loss of interest in activities
__ Hopelessness/Helplessness
__ Memory Difficulties: long term; short term
__ Sexual Functioning
__ Pain (Location)_____
__ Anxiety / Worry
__ Irritability
__ Panic / Fear
__ Rapid Heartbeat, Pounding Heart
__ Sweating/Trouble Breathing
__ Phobia: Fear of _____
__ Obsessive/Recurring Thoughts
__ Rituals/Compulsions_____
__ Flashbacks of traumatic event
__ Nightmares

__ Mood Swings: ☐-depression or ☐-euphoria/elevated
__ Racing Thoughts
__ Increased energy; Decreased need for Sleep
__ Promiscuity
__ Spending Sprees
__ Engaging in reckless or impulsive behavior
__ Talking too fast or too much
__ Hyperactivity
__ Decreased Attention Span
__ Distractibility / Difficulty planning ahead
__ Impulse Control Problems
__ Anger Outbursts
__ Police/Probation involvement
__ Rule breaking: stealing, lying, cheating
__ Hearing Voices when you are alone
__ Seeing things that are not there
__ Feeling paranoid

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Suicidal Risk Assessment

*Have you ever had feelings or thoughts that you didn't want to live? ☐**No** ☐**Yes**
*Do you have ANY history of suicide or self-harm (including mutilation, burning, carving/cutting or any other act or self harm)? ☐**No** ***(Skip to Prior Psychiatric History)***
☐**Yes,** please explain_____

*Do you **currently** feel that you don't want to live? ☐**No**
☐**Yes** → How often do you have these thoughts?_____
When was the last time you had thoughts of dying? _____
What situation(s) bring on these thoughts? _____
_____
Have you known anyone who has attempted or committed suicide? ☐**No**
☐**Yes,** Who_____
How did it affect you?_____
Do you have a plan? ☐**No** ☐**Yes,** please explain_____
Who/what stops you from harming yourself? _____
_____
*Do you have access to firearms at home? ☐**No** Yes, how?_____

Prior Psychiatric History

Psychiatric Outpatient treatment ☐**No** ☐**Yes**, Please describe below.

Facility Name	City / State	Reason/Diagnosis	Dates treated	Provider

Psychiatric Hospitalization ☐**No** ☐**Yes**, Please describe below.

Hospital Name	City / State	Reason/Diagnosis	Dates treated	Involuntary?

Current Psychiatric Medications

Medication Name	Dosage	Date Started	Response/Side-Effects

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Past Psychiatric Medications: Please list medications tried & any details you remember

Medication Name	**Dosage**	**Dates/Duration**	**Response/Side-Effects**

Substance Use History

How many caffeinated beverages do you drink a day?
Coffee _____ Sodas _____ Tea _____ Energy_____

Tobacco History
Do you smoke cigarettes? □No □Yes, # packs per day _____# years_____
Have you smoked in the past? □No □Yes, # packs/day_____#years_____
When did you quit? _____
Do you/Have you used other forms of Tobacco? (Pipe, cigars, chewing) □No
□Yes, what & how much?_____

Alcohol history:
How many alcoholic drinks do you consume in a day or when you drink?_____
How many days per week do you consume alcohol of any type?_____
What kind of alcohol do you typically drink?_____
When was your last consumption of ANY alcohol?_____

Illicit Drugs:
Have you used any "street drugs" in the past 3 months? UNo UYes, Which? How much? How often?
_____
_____

What "street drugs" have you experimented with in the past?

Substance	**Age 1st use**	**Last Use:**	**Amount**	**Health or Legal Consequences:**

Have you used drugs Intravenously (IV)? UNo UYes, Have you been tested for HIV? □No UYes

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Dependency Screening

- Have you ever thought you might need to "cut down" on your drinking /drug use? UNo UYes
- Do you get annoyed or irritable when people in your life ask you to "cut down" your use? UNo UYes
- Do you feel guilt or sadness about your use of substances? UNo UYes
- Do you ever use alcohol/drugs first thing in the morning to steady your nerves or to get rid of a hangover? UNo UYes
- Do you think your use of alcohol and drugs has become a "problem?" (ie. Impairing your ability to be present and functioning at your highest potential?) UNo UYes, which substance(s)?_____
  What Consequences have you suffered?_____

Have you ever overdosed? UNo UYes, On What?_____When?_____
Treatment for overdose?_____ _____

Have you ever had Seizures or Withdrawal from alcohol/drugs when you stopped? UNo UYes
What substance(s)?_____
Treatment for seizure?_____
When was your last seizure?_____

Have you ever been treated for alcohol, drug, or prescription medication abuse? UNo UYes

Chemical Dependency Treatment History:
Hospital / Facility City/State Reason Dates/Duration Provider

_____
_____
_____

Have you abused prescription medication? UNo UYes
Prescription abuse may be a concern if you are not taking the medication EXACTLY as prescribed (other than self-discontinuation which is non-adherence). Signs may include: *Running out of medication early and needing/requesting early refills *Getting pain/antianxiety/sleep medications prescribed by different doctors. It is important to maintain appointments with the prescribing doctor, and have one physician manage a particular medication.

PERSONAL MEDICAL HISTORY

Medication/Food/Environmental Allergies: □None
Allergen:_____ Reaction_____
Allergen:_____ Reaction_____
Allergen:_____ Reaction_____
Allergen:_____ Reaction_____

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MEDICAL PROBLEMS

*Please list all **current & previous** medical conditions you have been treated for*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any concerns about your physical health that you would like to discuss with me? UNo UYes

_____
_____
_____

CURRENT PRESCRIPTION MEDICATIONS

Medication Name	Dosage / How taken	Start Date	Benefit / Side Effects

"OVER THE COUNTER" MEDICATIONS & SUPPLEMENTS

Please include herbal products, dietary supplements, hormone creams, as needed pain medication, diet pills, caffeine pills.

Medication Name	Dosage / How taken	Start Date	Benefit / Side Effects

Who is currently your Primary Care Provider?_____
Street Address: _____
City State Zip:_____
Office Phone:_____
Fax:_____

Do I have consent to speak to this provider regarding your care? UNo UYes
Restrictions regarding any specific information not to discuss: UNo UYes, Please list specific information to remain confidential: _____
_____
Date of last physical exam:_____ _____
Date of last laboratory tests (blood panel/tests):_____
Results of laboratory tests? UNormal Uunknown Uabnormal_____

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Previous Medical Hospitalizations / Emergency Room visits UNo UYes
(Please include those for drug or alcohol toxicities/overdoses.)

Hospital	City/State	Reason	Dates/Duration	Was Tx Complete?

Have you ever had an EKG (to check on the heart)? UNo UYes, Date _____
Why was the EKG done?_____
Result of the EKG: Unormal Uunknown Uabnormal_____

For women only:
First day of last menstrual period _____ Cycles regular? UNo UYes
How many times have you been pregnant? _____ How many live births? _____Miscarriages?_____
Are you currently pregnant or do you think you might be pregnant? UNo UYes
Are you planning to get pregnant in the near future? UNo UYes, When?_____
Are you aware that if you were to become pregnant while on psychiatric medications there could be potential increased risks to a fetus? U No UYes. Birth control method _____

IF AT ANYTIME DURING THE COURSE OF YOUR TREATMENT you are considering becoming pregnant it is VERY IMPORTANT that we discuss your treatment options are. A fetus begins important development *before many women even know they are pregnant.* While some people are able to have a medication "break" during pregnancy many are not. With strong support and awareness there are many ways to reduce the potential risks while maintaining health and stability. If your sexual activity changes or your contraception changes it is very important to notify all providers.

FAMILY MEDICAL HISTORY:

Do You or any Family Members having any of the following conditions? Please list members if the answer is "Yes"

High Blood Pressure	UNo	UYes	_____
Heart Disease	UNo	UYes	_____
Diabetes	UNo	UYes	_____
High Cholesterol	UNo	UYes	_____
Thyroid Disease	UNo	UYes	_____
Epilepsy or seizures	UNo	UYes	_____
Asthma/respiratory problems	UNo	UYes	_____
Stomach or intestinal problems	UNo	UYes	_____
Cancer (type)	UNo	UYes	_____
Fibromyalgia	UNo	UYes	_____
Autoimmune Disorder	UNo	UYes	_____
Chronic Pain	UNo	UYes	_____
Anemia	ANo	Yes	_____
Kidney Disease	UNo	UYes	_____
Liver Disease	UNo	UYes	_____
Head trauma	UNo	UYes	_____
Other Medical Conditions	UNo	UYes	_____

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Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

Depression UNo UYes_____Medication:_____
Anxiety UNo UYes_____Medication:_____
Bipolar disorder UNo UYes_____Medication:_____
Schizophrenia UNo UYes_____Medication:_____
Post-traumatic Stress Disorder UNo UYes_____Medication:_____
Alcohol or Substance Abuse UNo UYes_____Substances?_____
Anger UNo UYes_____Medication:_____
Violence UNo UYes_____Legal consequences?_____
Suicide UNo UYes_____
Other, please describe:_____

SOCIAL HISTORY

Your Exercise Level:

Do you exercise regularly? UNo UYes, What Activites?_____
Time spent Exercising_____#Days per Week _____

Developmental:

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Were you adopted? UNo UYes
Where were you born? Raised?_____
How many times did your family move while you were growing up?_____
How old were you when you left home? _____
Did your parents' divorce? UNo UYes, how old were you when they divorced? _____
Who did you live with?_____

Trauma History:

Has anyone you know ever pushed, kicked or hit you? UNo UYes_____
Do you have a history of being abused emotionally, sexually, physically or by neglect? UNo UYes, please describe when, where and by whom._____

Have you ever purposely or accidentally injured another person? UNo UYes_____

Have you ever been charged with assault? UNo UYes, please explain_____

Has anyone in your immediate family died?UNo UYes,Who and when?_____

Educational History:

Highest grade / degree attained _____ UGED
Name of institution / location_____
Major_____

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Family Structure:

SIBLINGS: List your siblings and their ages:

_____ _____

_____ _____

PARENTS

Father's occupation? _____

Mother's occupation? _____

Describe your parents and your relationship with them:_____

_____

OCCUPATIONAL HISTORY

Current Status:

□ Employed: Company_____Position_____

Street/Suite_____City_____

Work Phone _____Time at position_____

UUnemployed: Last date employed_____Time at position_____

Company_____Position_____

URetired: Last date employed_____Time at position_____

Company_____Position_____

UDisabled: Date Disability began _____Reason for Disability _____

_____

Military Service:

Have you served for the armed forces? UNo UYes, Branch and When?_____

Honorable discharge U Yes U No _____

Legal:

Do you have any pending legal problems? UNo UYes _____

Have you ever been arrested? UNo UYes, Initial Charge_____

What was the resolution of this case?_____

Was drug or alcohol involved? UNo UYes

Have you ever had a DUI UNo UYes, When?_____BAC_____

Spiritual life

Do you belong to a particular religion or spiritual group? UNo UYes,_____

What is the level of your involvement? _____

Is your spiritual connection helpful during this illness OR does it make things more difficult or stressful for you?

Umore helpful Ustressful

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Relationship History and Current Family:

Marital Status: USingle UMarried _____years
UDivorced DSeparated UWidowed
_____years ago, # years married_____, # times divorced_____

Are you currently in a relationship?UNo UYes,_____years. Cohabitating? UNo UYes_____years
Name of Spouse/Significant Other_____Describe your relationship_____
_____
Are you sexually active? UNo UYes, form of contraception (OCP, Ring, condom):_____
Are you satisfied with your sexual activity? UYes UNo, Describe:_____
How would you identify your sexual orientation? U prefer not to answer Ustraight/heterosexual
Ulesbian/gay/homosexual Ubisexual Utranssexual Uunsure/questioning Uasexual
Uother_____

Offspring:
Do you have children?U No UYes, (Names, ages)
_____
_____

Describe your relationship with your children: _____
_____

List everyone who currently lives with you_____

Is there anything else about your or your history that might be important and influence your treatment?
_____
_____
_____

Signature_____Date_____
(Patient Signature) Patient Name, printed

Signature_____Date_____
(Legal Parent/ Guardian Signature,) Legal Parent/ Guardian Name printed

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