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New Patient Information

Name		
Date of Birth		
Address		
Phone Number	Cell:	Home:
E-mail address		
Emergency Contact		

Permission to leave voicemail? Cell phone: YES NO Home phone: YES NO

Insurance Information:

What is the reason for your visit?

Psychotherapy Psychological Evaluation Behavioral Pain Management
Neuro/Biofeedback Substance Abuse Issues Court Ordered Crisis Counseling
Couples/Family Counseling Other

Who referred you:

Please briefly describe current symptoms, feelings and/or complaints related to why you are here:

BEHAVIORAL / EMOTIONAL

Please circle all that apply

Anxiety	Depression	Anger/Irritability
Hopelessness	Low self-esteem	Easily Frustrated
Obsessive Thoughts	Suicidal Thoughts	Suicide Attempts
Self Harming Behavior(s)	Hallucinations	Mood Swings
Impulsivity	Relationship problems	Family problems
Job problems	Sleep Disturbances	Nightmares
Recent Trauma	Easily Overwhelmed	Less inhibited
More Emotional	Less Emotional	Changes in Energy Level: more/less
Doing things automatically	Feeling on top of the world	

PHYSICAL

(please circle all that apply)

Dizziness	Speech	Weakness	Nausea/Vomiting
Coordination	Pain	Headaches	Touch
Sleep difficulties	Changes in eating	Balance problems	Tremor/Shakiness
Seizures	Ringing Ears	Fatigue	Tingling/Numbness

Weakness on one side of body
Urinary Incontinence
Change in sense of taste
Bowel problems
Problems with fine motor control
Fainting/blackouts
Tics/strange movements
Bumping into things
Hearing strange sounds
Difficulty telling hot from cold
Vision Problems

COGNITIVE

(please circle all that apply)

Problem Solving:

Difficulty figuring out how to do new things
Difficulty planning ahead
Not thinking quickly
Problems doing things in the right order
Difficulty figuring out problems that most others can do
Problems changing a plan or activity when necessary
Difficulty completing an activity in time

Language and Math:

Difficulty finding the right word
Slurred speech
Odd or unusual speech sounds
Difficulty expressing thoughts
Difficulty understanding what others say
Problems understanding reading
Difficulty Writing
Difficulty with Math

Nonverbal skills:

Difficulty telling right from left
Difficulty drawing or copying
Difficulty dressing
Not aware of time
Slow reaction time
Problems finding ways around familiar places
Difficulty recognizing objects or people
Problems doing things I should automatically be able to do

Awareness and concentration:

Lose train of thought easily
Highly distractible
Mind goes blank frequently
Easily confused or disoriented

Don't feel alert or aware of things
Tasks require more effort or attention
Aura
Difficulty doing more than one thing at a time

Memory:
Forget where I leave things
Forget what I should be doing
Forget where I am or where I am going
Forget recent events (e.g., breakfast)
Forget events from long ago
More reliant on others or notes to remind me of things
Forget faces of people I know
Forget names
Forget appointments
Forget order of events

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

Are you having difficulty with driving? YES NO
If yes, please explain.
Have you ever been arrested for DUI? YES NO

SOCIAL HISTORY

Are you married? YES NO
Previous marriages? YES NO If yes, how long were you married? _____
If previously married, how many times? _____
Have you even been in couples/marriage counseling? YES NO

Do you have any children? YES NO
If yes, please give their gender, age, and whether they live with you.

Age	Gender	Live with you?
	Male Female	YES NO
	Male Female	YES NO
	Male Female	YES NO
	Male Female	YES NO

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

DEVELOPMENTAL HISTORY

Was your birth normal? YES NO UNSURE
Did you experience any delays in meeting developmental milestones? (crawling, walking, talking, etc.)

Did you have any major diseases, illness, accidents, surgeries, or hospitalizations as a child before the age of 16 years old?
If yes, please list here:

Was your childhood home happy? YES NO
Were you ever placed in foster care as a child? YES NO
Were you the victim of any abuse as a child? YES NO

Mother's age: _____ Mother: LIVING DECEASED
Occupation: _____Education completed_____

Father's age: _____ Father: LIVING DECEASED
Occupation: _____ Education completed: _____

Siblings: How many brothers do you have?_____How many sisters?_____

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

Does anyone in your family have any of the following? *(please circle all that apply*)

Depression	Anxiety	Alzheimer's Disease
Learning Disabilities	Attention Deficit Disorder (ADD/ADHD)	
Parkinson's Disease	Suicide	Drug abuse or addiction
Alcoholism	Schizophrenia	Other Psychological Problem(s)

Do you have, or have you ever been diagnosed with *(please circle all that apply*)

Depression	Anxiety	Learning Disabilities	Alcoholism
Drug abuse or addiction		Attention Deficit Disorder (ADD/ADHD)	
Alzheimer's Disease		Dementia	

Health History

(please circle all that apply)

Chicken Pox	Whooping Cough	Diphtheria
Scarlet Fever	Rheumatic Fever	Malaria
Headaches	Epilepsy (Seizures)	Coma
Tuberculosis	Extreme Tired or Weakness	Meningitis
Encephalitis	High Fever	Concussion
Tumor	Cancer	Paralysis
Eye or Vision Problems	Ear or Hearing Problems	Loss of Sense of Touch Eczema or
Hives	Polio	Tingling or Numbness
Fainting Spells	High Blood Pressure	Loss of Sense of Smell
Stroke	Heart Disease	Loss of Sense of Taste
Heart Attack	Muscle Disease	Bone or Joint Disease
Bleeding Problems	Anemia	AIDS
Sunstroke	Near Drowning	Altitude Sickness
Electrical Shock	Kidney Dialysis	Stomach Problems
Lead Poisoning	Alcoholism	Broken Bones
Nutritional Deficiencies	Sexually Transmitted Infection (STI)	
Fetal Alcohol Syndrome	Lead Poisoning	Exposure to Pesticides
Carbon Monoxide Poisoning	Exposure to Toxic Chemicals	Chronic Fatigue
Lyme Disease	Other (please describe)	

Please list any other major diseases or other medical conditions you have now or have had in the past.

Did you ever lose consciousness as a child or as an adult? YES NO
If yes, please give age, cause and approximate duration of loss of consciousness

Please list any surgeries or hospitalizations

Approximate Date	Reason

Currently Prescribed Medications

Name of Medication	Dose (if known)	Reason for Taking	How long have you used this medication?

Please check any recreational drugs you currently use or have used in the past:

Drug	Current Use	Past Use
Marijuana/Cannabis		
Opiate narcotics		
Cocaine		
Amphetamines		
MDMA (Ecstasy)		
Barbiturates (downers, etc)		
Cocaine or crack		
Hallucinogens		
Inhalants (glue, etc.)		
PCP		
Others (list)		

Do you consider yourself dependent on any of the above drugs? YES NO
If yes, which one(s):

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

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

Typical number of alcoholic beverages I have at one time: _____
My last drink was:_____less than 24 hours ago ____24-48 hours ago _____over 48 hours ago
I can drink more than most people my age and size before I get drunk: YES NO
I sometimes get into trouble (fights, legal difficulty, work problems, conflicts with family) after drinking: YES NO
I sometimes black out after drinking: YES NO

Do you smoke or use tobacco products? YES NO
If yes, how much per day: _____

Do you consume caffeinated beverages daily? YES NO
If yes, how many beverages per day?_____

LEGAL HISTORY

Have you ever been in jail or arrested? YES NO
If yes, what was the length of imprisonment? Please list incarcerations.

Have you had any alcohol or drug related driving offenses?	YES	NO
Are you suing anyone at this time?	YES	NO
Have you ever sued anyone?	YES	NO
Do you have an attorney now?	YES	NO

If yes, for what reason? _____

EDUCATION HISTORY

Where did you go to high school? _____
Have you ever been told that you have a learning disability? YES NO
If yes, please explain:

Were you ever told that you were hyperactive or have ADD / ADHD? YES NO
If yes, please explain:

Were you ever placed in special classes in school? YES NO
If yes please explain:

Were you ever held back a grade in school? YES NO

Did you do any of the following while in school or before or after the age of 16 (circle all that apply).

Shoplifting Stealing Fighting Truancy

Did you complete high school? YES NO If not, what grade did you complete?_____
Do you have a GED? YES NO
Did you complete college? YES NO
If yes, where did you attend college?_____
What college degree(s) do you have?

Have you had any other education or training such as vocational school, trade school or any other education? If yes, please explain:

VOCATIONAL / WORK HISTORY

Are you presently employed? YES NO
If yes, place of employment: _____

If employed, how many hours do you work per week?_____

Please describe the type of work you do (work responsibilities and the nature of the work).

Please list other jobs you have had. Please put this in order from most recent to first job.

Place of Employment Your Position Year Began/Year Ended Reason for Leaving
_____
_____
_____
_____

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

Were you in the military? YES NO

Branch_____From_____To____Discharge Status_____

Have you ever been in any kind of counseling or psychotherapy as an adult or child for any reason?
YES NO
If yes please list below. 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.

Goals for therapy:

Thank you.