



Adult New Patient Information

Name (First, MI, Last, Suffix): _____

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone (main): _____ Consent to leave a message? Yes No

Alt Phone: _____ Consent to leave a message? Yes No

Primary Email: _____ Please note that email is not considered to be a confidential medium of communication

May we email you? Yes No Contact Preference: cell, home phone, email? (circle one)

Spouse/Emergency Contact: _____ Relationship: _____

Address: (check if same as patient) _____

City: _____ State: _____ Zip: _____

Patient Demographics:

DOB:(mm/dd/yyyy): _____ Age: _____

Race: _____ Ethnicity: _____ Sexual Orientation _____

Gender Identity _____ Assigned sex at birth: _____ Pronouns: _____

Guarantor Demographics (who is Primary on Insurance)

Guarantor name: _____ DOB:(mm/dd/yyyy): _____

Mobile Phone (main): _____ Consent to leave a message? Yes No

SSN: _____ Email: _____

Employer: _____ Patient's relationship to guarantor: _____

Guarantor's Mailing Address: (check if same as patient)

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance:

Company Name: _____ Phone: _____

Address (may be a PO Box): _____

City: _____ State: _____ Zip: _____

ID#: _____ Group #: _____

Subscriber (Primary on Insurance): _____ Relationship: _____

Secondary Insurance (if applicable): None

Company Name: _____ Phone: _____

Address (may be a PO Box): _____

City: _____ State: _____ Zip: _____

ID#: _____ Group #: _____

Subscriber (Primary on Insurance): _____ Relationship: _____

Visit Information

What events or circumstances prompted you to contact us at this time? _____

Please describe what you believe has caused the difficulties you are experiencing. _____

What have you done to help these challenges? _____

List any family difficulties or upsetting events (ex. Illness or death of a family member or close relative, moves, financial challenges, marital stress, abuse (emotional/sexual/physical)? _____

What would you like to gain from working with us? What are your goals? _____

List all Current psychiatric and non-psychiatric medications including over the counter, herbal medications and vitamins.

Name of Medication	How many milligrams (mg)?	When is it taken? (am, pm, twice a day, etc.)	Reason for medicine?
1			
2			
3			
4			
5			
6			
7			

Preferred Pharmacy Name: _____ Location: _____

Mail Order Pharmacy: None _____

Previous Psychiatric/Psychological Treatment

Prior Psychiatric diagnoses: None _____

Suicide Attempts? No Yes (when/what age?) _____

Self-Harm? (eg. Cutting, burning) No Yes (how often?) _____

Violent behavior? No Yes (when/where?) _____

Have you had any suicidal thoughts recently? Frequently Sometimes Rarely Never

Have you ever engaging in talk therapy before? Yes No

Have you ever worked with a Psychiatrist before? Yes No

Psychiatrist or Therapists name(s). Please indicate when and how long were you were in treatment?

Any guns or weapons at home? No Yes If yes, how/where are they stored? _____

Previous Psychiatric Medication trials:

Medication	Dose	Frequency	Duration of treatment (ex. days, weeks, months, years)	Side Effect(s)
1				
2				
3				
4				
5				

Psychiatric Hospitalizations and/or Residential Treatment:

Dates	Hospital	Reason

Social History:

Family Members at home (spouse, parents, children, siblings and/or other relatives):

- 1. Name _____ Relationship to the patient: _____
- 2. Name _____ Relationship to the patient: _____

3. Name _____ Relationship to the patient: _____
4. Name _____ Relationship to the patient: _____
5. Name _____ Relationship to the patient: _____
6. Name _____ Relationship to the patient: _____

Are you Married/Single/Separated/Divorced? (circle one) Past Marriages? No Yes (how many?) _____
Children? No Yes (how many?) _____ If divorced, who is the custodial parent? _____

Occupation: Currently Working? Yes No On Disability Retired

If currently working, where: _____ How Long: _____

Education: Years completed: _____ Degree(s) obtained: _____

Religious/Spiritual Information:

Do you consider yourself to be religious? No Yes If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? No Yes

Thank you for completing this form.

Who may we thank for your referral (Physician, Nurse, Teacher, Counselor, Family, Friend): _____

Signature Acknowledgement

Your signature serves as a comprehensive signature acknowledgement for the following forms and policies. Please access the patient portal to review and print your documents, or they can be printed for you upon request. You further acknowledge that you have read, understand and accept each policy in its entirety.

- ✓ **HIPPA Form**
- ✓ **Controlled Substance Agreement**
- ✓ **Payment Policy**
- ✓ **Treatment Consent**

Patient/Guardian Signature: _____ Date: _____

Print name: _____