NEW PATIENT FORM

Name			Date	
Home Address			Suite/Apt.#	
City			Zip code	
personal home	rental home	apartment	assisted living	other
Email address				

Age	Date of birth (day/month/year)	SS#
Gender:	male	female
Marital Status:	never married	living cooperatively
	married	if married, how many times?
	divorced	if divorced, how many times?
	separated	widow/widower

Education (highest grade level completed and degree if any)	
Occupation	
Name of person(s) with whom you live	Relationship

Personal physician	Phone	
Psychotherapist	Phone	
Name of referring clinician or individual		
Insurance carrier	ID#	Group#

PLEASE STATE THE PRINCIPAL REASON YOU ARE SEEKING CONSULTATION OR TREATMENT		
TIME OF ONSET OF INITIAL SYMPTOMS		
CIRCUMSTANCES AT ONSET OF ILLNESS PROCESS		
INITIAL SYMPTOMATOLOGY		
PROGRESSION OF SYMPTOMS UP TO THE CURRENT TIME		
IMPACT ON ADAPTIVE FUNCTIONING	Interpersonal Family	
	Academic Work	
TREATMENT INTERVENTIONS FOR CURRENT EPISODE	Psychotherapy nature / frequency / duration	
	Medications	
	Hospitalization location / reason / duration	
DEGREE OF IMPROVEMENT	none slight moderate significant exceptional	

PRIOR EPISODES OF PSYCHIATRIC OR MEDICAL ILLNESS			
NUMBER OF PRIOR EPISODES			
AGE AT FIRST ONSET		DIAGNOSIS	
CIRCUMSTANCES AT ONSET			
CLINICAL SYMPTOMS			
TREATMENT INTERVENTIONS	Psychotherapy		
	Medications		
	Hospitalization		
DURATION	Degree of Recovery		none slight moderate complete
RESIDUAL SYMPTOMS			
AGE AT NEXT EPISODE		DIAGNOSIS	
CIRCUMSTANCES AT ONSET			
CLINICAL SYMPTOMS			
TREATMENT INTERVENTIONS	Psychotherapy		
	Medications		
	Hospitalization		
DURATION	Degree of Recovery		none slight moderate complete
RESIDUAL SYMPTOMS			
AGE AT NEXT EPISODE		DIAGNOSIS	
CIRCUMSTANCES AT ONSET			
CLINICAL SYMPTOMS			
TREATMENT INTERVENTIONS	Psychotherapy		
	Medications		
	Hospitalization		
DURATION	Degree pf Recovery		none slight moderate complete
RESIDUAL SYMPTOMS			

Current Prescription Medications					
Medication	Dosage	Directions	Date Started	Diagnosis	Adverse Effects

Over the Counter and Herbal Medications				
Medication	Dosage	Directions	Date Started	Adverse Effects

Previous Psychotropic Medication Trials					
Medication	Year Initiated	Duration Months	Max. Dose	Degree of Response (1-5)*	Adverse Effects
					Moderate: Severe: Reason for Discontinuance:
					Moderate: Severe: Reason for Discontinuance:
					Moderate: Severe: Reason for Discontinuance:
					Moderate: Severe: Reason for Discontinuance:
					Moderate: Severe: Reason for Discontinuance:

*Degree of Response: none – 1, limited – 2, moderate – 3, significant – 4, exceptional - 5