New Patient Information

First Name ____________________________ Last Name __________________________________

DOB _____________ Preferred name ____________________ Preferred pronouns _____________

Mailing Address ____

____

Primary Phone _________________________ Alternate Phone ___________________________

Email Address: ____

Emergency Contact Name: ____

Relationship to patient: _________________________ Phone Number: _____________________

Insurance Company: ____

Insurance Policy Holder Name: ____

Insurance Policy Holder Birthdate: _____________________ Insurance ID: _________________

Preferred Pharmacy Name and Address: ____

Primary Care Doctor: ____

Contact #: ____

Legal Guardian (if any): ____

Relationship to patient: ______________________ Phone Number: ________________________

Today Concerns (a brief description of what you would like to discuss today):

____

____

Current Medications: Include all prescription medications, over the counter medications and herbal supplements.

Name	Dose	Time Taken	Effective? Y/N	Side Effects?

Allergies to medications or food:____

Any Lab work performed in the last 6 months? If yes, where? ______________________________
Any major health concerns that may have affected consumer's mental health, such as injuries or physical issues like seizures, head injury, heart problems, or asthma?

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Any previous mental health treatment, such as outpatient psychiatry, psychiatric hospitalizations, therapy/counseling, psychological testing?

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Has any immediate family member (parent, grandparent, or sibling) experienced any of the following conditions? If Yes, please list relationship to the patient

Heart Condition: NO YES______________________

High Blood Pressure: NO YES_________________

Diabetes: NO YES____________________________

High Cholesterol: NO YES_____________________

Anxiety: NO YES______________________________

ADD/ADHD: NO YES__________________________

Bipolar Disorder: NO YES_____________________

Sudden Death before age 50: NO YES__________

Eating Disorder: NO YES________________

Depression: NO YES____________________

Schizophrenia: NO YES_________________

Substance Abuse: NO YES_______________

Suicide Attempt: NO YES________________

Suicide Completed: NO YES_____________

Psych Hospitalization: NO YES___________

Glaucoma: NO YES_____________________

MILESTONES
Mental Health and Wellness

Check any system experienced within the last 30 days.

☐ Fever	☐ Weight Gain	☐ Chills	☐ Night Sweats
☐ Weight Loss	☐ Sleep Problems	☐ Fatigue	☐ Vision Changes
☐ Glasses	☐ Blurry Vision	☐ Contact Lenses	☐ Double Vision
☐ Glaucoma	☐ Runny Nose	☐ Sinus Congestion	☐ Dizziness
☐ Nosebleeds	☐ Ringing in Ears	☐ Sore Throat	☐ Sinus Pain
☐ Bleeding Gums	☐ Pain with Swallowing	☐ Ear Pain	☐ Chest Pain
☐ Cough	☐ Shortness of Breath	☐ Wheezing	☐ Palpitations
☐ Coughing Blood	☐ Fainting	☐ Abdominal Pain	☐ Vomiting
☐ Bloating	☐ Difficulty Swallowing	☐ Constipation	☐ Heartburn
☐ Nausea	☐ Changes in Stool	☐ Low Appetite	☐ Increased appetite
☐ Diarrhea	☐ Urinary Frequency	☐ Discharge	☐ Pain with Urination
☐ Pelvic Pain	☐ Incontinence	☐ Menstrual problems	☐ Kidney Stones
☐ Joint Pain	☐ Joint Stiffness	☐ Joint Swelling	☐ Arthritis
☐ Rashes	☐ Itchy Skin	☐ Sores	☐ Acne
☐ Dry Skin	☐ Breast Problems	☐ Headache	☐ Seizures
☐ Limb Weakness	☐ Balance Problems	☐ Limb Numbness	☐ Tingling arms/legs
☐ Nervousness	☐ Mood Changes	☐ Depression	☐ Thyroid Problems
☐ Nail Changes	☐ Heat Intolerance	☐ Hair Changes	☐ Cold Intolerance
☐ Excessive Thirst	☐ Tremor	☐ Dry Skin	☐ Anemia
☐ Frequent Illnesses	☐ Easy Bruising	☐ Allergy Symptoms	☐ Swollen Glands