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NEW PATIENT FORM

Patient Name: ____

Parent/Guardian Name (if patient is a minor):______________________________

Home Address: ____

____

If necessary, may I send correspondence to your home? ☐ Yes ☐ No

Email: ____________________ May I send a message here? ☐ Yes ☐ No

I typically send a mass BCC email to all my patients when I must cancel appointments due to illness or a planned vacation.

Phone: ____________________ This number is: ☐ Home ☐ Work ☐ Cell
This number belongs to: ☐ Patient ☐ Parent/Guardian
May I leave a message here? ☐ Yes ☐ No

Phone: ____________________ This number is: ☐ Home ☐ Work ☐ Cell
This number belongs to: ☐ Patient ☐ Parent/Guardian
May I leave a message here? ☐ Yes ☐ No

Phone: ____________________ This number is: ☐ Home ☐ Work ☐ Cell
This number belongs to: ☐ Patient ☐ Parent/Guardian
May I leave a message here? ☐ Yes ☐ No

Phone: ____________________ This number is: ☐ Home ☐ Work ☐ Cell
This number belongs to: ☐ Patient ☐ Parent/Guardian
May I leave a message here? ☐ Yes ☐ No

Emergency Contacts:

Name	Relationship	Phone Number

Referral Source:

Kindly provide the name of the person who (or agency or website that) referred you to see me:

____

Demographics and Identity Group Memberships:

Birth Date: _____ Age: _____

Gender: _____ Sexual Orientation: _____

If applicable, regarding gender and/or sexuality, have you come out? □ Yes □ No □ Partially

Relationship Status – Part I:

- □ Never married
- □ Engaged
- □ Married/Life Partner
- □ Separated
- □ Divorced
- □ Widowed

Relationship Status – Part II:

- □ Not in a relationship and not dating
- □ Not in a relationship and casually dating
- □ In a committed, exclusive relationship
- □ In a relationship and having an affair
- □ Have an open relationship
- □ Other: _____

Race: _____ Ethnicity: _____

Immigration History (if applicable):

Country of origin: _____ Year of immigration: _____

Circumstances of your immigration (traumatic and/or non-traumatic): _____

_____

Religious or Spiritual Background: _____

Devotion to Religious or Spiritual Practice:

- □ Practicing/observant/devout
- □ Practicing, but only in some respects
- □ Non-practicing, but culturally identified with my religious or spiritual community
- □ Non-practicing and not particularly identified with my religious or spiritual background

Socioeconomic Status or Class Background: _____

Other meaningful identity group memberships: _____

Presenting Issues:

What would you like to address in psychotherapy? _____

_____

_____

_____

Family of Origin: (e.g. your parents, brothers and sisters, etc.)

Name	Relationship	Still living?	Current age OR age at death	Lives With you?	Where living, and with whom, if not with you?	Current, retired, or former occupation

Current Family: (e.g. your spouse/domestic partner, children, etc.)

FOR ADULT PATIENTS						
Name	Relationship	Still living?	Current age or age at death	Lives with you?	Where living, and with whom, if not with you?	Current, retired, or former occupation

Other Important Relationships: (e.g. romantic partners, ex-partners, close friends, mentors, etc.)

Name	Relationship	Still living?	Current age or age at death	Lives with you?	Where living, and with whom, if not with you?	Current, retired, or former occupation

Trauma History:

Have you experienced any of the following traumas? Please check all that apply.

- □ Relational Trauma (e.g. physical, sexual, or emotional abuse; domestic violence, etc.)
- □ Military Trauma (e.g. exposure to war, torture, hostage situations, genocide, etc.)
- □ Crime-Related Trauma (e.g. robbed at gunpoint, witnessed a murder, raped, etc.)
- □ Disaster-Related Trauma (e.g. hurricane/earthquake survivor, homeless due to fire/flood, etc.)
- □ Terrorism (e.g. 9/11, bombing, or school shooting survivor, etc.)
- □ Immigration-Related Trauma (e.g. refugee, asylum seeker, separation from family, etc.)
- □ Political Trauma (e.g. government dictatorship/repressive regime, coup, occupation, etc.)
- □ I am not sure if I have trauma history.
- □ I have no trauma history.

Risk Assessment:

Have you ever done any of the following things? Please check all that apply.

- □ Engaged in self-mutilating behaviors, such as cutting or burning yourself
- □ Threatened to take your life
- □ Tried to take your life
- □ Threatened to take someone else's life
- □ Tried to take someone else's life
- □ Threatened to harm someone physically
- □ Harmed a human or animal physically to the point of marks, bruises, blood, etc.
- □ Got physical with someone in the form of pushing and shoving, slapping, hair pulling, etc.
- □ Threatened to harm someone sexually
- □ Harmed a human or animal sexually
- □ I have never done any of these things.

Substance Use:

Please indicate your present and previous substance use, including alcohol, even if you drink only socially or with meals. Do not include psychatric medications prescribed for you that you take as directed, which you should instead enter under the MEDICAL HISTORY section on the last page.

Substance	When last used?	Typical use? (e.g. 3 beers, 2 bags, 1 joint, 4 lines, dime bag, 1gram, $50 worth, etc.)	Frequency of use? (e.g. daily, 3 x week, on weekends, once every 6 months, etc.)	Duration of use? (e.g. 3 times, 15 years, 6 months, on and off for 10 years, etc.)

Treatment History:

Please indicate past mental health and/or substance abuse treatment in which you have participated, beginning with the most recent treatment. Use the appropriate keys below to indicate the correct codes for the TYPE OF SERVICE and TREATMENT MODALITY columns.

Name of therapist and/or treating facility	Type of service*	Treatment modality**	Duration of services (e.g. 20 sessions, 30 days, 8 months, 3 years, etc.)	Time in treatment (start date - end date)

*TYPE OF SERVICE:
- **MH** = mental health
- **CD** = substance abuse/chemical dependency
- **MICA** = both mental health and substance abuse/chemical dependency

**TREATMENT MODALITY:
- **OP1** = 1x per week face-to-face outpatient psychotherapy
- **OP2** = 2x per week face-to-face outpatient psychotherapy
- **OP3** = 3x per week face-to-face outpatient psychotherapy
- **PSY** = psychoanalysis (3x, 4x, or 5x per week on the couch)
- **IOP** = 3x per week intensive outpatient program
- **DAY** = 4x or 5x per week day program or partial hospitalization
- **IP** = inpatient hospitalization
- **REH** = inpatient rehabilitation program
- **DET** = inpatient or outpatient detoxification program
- **METH =** methadone maintenance
- **MED =** medication management

Educational History:

FOR ADOLESCENT PATIENTS					
Level of education	Name of school	Years in attendance (start date - end date)	Did you graduate?	High school diploma or GED?	High school concentration (e.g. college prep, vo-tech, art, military, etc.)
Pre-school					
Kindergarten					
Elementary school					
Middle school					
High school					

FOR ADULT PATIENTS					
Level of education	Name of school	Years in attendance (start date - end date)	Did you graduate?	Type of diploma, degree, or certificate	Major, minor, concentration, discipline, or field
Traditional public, private, or religious high school					
Vo-tech, art, military, or therapeutic high school					
Post-secondary trade school or apprenticeship program					
Community college					
4-year college					
Graduate school - Master's level					
Graduate school - Doctorate level					

Military History:

Division	Duration of service (e.g. number of years)	Years in attendance (start date - end date)	Highest position attained
Army			
Navy			
Air Force			
Marines			
Coast Guard			
National Guard			
Reserves			

Occupational History:

Position/Title	Employer	Duration of employment (e.g. number of years)	Years employed (start date - end date)

Hobbies, Interests, Clubs, Community Service:

Please list: _____

_____

_____

_____

Legal History:

Please describe any illicit activity and resulting charges or other consequences: _____

_____

_____

_____

Medical History:

Please list any serious illnesses, major injuries, significant medical hospitalizations, or surgeries:

Medical Event	Year	Medical Event	Year

Please list all medical and psychiatric medications that you currently take and what they treat:

Medication	Condition	Medication	Condition

If you are currently taking psychiatric medication, please indicate who prescribes it:

Name	Type (e.g. psychiatrist, PCP, OB/GYN, etc.)	Town/City	Phone Number

Please list all psychiatric drugs that you have previously tried:_____

_____

_____

Goals and Expectations for Psychotherapy:

Please describe what you hope to gain from psychotherapy: _____

_____

_____

_____

_____ _____

Signature of Patient (age 14 and above) Date