Please Fill Out and Bring to Your First Appointment

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Please list who, if anyone, provides the following:

Guardian/s: _____

Primary Care Physician: _____

Medication Manager: _____

Counselor/Therapist: _____

Payee: _____

Group Home: _____

Day Treatment: _____

Pharmacy: _____

School: _____

Current Grade: Teacher: _____

Performance: _____

Probation Officer: _____

Developmental Therapy: _____

Psychosocial Rehabilitation: _____

Case Manager: _____

Reason for seeking psychiatric medication/counseling services: _____

_____

What symptoms are you currently experiencing? (Please be specific) _____

_____

_____

How long have you experienced these symptoms? _____

Please list all psychiatric and medical medications you currently are taking: (Drug name, dosage & frequency)

_____

_____

Please list all **past** psychiatric and medical medications and response to them:

_____

_____

Yes	No	
☐	☐	Have you been hospitalized for mental health reasons? If so, when and where?
☐	☐	Have you had past behavioral health treatment? **Date**:_____ **Provider:**_____ **Service:**_____ **Response/Outcome:** **Date**:_____ **Provider:**_____ **Service:**_____ **Response/Outcome:** **Date**:_____ **Provider:**_____ **Service:**_____ **Response/Outcome:**
☐	☐	Has anyone in your family been diagnosed with a mental illness? If so, please list who and what:
☐	☐	Have you seen any other providers (MD, NP, PA-C or counselors in the last 2 years? If so, please provide names and reason for services:
☐	☐	Do you have any medical conditions? (Chronic pain, asthma, high blood pressure, etc.) If so, please list: **Date**:_____ **Provider:**_____ **Service:**_____ **Response/Outcome:** **Date**:_____ **Provider:**_____ **Service:**_____ **Response/Outcome:** **Date**:_____ **Provider:**_____ **Service:**_____ **Response/Outcome:**
☐	☐	Do you have any drug allergies? If so, please list:
☐	☐	Have you had a physical in the last 12 months? If so who is your Primary Care Physician/Which Clinic? **PCP:**_____ **Clinic Name:**_____ **If not, we highly encourage you to do so and inform our office once you have completed a physical.**
☐	☐	Are you on birth control? If so, please list the type:
☐	☐	Have you had any previous surgeries? If so, please list: **Date**:_____ **Provider:**_____ **Procedure:**_____ **Result:** **Date**:_____ **Provider:**_____ **Procedure:**_____ **Result:** **Date**:_____ **Provider:**_____ **Procedure:**_____ **Result:**
☐	☐	Have you ever had a seizure with loss of consciousness, been diagnosed with heart arrhythmia or defect, or had major head trauma?

☐	☐	Is there anyone in your family with cancer, diabetes, bleeding/clotting disorders, cardiac issues or other significant medical issues? If so, please list who and what:
☐	☐	Are there any special religious or cultural practices we should be aware of in providing you care? If so, please list:

Developmental: Please fill out age in which developmental milestones were achieved.

_____ Crawl _____Sit _____Walk _____Talk _____ Potty Train

Psychological: Please check all that apply.

☐ Interacts with others in an age appropriate way
☐ Good insight for self
☐ Good insight for others

Academic: Please check all that apply.

☐ GED ☐ High School ☐Some College or Associate Degree ☐College Graduate

☐ Post-Graduate ☐ IEP/504

Alcohol Use:

☐Past ☐Present Type: _____ Frequency? _____

Illicit Drug Use:

☐Past ☐Present Type: _____ Frequency? _____

Prescription drugs (not prescribed):

☐Past ☐Present Type: _____ Frequency? _____

Over the counter medications:

☐Past ☐Present Type: _____ Frequency? _____

Tobacco Use:

☐Past ☐Present Type (circle type): None Cigarettes Chewing Tobacco

Current Used Per Day? _____ Years Used? _____

Family history of substance abuse:_____

_____

_____

_____

How many hours of sleep do you get per night?	<4	4-6	6-8	>8
How often do you exercise per week?	<1	1-3	>3	
Daily caffeine use/cups per day	<1	1-3	>3	(circle type) Soda Coffee

Office Use Only	Providers Initials/Date: