

PATIENT INFORMATION FORM

IDENTIFYING INFORMATION

Patient's Name: _____ DOB: _____

Ethnicity/race: _____

Gender: _____ Primary language if other than English: _____

Address: _____

Phone: Home/ Mobile/ Work _____

Email: _____ Preferred method of contact: _____

Occupation: _____ Employer: _____

Marital Status: _____ Years of Education/Degree: _____

REASONS FOR EVALUATION

Who referred you to this practice?

Please state your concerns; specify nature of problem, onset, duration, frequency, and severity:

Current or recent stressors:

Goal(s) for treatment:

MEDICAL/PHYSICAL HISTORY

Primary Care Physician: _____ Phone #: _____

Medical problems (active and past): _____

History of medical hospitalizations and/or surgeries: _____

PHARMACY INFORMATION: _____

Current list of medications: · Yes · None

Name of medication(s):	Condition(s):	Prescribing MD:	Dose/schedule:	Response/side effects:

Homeopathic, naturopathic, herbal and/or other alternative medicine treatments for physical health: · Yes · None

Have you had any problems of the following (please give details):

1. Constitutional: weight changes, appetite changes, chills, fever, night sweats, fatigue / tiredness, lethargy, persistent infections
2. Head and Neck: head injury/ headaches/ migraines/ neck stiffness/ pain/ swollen glands
3. Eyes: sudden loss or change in vision / burning or itching; excessive tearing / redness / discharge / swelling of lid or growth/ double vision/ dryness

4. ENT (Ears, nose, mouth and throat): sinus pressure / congestion / post nasal drip/ ear pain/ ear discharge/ hearing loss / ringing/ dizziness/ dry mouth /bleeding gums/ nose bleeds/ hoarseness/ difficulty swallowing
5. Cardiovascular: chest pain / shortness of breath / palpitations/ exercise intolerance / ankle swelling/ cyanosis/ fainting/ lightheadedness/ high blood pressure
6. Respiratory: Congestion/ cough – dry/ productive/ blood tinged sputum / wheezing / shortness of breath/ snoring
7. Breast: lump/ nipple discharge/ nipple pain/ recent size changes/ swelling or glands/ skin changes
8. Gastrointestinal: nausea / vomiting / indigestion/ diarrhea / constipation/ abdominal pain / bowel pattern changes/ bloody stools / black tarry stools/ appetite changes
9. Genitourinary: Incontinence / Blood in urine / Pain with urination / Difficulty emptying/ increased frequency of urination/ testicular mass/ testicular pain/ menstrual irregularities/ cramps/ hot flushes/ excess bleeding/ missed cycles/ discharge(foul smelling/ non foul smelling)/ sexual dysfunction / contraception use
10. Integumentary: Rash; itching vs non itching / Excessive dryness / nail/ hair/ skin changes or discoloration / Bumps or nodules/ warts or growths changing in size
11. Neurological: Headache / Loss of balance / Weakness / Tingling/ Tremors/ Loss of consciousness/ Seizures/head injury/ memory loss/ inattention/ sensory loss
12. Musculoskeletal: weakness/ pain or swelling of joints / Loss of range of motion/ chronic pain; location Loss of sensation/ joint stiffness/
13. Hematologic / Lymphatic: Increased frequency of infections / Non-healing wounds / Bruises / Excessive bleeding Excessive clotting
14. Allergic / Immunologic: Allergies to new medicines / foods / clothing / Hay fever
15. Psychiatric: mood changes/ psychotic symptoms/ Changes in sleep. Appetite and energy states/ body image disturbances/ anxiety / panic attacks/ developmental delay/ social and communicative issues/ speech changes or delay/ memory changes/ obsessions and compulsions/
16. Endocrine: Increased urination or thirst / Palpitations / Anxiety / Fatigue / energy changes/ skin changes/ metabolic change if any in recent labs/ cold or heat intolerance/ sweating excessively
17. Gyn/ Obstetric issues; pregnancy details/ outcomes/ contraception use

Any pain issues or concerns? · Yes · No If yes, explain:

FAMILY MEDICAL HISTORY

List family history of medical disorders, psychiatric illnesses and treatments (both maternal, paternal and sibling history related to patient):

DEVELOPMENTAL HISTORY

Comment on gestational/ birth complications, developmental milestones, early childhood behaviors, parental support and peer relationships :

PAST PSYCHIATRIC HISTORY

Specify with most recent dates.

List history of psychiatric hospitalization and/or residential treatment(s) with reason for hospitalization(s):

List outpatient psychiatric/psychological/mental health services (current and past services)

Provider Name(s):	Dates of tx:	Services provided:	Outcomes:	Termination reason(s):

List previous trials of psychiatric medications and recent for changes/ treatment cessation:

Name of medication(s):	Condition(s):	Prescribing MD:	Dose/schedule:	Response/side effects:

History of self-harm or suicidal attempt, if any: · Yes · No

What are the means of self-harm or suicidal attempts?

Duration of self harm?

Last event was?

History of abuse/ neglect/ trauma you may have experienced in your life: · Yes · No

Past/ current substance use/abuse? · Cigarettes · drugs · alcohol · drugs/alcohol · remission 90+ days · none

If yes, please describe onset of use, substances used, amount/frequency and impact on function:

History of legal issues? · Yes · No (History of arrest, detention, gang involvement, diversion, divorce, custody etc.,)

SOCIAL HISTORY

Marital status: _____

Current living situation: _____

Current stressors you or your family is experiencing. _____

List family members / friends and / or adults in the area that you can rely on for help? · Yes · No

Interests and strengths that help you cope:

ACADEMIC / WORK HISTORY

School/ Grade/ Performance or if completed education specify education level/ area of interest:

504 or IEP plans or accommodations in school:

Details of Neuropsychological / Cognitive Testing results, if any:

Current work status: provide details of work/ achievement(s) / performance (s) and interpersonal relationship issues if any:

Is there anything important you would like me to know? _____