

## NEW PATIENT INFORMATION

**NOTE: This form is not intended to be comprehensive. It simply serves as a *checklist of important topics* to discuss in-depth during our appointments. Please do not feel the need to provide great detail. If you prefer to wait until our appointment to discuss a particular topic, please leave that section blank.**

**What is the main reason you are here today?**

### **I: PAST PSYCHIATRIC HISTORY:**

- 1) Please list all previous psychiatrists or psychiatric ARNPs, with approximate dates of service.

<b>Name of Provider</b>	<b>Date</b>
_____	_____
_____	_____
_____	_____

- 2) Please list all previous therapists or counselors, with approximate dates of service.

<b>Name of Provider</b>	<b>Date</b>
_____	_____
_____	_____
_____	_____

Have you ever been treated for any of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Eating disorder  | <input type="checkbox"/> ADHD             | <input type="checkbox"/> OCD           |
| <input type="checkbox"/> PTSD             | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Drug problems    | <input type="checkbox"/> ECT treatment |

- 3) Please provide information about **previous** trials of medications:

<b>Medication Name</b>	<b>Approx. Date</b>	<b>Dosage</b>	<b>Helpful?</b>	<b>Side Effects?</b>
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No

4) Please list all psychiatric hospitalizations:

**Name of Hospital**

**Date**

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5) What other treatments and remedies have you pursued to treat mental health symptoms?

Have you ever experienced the following:

Feelings of hopelessness and that life is not worth living:  No  Yes

Thoughts of actually hurting yourself:  No  Yes

Plan to hurt yourself:  No  Yes

Suicide attempts:  No  Yes → Date: \_\_\_\_\_

Do you self-harm?  No  Yes → please fill out below

Cutting

Burning

Other: \_\_\_\_\_

**II: PAST MEDICAL HISTORY:**

1) Who is your Primary Care Physician (PCP)? \_\_\_\_\_

2) Do you get care anywhere other than the University of Washington on a regular basis?

3) Please list all active health conditions.

4) Please list all major past health conditions.

**III: Current MEDICATIONS** (please list all meds and doses)

<b>Medication Name</b>	<b>Dosage</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**IV: ALLERGIES** (please list all medication, food, and other allergies):

**V: FAMILY PSYCHIATRIC HISTORY** (please list all diagnosed or suspected mental health disorders, suicide attempts, and substance abuse disorders occurring in your grandparents, parents, siblings, and children)

Do you have a family history of psychiatric conditions?  No  Yes → please fill below

<b>Conditions</b>	<b>Relation to Family Member</b>
Schizophrenia	_____
Bipolar Disorder	_____
Depression	_____
Anxiety	_____
Substance Abuse Disorder	_____
Suicide Attempts	_____
Obsessive Compulsive Disorder	_____
Other	_____

**VI: SUBSTANCE USE**

<b>Substances</b>	<b>Currently Use?</b>	<b>Amount/Frequency</b>
Caffeine	No / Yes	_____
Smoking	No / Yes	_____
Alcohol	No / Yes	_____
Marijuana	No / Yes	_____
Other Drugs?	No / Yes	_____

**VII: Social History**

1. How far did you go in school?  
\_\_\_\_\_
2. What is your current job/occupation?  
\_\_\_\_\_
3. Are you married? If so, for how long?  
\_\_\_\_\_
4. Do you have children? If so, how many?  
\_\_\_\_\_
5. What do you do in your free time to relax?  
\_\_\_\_\_
6. Do you have a religious affiliation?  
\_\_\_\_\_
7. Have you had any legal issues (arrests, charges, time in jail)?       No    Yes  
\_\_\_\_\_
8. Have you ever been the victim of physical abuse?       No    Yes
9. Have you ever been the victim of sexual abuse or rape?       No    Yes

**VIII: Please briefly describe any concerns not otherwise addressed above. Please also briefly describe your treatment goals.** (No need for much detail here, okay to just write a shorthand-list. We will discuss in greater depth during our appointments. Also ok to leave this section blank if preferred.)

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