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NEW PATIENT INFORMATION FORM

Welcome to our office. In order to serve you properly, please provide the following information:

PERSONAL INFORMATION

NAME: (*First, MI, Last*)	SSN:
TX driver license #:	Date of birth:
Insurance ID Number (BCBS or Aetna): ____ Name of the Insured:_________________________ DOB of insured:____________________________ _	Home Phone number:____________________________ Mobile:____
HOME ADDRESS: ____ ____ ____ MAILING ADDRESS (*if different from home)*: ____ ____	Email: ____ Is it okay to email you appointment reminders? (*circle*) Yes No
EMERGENCY CONTACT: Name:______________________________________ Phone:______________________________________ Relation to you:______________________________	Allergies:
Valid Credit Card number for charges: ____	Expiration date on credit card: ____ V code: _____________________________

Briefly state why you are seeking treatment and when your problems began:
____
____
____
____
____

What psychiatric diagnosis have you been told you have in the past? _______________________________
____

List Prior psychiatric meds tried: ____
____

Ever been hospitalized for psychiatric reasons: □ Yes, □ No

Have you ever seen a psychiatrist in the past? □ Yes, □ No
Name and telephone number of most recent psychiatrists:
Dr.________________________________ Phone:___________________________________

MEDICAL AND SURGICAL HISTORY:
Do you have any of the following conditions:

Heart conditions : □ Yes, □ No | Pulmonary disease: □ Yes, □ No
Head injuries: □ Yes, □ No | Seizures: □ Yes, □ No

Disease of eyes: ☐ Yes, ☐ No | Kidney disease: ☐ Yes, ☐ No
Liver disease: ☐ Yes, ☐ No | Joint problems: ☐ Yes, ☐ No
Skin conditions: ☐ Yes, ☐ No | Gastrointestinal problems: ☐ Yes, ☐ No
Urinary problems: ☐ Yes, ☐ No | Cancer: ☐ Yes, ☐ No
History or heart attacks: ☐ Yes, ☐ No | Diabetes: ☐ Yes, ☐ No
Other not listed: ____
Are you currently pregnant: ☐ Yes, ☐ No
Surgeries you have had: ____

CURRENT MEDICATIONS: List all medications that you are taking (prescribed and not)

____
____
____
____
____

Are you allergic to any medication: ☐ Yes, ☐ No , which ones: ______________________

SOCIAL HISTORY:

Where were you born and raised: ______________________________
Where you ever physically, emotionally, or sexually abused: ☐ Yes, ☐ No
Marital status: ☐ single, ☐ married, ☐ divorced ☐ other ______________________
Who do you live with?______________________ Relationship______________________
Education level: ☐ high school, ☐ college, ☐ other : ______________________
Do you smoke tobacco: ☐**Y,** ☐ **N** If Yes, how much/day ?______________________
Ever been in jail or prison? ☐ **Y,** ☐ **N,** If yes, why?
____
Any current legal problems? ______________________________
Current occupation or prior work history:
____
If not working, state why or when you retired: ______________________

USE OF DRUGS:

ALCOHOL: how much: ____
Any history or legal problems due to alcohol? (DWI, PI, etc) ☐ Yes, ☐ No
Have you had any problems stopping alcohol? : ☐ Yes, ☐ No
Marijuana: ☐ Yes, ☐ No, if yes how much/week or month: ______________________
Tobacco: ☐ Yes, ☐ No, if yes, how much/day or week: ______________________
Opiates: ☐ Yes, ☐ No, if yes how much/day:______________________________
Others (cocaine, amphetamines, etc): ☐ Yes, ☐ No

FAMILY HX: List family psychiatric & medical conditions:
Mother: ____
Father: ____
Siblings:____
Children:

I verify that the above information is truthful to my best knowledge. I agree to have my credit card charge for services not covered by my insurance (if applicable). $25.00 for returned checks. $25.00 for schedule II refills. $35.00 for cancellations made less than 24 hours before appointment. $65.00 for no shows.

______________________________ ______________________
Signature date

____
Printed name