	Name: _____ _
	DOB:_____
	Date of Appt: _____

OUTPATIENT CLINIC NEW PATIENT HEALTH DATA FORM

Name of person completing this form (if different than patient) and relationship to patient:

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care and that information you provide will be kept confidential.

What problems or concerns are you experiencing that have prompted you to come to this clinic?

What are your hopes and/or goals for treatment?

Have you been in the hospital for psychiatric illness in the past? ☐ No ☐ Yes

If yes, when, where and for how long?

Have you been in outpatient treatment by a psychiatrist in the past? ☐ No ☐ Yes

If yes, by whom, and for how long?

Have you ever received counseling or psychotherapy in the past? ☐ No ☐ Yes

If yes, by whom and for how long?

FAMILY HISTORY

Considering your biological family and their relatives on both sides (grandparents, aunts, uncles, parents, brothers, sisters, cousins, etc.), review the list below and describe the relative (e.g. – "paternal uncle"), and any pertinent treatment history if known (e.g. – "treated with antidepressants and now doing well.").

☐ Schizophrenia	☐ Autism Spectrum Disorder
☐ Bipolar Disorder	☐ Post Traumatic Stress Disorder
☐ Depression	☐ Obsessive Compulsive Disorder
☐ Anxiety	☐ Suicidal Attempts
☐ Alcohol / Drug Dependency	☐ ADHD

PAST MEDICAL HISTORY

Do you have a primary care doctor/physician? ☐ No ☐ Yes

If yes, where and how long have you seen him/her?

Date of last appointment:

Date of last lab work:

Do you have a past history of any of the following conditions? If so, please describe.

- ☐ Heart Disease_____
- ☐ High Blood Pressure_____
- ☐ Hyperlipidemia/hypercholesterolemia_____
_____
- ☐ Lung Disease _____
- ☐ Tuberculosis _____
- ☐ Diabetes _____
- ☐ Endocrine/hormone Disorders _____
_____
- ☐ Thyroid Disorder _____
- ☐ GERD/ Peptic Ulcer disease _____
- ☐ Seizure Disorder _____
- ☐ Migraine/other headaches _____
- ☐ Urologic problems (prostate, loss of bladder control, etc.)_____
- ☐ Irritable Bowel Syndrome_____
- ☐ Liver Problems_____
- ☐ Kidney Disease_____
- ☐ Stroke_____
- ☐ Head Injury_____
- ☐ Skin Disorder_____
- ☐ Visual Problems_____
- ☐ Arthritis_____
- ☐ Hearing Problems_____
- ☐ Cancer_____
- ☐ Anemia_____
- ☐ Bleeding Disorder_____
- ☐ Clotting Disorder_____
- ☐ Sexually transmitted diseases (HIV, Herpes, Gonorrhea, Chlamydia, Syphilis, etc.)
_____
_____
__

Have you undergone any surgical procedures? ☐ No ☐ Yes

Please list the surgical procedure with the date(s) of surgery:

Do you have problems with ongoing physical pain? ☐ No ☐ Yes

If yes, what part(s) of your body?

Is this pain ☐ new (within the last week) ☐ chronic (has been present for how long?)

Rate your average pain level: (circle one) 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐

Have you ever suffered a severe head injury with loss of consciousness? ☐ No ☐ Yes

Have you fallen in the past year? ☐ No ☐ Yes

Do you have problems with walking or balance? ☐ No ☐ Yes

SOCIAL HISTORY

Do you live alone? ☐ No ☐ Yes List who lives with you:

Are you married or in a relationship currently? ☐ No ☐ Yes

Name of significant other:

Significant other's employment:

Status of relationship with significant other:

How many previous marriages or long-term relationships?

Children? ☐ No ☐ Yes (please list)

Name	Age	Relationship	Living with you?

Do you have any pets? ☐ No ☐ Yes

Where did you grow up?

Did your parents stay together while you were growing up? ☐ No ☐ Yes

How old were you when they separated?

Who did you live with after the separation?

Father's occupation while you were growing up:

Mother's occupation while you were growing up:

How many siblings do you have? ☐ None _____Brothers _____Sisters

Do you exercise? ☐ No ☐ Yes If yes, how often?

Do you need daily help to care for yourself? (such as bathing, cooking and other household duties)
☐ No ☐ Yes (if yes, explain):

What are some things you enjoy doing (hobbies, sports, past times)?

Have you ever been convicted of any crimes, incarcerated in prison, or placed on probation?
☐ No ☐ Yes (If yes, describe):

Trauma History: ☐ No ☐ Yes

If yes, what was the nature of the trauma? (Please check all that apply):

☐ Physical ☐ Emotional ☐ Neglect ☐ War
☐ Accidents ☐ Disasters ☐ Sexual
☐ Witnessing Violence ☐ Other:

Education/Learning

Did you graduate from High School? ☐ No ☐ Yes Last Grade Attended:

If not, why did you stop going to school?

Any college or further training? ☐ No ☐ Yes

What type of jobs have you had in the past?

How do you learn best?

☐ Verbal Explanation ☐ Written Handouts
☐ Other:

Do you have any limitations that make learning difficult for you? (such as trouble seeing/hearing/difficulty reading, doing math, etc.) ☐ No ☐ Yes (please explain)

Have you had trouble keeping jobs? ☐ No ☐ Yes

Are you currently employed? ☐ No ☐ Yes If yes, where and how long?

Are you receiving or applying for: ☐ SSD ☐ SSI ☐ MCAID

SOCIAL SUPPORTS

Is there anyone you trust or confide in during times of trouble? ☐ No ☐ Yes
(Name supports of family, friends, others):

Do you have any religious ties or involvement in a church? ☐ No ☐ Yes (please describe):

Are you involved in any support groups or other activities? ☐ No ☐ Yes

LIST OF MEDICATIONS

(To ensure accuracy, please take this information directly from your prescription bottles/containers if available. Please include vitamin, herbs and over the counter medications.)

Medication Name	Dosage	Prescribing Doctor

Please list any medication you have an allergy to and the type of allergy (e.g. skin rash, trouble breathing, anaphylaxis, etc.)

_____

_____

_____

_____

PSYCHIATRIC MEDICATION USE HISTORY

Which medications have you taken in the past and what was your response to them?

Antidepressants	***Response*** *(improved, didn't improve, worsened, other)*	***Side Effects / Intolerance***
Amitriptyline (Elavil)		
Amoxapine (Ascendin)		
Bupropion (Wellbutrin)		
Citalopram (Celexa)		
Clomipramine (Anafranil)		
Desipramine (Norpramin)		
Desvenlafaxine (Pristiq)		
Doxepin (Sinequan)		
Duloxetine (Cymbalta)		
Escitalopram (Lexapro)		
Fluoxetine (Prozac)		
Fluvoxamine (Luvox)		
Imipramine (Tofranil)		
Isocarboxazid (Marplan)		`
Maprotiline (Ludiomil)		
Milnacipram (Savella)		
Mirtazapine (Remeron)		
Nefazodone (Serzone)		
Nortriptyline (Pamelor, Aventyl)		
Paroxetine (Paxil)		
Phenelzine (Nardil)		
Protriptyline (Vivactil)		
Selegiline (Esam)		
Sertraline (Zoloft)		
Tranylcypromine (Parnate)		
Trazodone (Desyrel)		
Trimipramine (Surmontil)		
Venlafaxine (Effexor)		
Vilazodone (Vybrid)		
Vortioxetine (brintellix)		
Bipolar Medications	***Response*** *(improved, didn't improve, worsened, other)*	***Side Effects / Intolerance***
Lithium Carbonate (Eskalith)		
Valproic Acid (Depakote)		
Carbamazepine (Carbatrol, Tegretol)		
Lamotrigine (Lamictal)		
Antipsychotic / Mood Stabilizers	***Response*** *(improved, didn't improve, worsened, other)*	***Side Effects / Intolerance***
Aripiprazole (Abilify)		
Chlorpromazine (Thorazine)		
Olanzapine (Zyprexa)		
Lurasidone (Latuda)		
Quetiapine (Seroquel)		
Risperidone (Risperdal)		
Ziprasidone (Geodon)		
Asenapine (Saphris)		

Antipsychotic Medications	***Response*** *(improved, didn't improve, worsened, other)*	***Side Effects / Intolerance***
Droperidol (Inapsine)		
Fluphenazine (Prolixin)		
Haloperidol (Haldol)		
Loxapine (Loxitane)		
Perphenazine (Trilafon)		
Pimozide (Orap)		
Prochlorperazine (Compazine)		
Thiothixene (Navane)		
Thioridazine (Mellaril)		
Trifluoperazine (Stelazine)		
Molindone (Moban)		
Clozapine (Clozaril)		
Iloperidone (Fanapt)		
Paliperidone (Invega)		
ADD Medications	***Response*** *(improved, didn't improve, worsened, other)*	***Side Effects / Intolerance***
Methylphenidate (Concerta, Ritalin)		
Dextroamphetamine (Dexedrine, Adderal)		
Pemoline (Cylert)		
Benzphetamine (Didrex)		
Dexmethylphenidate (Focalin)		
Modafinil (Provigil)		
Atomoxetine (Strattera)		
Diethylpropion (Tenuate)		
Guanfacine (Tenex)		
Phentermine (Adipex-P)		
Anti-Anxiety Medications	***Response*** *(improved, didn't improve, worsened, other)*	***Side Effects / Intolerance***
Gabapentin (Neurontin)		
Buspirone (Buspar)		
Alprazolam (Xanax)		
Lorazepam (Ativan)		
Clonazepam (Klonopin)		
Chlordiazepoxide (Librium)		
Diazepam (Valium)		
Oxazepam (Serax)		
Clorazepate (Tranxene)		
Sedative / Sleeping Aids	***Response*** *(improved, didn't improve, worsened, other)*	***Side Effects / Intolerance***
Zolpidem (Ambien)		
Zaleplon (Sonata)		
Triazolam (Halclon)		
Chloral Hydrate		
Flurazepam (Dalmane)		
Estazolam (ProSom)		
Eszopiclone (Lunesta)		
Other Medications	***Response*** *(improved, didn't improve, worsened, other)*	***Side Effects / Intolerance***
Disulfiram (Antabuse)		
Donepezil (Aricept)		
Clonidine (Catapres)		
Prazocin		
Tiagabine (Gabitril)		
Topiramate (Topamax)		
Naltrexone (ReVia)		

CONSITUTIONAL	Weight loss ☐	Weight gain ☐	Sleep difficulties ☐	Appetite increase ☐	Appetite decrease ☐	Fever ☐	Chills ☐	Increase in energy ☐	Night sweats ☐
NEURO	Headache ☐	Seizure ☐	Involuntary movements ☐	Balance Problems ☐	Faint ☐	Weakness ☐	Dizziness ☐	Tingling sensation ☐	Migraines ☐
ENDOCRINE	Heat intolerance ☐	Cold intolerance ☐	Thyroid dysfunction ☐	Hair loss ☐	Excessive hair ☐	Increased thirst ☐	Increased frequency of urination ☐		
GASTROINTESTINAL	Yellowing skin ☐	Abdominal swelling ☐	Nausea ☐	Vomiting ☐	Blood in stool ☐	Heartburn ☐	Diarrhea ☐	Constipation ☐	Pain in abdomen ☐
GENITOURINARY	Blood in urine ☐	Change in urine color ☐	Painful urination ☐	Menstrual problems ☐	Testicular pain ☐	Sexual dysfunction ☐	Vaginal discharge ☐	Penis discharge ☐	
EYE/EAR/NOSE THROAT	Ear pain ☐	Nosebleed ☐	Vision problems ☐	Decreased hearing ☐	Ringing in ears ☐	Difficulty swallowing ☐	Sinus problems ☐	Vertigo ☐	Toothache ☐
CARDIOVASCULAR	Chest pain ☐	Shortness of breath ☐	Heart racing ☐	Lightheadedness ☐	High blood pressure ☐	Swelling in legs ☐			
RESPIRATORY	Cough ☐	Sputum production ☐	Blood in sputum ☐	Chest pain when breathing ☐	Wheezing ☐	Shortness of breath ☐			
MUSCULOSKELETAL	Neck pain ☐	Back pain ☐	Pain in joint ☐	Pain in muscles ☐	Arthritis ☐	Difficulty walking ☐			
SKIN BREASTS	Rash ☐	Lumps ☐	Sores ☐	Itching ☐	Increased lactation ☐	Dischgre from nipples ☐			
HEMATOLOGIC LYMPHATIC	Swollen lymph nodes ☐	Bleeding problems ☐	Blood clotting disorder ☐						
ALLERGIC IMMUNOLOGIC	Arthritis ☐	Eczema ☐	Hay fever ☐	Asthma ☐	Runny nose ☐	Congestion ☐			