New Patient History Form

Patient Name: _______________________________ Referral Source: __________________________

DOB: ______/______/______ SSN: _____________________ Employer: _______________________

Primary Care Physician: ____________________________________ Phone: _____________________

Therapist/Psychologist: ____________________________________ Phone: ____________________

Pharmacy: ____ Phone: ____________________

Current medications:

Drug	Dose	Prescriber

Allergies: ____

Past psychiatric medications:

____
____
____

Current medical issues you are being treated for:

____
____
____

Psychiatric history:
(Please provide all past mental health and/or substance abuse treatment, including inpatient and outpatient)

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____
____

Family history of mental illness/substance abuse issues:

Relationship	Diagnosis

Describe your current alcohol/tobacco/drug use habits:

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