

# 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:

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Current medical issues you are being treated for:

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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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**Penfield Psychiatry**  
481 Penbrooke Drive  
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Penfield, NY 14526  
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Fax: (585) 388-6004

**Long Pond Psychiatry**  
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