New Patient Assessment

Date: ____________________

Reason for Visit: ◯ Depression ◯ Anxiety ◯ PTSD ◯ Delusions/Voices ◯ Other _____________

Current Symptoms/History of Present Illness: Please select all that apply

Have you experienced the following symptoms in the past month?

◯ Sadness ◯ Worthlessness ◯ Constant Worrying ◯ Guilt ◯ Hopelessness

◯ Sleeping too much ◯ Sleeping less ◯ Eating too much ◯ Eating less ◯ Poor Energy

◯ Fatigue/Feeling Tired ◯ Muscle tension ◯ Irritable ◯ Anxiety

◯ Trouble Focusing ◯ Impulsivity ◯ Trouble Concentrating ◯ Feeling impatient

◯ Feeling Paranoid ◯ Hearing Voices ◯ Memory Difficulty

Recent Life Stressors: ◯ None ◯ Financial ◯ Relationship ◯ Death in Family ◯ Work Stress

Suicidal Thoughts: ◯ None ◯ Yes – do you have a plan _____________________________________

Homicidal Thoughts: ◯ None ◯ Yes – do you have a plan ___________________________________

Past Psychiatry History:
Psychiatric hospitalizations: ________. Suicide Attempts: __________
History of □ Depression, □ Anxiety, □ Schizophrenia, □ Bipolar disorder, □ Obsessive Thinking, □ Compulsive Behavior, □ ADHD, □ Autism, □ Eating Disorder, □ Exposed to Trauma, □ Cutting/Self-Harm Behavior, □ Dementia, □ Panic Attacks, □ PTSD. Other: ____

Past medication trials:____

Family History:
Has anyone completed suicide in your family? ____
Does anyone have psychiatric history in your family: (Please provide illness and relationship)
____

Social History:
Relationship: □ Single, □ Divorced/separated, □ dating, □ married – how many times _________
How many children (age/gender) _______________________. Custody – Yes No Shared
Highschool: □ attending, □ graduated, □ dropped, □ GED only
Work: □ employed, □ retired, □ disabled, □ unemployed, time since last job? ______, longest job______
Living: □ alone, □ with family, □ with friends, □ own, □ rent, □ homeless

New Patient Assessment

Date: ______________________

Substance Use History:

Do you smoke □ – how many cigarettes in a day: ______________. Are you interested in Quitting? ___________
Do you drink □ – How many drinks do you have in a week: □ less than 7 □ less than 14 □ more than 15
Do you have history of alcohol use □ Yes □ No Ever received a DUI or public intoxication? □ Yes □ No
History of SA treatment – How many outpatient treatment ______, How many inpatient treatment ______
Age started to drink _________, How long did the longest period of sobriety last _________________

DRUGS: Have you used these substances in the past illegally on the regular basis: □ Meth, □ Cocaine, □ Opioids, □ Benzos, □ Marijuana, □ Stimulants, □ Other ____________________________

Past Medical History:

Do you have history of: □ Head Injury, □ Concussion, □ Seizure – last seizure ______________
Select if History: □ Asthma, □ COPD, □ Diabetes, □ Liver Disease, □ Kidney Disease/Stones, □ Cholesterol, □ High Blood Pressure, □ Clotting Disorder, □ DVT/PE, □ Hypothyroidism, □ Hyperthyroidism
Other: ____

Allergies to medications: ____

Review of System: □ No concerns

Constitutional: □ No concerns, □ Weight Change, □ Fever, □ Chills, □ Fatigue
ENT/Mouth: □ No concerns, □ Hearing Changes/Ear Pain, □ Sinus congestion, □ Sore throat
Eyes: □ No concerns, □ Eye Pain, □ Redness, □ Discharge, □ Vision Changes
Cardiovascular: □ No concerns, □ Chest Pain, □ Shortness of breath, □ Palpitations
Respiratory: □ No concerns, □ Cough, □ Wheezing, □ Dyspnea
Gastrointestinal: □ No concerns, □ Nausea/Vomiting, □ Diarrhea, □ Constipation
Genitourinary: □ No concerns, □ Dysmenorrhea, □ Urinary Frequency, □ Urinary Incontinence
Skin: □ No concerns, □ Skin Lesions/rash, □ Hair Changes, □ Breast Changes, □ Nipple Discharge
Musculoskeletal: □ No concerns, □ Myalgias, □ Joint/muscle Stiffness
Neuro: □ No concerns, □ Weakness, □ Paresthesia, □ Dizziness, □ Headache, □ Recent Falls

Vitals: BP ____________ HR ___________ Weight ____________ lbs.

Current Medications:

Name	Dose	Frequency