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Adult Introductory Form

Patient Name: _____

Patient Age: _____ Patient Date of Birth:____/____/____ Gender: _____

Email: _____ @_____

Current Address:_____

Preference for Appointment Reminders: [ ]Text [ ] Email [ ] Do not send reminders

Emergency Contact's Name: _____

Emergency Contact's Relationship to the Patient: _____

Emergency Contact's Phone Number: _____

Primary Care Physician's Name: _____ Phone #: _____

Are you or family member currently involved in any court case? Y N

If yes, describe: _____

_____

_____

Chief Complaint:

_____

_____

_____

_____

_____

History of Present Illness:

_____

_____

_____

_____

_____

_____

Attempted Solutions and Efficacy:

Treatment History

Psychiatric Hospitalizations

Hospital	Dates	Reason	Outcome

Psychiatric Outpatient

Provider	Dates	Reason	Outcome

Psychiatric Medications Tried

Medication	Dose	Dates	Response

Current Medications

Prescriber	Medication	Dose	Start Date	Response

Family and Living Arrangements

Other People Currently Residing with Patient

Name	Age	Gender	Relationship	Grade/Occupation

Other Important Family Members or Significant Support People

Name	Age	Gender	Relationship	Grade/Occupation

Important Family Events: _____

_____

_____

_____

History of Abuse: _____

_____

_____

Medical/Surgical History:

[ ] no prior illnesses except usual childhood diseases

Illnesses (List and explain): _____ **at age:** _____

_____ **at age:** _____

_____ **at age:** _____

Sexually Active: [ ] No [ ] Yes If Female, Number of Pregnancies _____ **Deliveries**_____

Other Relevant Details of Pregnancies and/or Deliveries: _____

_____

_____

Tobacco/Nicotine Use [ ] No [ ] Yes If yes, how much: _____

Caffeine Use: [ ] No [ ] Yes If yes, how much: _____

Alcohol Use: [ ] No [ ] Yes If yes, how much: _____

Marijuana Use: [ ] No [ ] Yes If yes, how much: _____

Other Substance Use: [ ] No [ ] Yes If yes, please explain substance of choice, frequency, and quantity of use: _____

Allergies: _____

_____

Family History

[ ] No Serious Illnesses

History of Serious Illnesses in Immediate Family: _____

_____

_____

_____

[ ] No Serious Psychiatric Illnesses

History of Serious Psychiatric Illnesses in Family: _____

_____

_____

_____

[ ] No Legal History

Family Legal History (Contact with Department of Social Services, Police, etc.): _____

_____

_____

Cultural Influences: _____

_____

Educational/Employment History

Current Employer: _____

Current Job Title: _____

Work-Related Stressors: _____

_____

_____

Other Relevant Work-Related Information: _____

_____

_____

Highest Level of Education Completed: _____

Top Three Treatment Goals: _____

_____

_____

_____

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____