

Elm Creek Psychiatry
New Patient History

First Name _____ Last Name _____ Date _____

Address: _____ City: _____ Zip: _____ Mar Status: _____

DOB _____ Age _____ Sex _____ Soc Sec # _____

Phone: _____ Alt. Phone: _____ Ethnicity: _____ Race: _____

Insurance Company: _____ Policy Number: _____ Group Number: _____

Relationship to Insured: _____ Policy Holder Name: _____

Child (under 18 y/o) Adult w/guardian Adult-own Legal Representative

Emergency Contact (Name & Number): _____

Name of Legal Guardian: _____ Relationship: Parent Other

Legal Guardian Address: _____ City: _____ Zip: _____

Chief Complaint: _____

Describe the reason for the clinic visit:

Referral Sources: FQHC IDD Providers Hospital Providers Psych Hospitals

Specify: _____

Current Symptoms:

poor appetite overeating insomnia hypersomnia poor impulse control weight loss

- weight gain
- anxiety
- isolating
- loss of interest in activities
- tearful
- affect doesn't match mood
- low frustration tolerance
- enuresis
- encopresis
- anger
- verbal aggression
- physical aggression (inanimate objects animals people)
- poor academic performance
- hyperactivity
- poor attention
- alcohol/drug abuse
- running away
- suicidal thoughts
- suicide attempt
- hallucinations
- delusions (believing things to be true that others do not)
- purposeful self-injury (cutting, burning, scratching, etc...self)
- other: _____

Describe how long symptoms have persisted: _____

For suicidal thoughts/attempts, explain and give dates: _____

Previous psychiatric care: _____

Hospitalizations (give dates & name of facilities) * request records for hospitalizations within last 3 years

Outpatient psychiatry: (give dates & name of provider) * request records for hospitalizations within last 3 years

Previous medications/dosage/frequency/prescriber/condition being treated/effectiveness:

Current medications/dosage/frequency/prescriber/condition being treated/effectiveness:

Drug Allergies: _____

Substance Allergies: _____

Medical History

- medical hospitalization
- had surgery
- serious accidents
- had head injury w/unconsciousness
- neurological problems
- cardiovascular problems
- respiratory problems
- diabetes
- thyroid disorder
- liver disease
- gastrointestinal disorder
- musculoskeletal disorder
- chronic pain
- skin problems
- genitourinary/kidney problems
- sexually transmitted disease
- sexual dysfunction
- reproductive problems
- cancer
- vision problems
- hearing problems
- speech problems
- Seizures
- physical activity limited by physical/health problems

Describe all boxes checked: _____

Substance abuse:

- tobacco use (smoker dip eCigarette)
- alcohol
- marijuana
- synthetic marijuana
- cocaine
- methamphetamine
- narcotic analgesics
- sleeping pills/meds
- benzodiazepines (Xana,Ambien,Valium,Ativan,Klonopin, etc.)
- huffing/inhalants
- other: _____

Describe any current stressors and/or precipitating events:

- Birth
- Death
- employment
- Divorce/relationship dissolution
- homelessness
- financial
- family conflict
- school problems
- health problems
- other: _____

Any Legal Issues: yes / no