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: _________________________________

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

Emergency Contact (Name & Number):____

Name of Legal Guardian: _______________________________ Relationship: O Parent O Other

Legal Guardian Address: ___________________________________City:___________Zip:_____________

Chief Complaint: ____

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Describe the reason for the clinic visit:

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Current Symptoms:

O poor appetite O overeating O insomnia O hypersomnia O poor impulse control O weight loss
O weight gain O anxiety O isolating O loss of interest in activities O tearful
O affect doesn't match mood O low frustration tolerance O enuresis O encopresis
O anger O verbal aggression O physical aggression (O inanimate objects O animals O people)
O poor academic performance O hyperactivity O poor attention O alcohol/drug abuse

O running away O suicidal thoughts O suicide attempt O hallucinations
O delusions (believing things to be true that others do not)
O purposeful self-injury (cutting, burning, scratching, etc…self) O other: ________________________

Describe how long symptoms have persisted: ____

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

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Previous psychiatric care: ____

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

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

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

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

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Drug Allergies:____

Substance Allergies: ____

Medical History

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

Describe all boxes checked: ____

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Substance abuse:

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

Describe any current stressors and/or precipitating events:

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

Any Legal Issues: O yes / O no