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: _____

_____

_____

_____

Describe the reason for the clinic visit:

_____

_____

_____

_____

Referral Sources: O FQHC O IDD Providers O Hospital Providers O Psych Hospitals

Specify: _____

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: _____

_____

_____

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

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: _____

_____

_____

_____

_____

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