elm creek psychiatry
at betty hardwick center

Elm Creek
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