Patient name: ______________________________________
Date of birth: ____________________

# PSYCHIATRIC & BEHAVIORAL HEALTH ADDITIONAL NEW PATIENT INFORMATION

**Educational/job aspirations**

Are you currently in school? ❑Yes ❑No What was your last grade completed? ____________________

What are your future educational goals? ____________________________________________________

What do you want to do in the future? ______________________________________________________

**Self-assessment**

Why do you wish to see a behavioral health provider today? What symptoms are you seeking to alleviate at this time? Please check the box of the description that fits you most.

Your mood: ❑Very depressed ❑Down/low ❑Content ❑Happy ❑Very happy

Your pleasure and interest in activities: ❑None ❑Poor ❑Average ❑Good ❑Excellent

Feelings of guilt: ❑Excessive ❑Some ❑Little ❑Rare ❑None

Your energy level: ❑None ❑Poor ❑Average ❑Good ❑Excellent

Your concentration: ❑Extremely poor ❑Poor ❑Average ❑Good ❑Excellent

Your sleep: ❑Extremely poor ❑Poor ❑Average ❑Good ❑Excellent

Your appetite: ❑Extremely poor ❑Poor ❑Average ❑Good ❑Excellent

Have you experienced any thoughts of hurting yourself or others? ❑Yes ❑No

(If yes, please explain:) __________________________________________________________________

Please list any current medical problems: ___________________________________________________

Please list any prescription or over-the-counter medications you are taking, including dosage:

______________________________________________________________________________________

Please list your use of caffeine, alcohol, tobacco, and other drugs/substances in the last month:

______________________________________________________________________________________

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## History of abuse or trauma

| Type of abuse or trauma | Your age | By whom | Was it reported? |
|---|---|---|---|
| Verbal ❑Yes ❑No | | | ❑Yes ❑No |
| Emotional ❑Yes ❑No | | | ❑Yes ❑No |
| Mental ❑Yes ❑No | | | ❑Yes ❑No |
| Physical ❑Yes ❑No | | | ❑Yes ❑No |
| Sexual ❑Yes ❑No | | | ❑Yes ❑No |
| Rape ❑Yes ❑No | | | ❑Yes ❑No |
| Other ❑Yes ❑No | | | ❑Yes ❑No |

## Current living situation

Check the box(es) that apply.

Do you live in? ❑House ❑Apartment ❑Trailer ❑Rent ❑Own ❑Homeless

Do you live with? ❑Family member ❑Friend ❑Alone

Do you have? ❑Electricity ❑Heat ❑Water

## Leisure/recreational activities

What do you do for fun, hobbies, interests, special talents, etc.? ________________________________

What do you expect from treatment? ________________________________

What are your strengths? ________________________________

What do you like about yourself? ________________________________

What are your weaknesses? ________________________________

What do you NOT like about yourself? ________________________________

Is there anything that will keep you from getting better? Explain: ________________________________