



# BEHAVIORAL HEALTH NEW PATIENT HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Partnered Gender: Male Female Handed: Right Left  
Occupation: \_\_\_\_\_

Others Living in Your Household: \_\_\_\_\_  
\_\_\_\_\_

Referred By: \_\_\_\_\_ address: \_\_\_\_\_ Ph#: \_\_\_\_\_  
city, st, zip: \_\_\_\_\_

Previous Treating Psychiatrist: \_\_\_\_\_ address: \_\_\_\_\_ Ph#: \_\_\_\_\_  
city, st, zip: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ address: \_\_\_\_\_ Ph#: \_\_\_\_\_  
city, st, zip: \_\_\_\_\_

Therapist: \_\_\_\_\_ address: \_\_\_\_\_ Ph#: \_\_\_\_\_  
city, st, zip: \_\_\_\_\_

Neurologist: \_\_\_\_\_ address: \_\_\_\_\_ Ph#: \_\_\_\_\_  
city, st, zip: \_\_\_\_\_

Other Providers: \_\_\_\_\_

Are you allergic to any medications? YES NO  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized? YES NO Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Previous surgeries: YES NO Date: \_\_\_\_\_ Surgery: \_\_\_\_\_  
Date: \_\_\_\_\_ Surgery: \_\_\_\_\_  
Date: \_\_\_\_\_ Surgery: \_\_\_\_\_  
Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

## HABITS

Tobacco Use  No  Yes

Circle One: current every day smoker current someday smoker former smoker  
never smoked smoker, status unknown unknown if ever smoked

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Drug of Choice	NA	Age first used	How often do you use	How much	Last use	Route: smoke, IV, inhale, etc.
Alcohol						
Marijuana						
Cocaine						
Heroin						
Demerol						
Vicodin						
Lortab/Norco						
Dilaudid						
Methadone/Suboxone						
Xanax						
Valium						
Ativan						
Klonopin						
Soma						
Barbiturates						
PCP						
Amphetamines						
Ecstasy						
Diet pills						
Ritalin						
Inhalants						
Other: prescription drug						
Other: street drugs						

Patient Name: \_\_\_\_\_

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Please review the items below and indicate if you or your family has or has had any of the problems listed. Write the letter of the person who has had the issue in the box next to the problem.

(X) Self      (M) Mother      (F) Father      (G) Grandparent      (B) Brother      (S) Sister

GENERAL		PULMONARY/LUNG		MUSCULOSKELETAL		NEUROLOGICAL	
Chills		Asthma		Arthritis		Alzheimer's	
Fatigue		COPD		Atrophy		Brain Tumor	
Fever		Coughing		Back pain		Dizziness	
Glaucoma		Coughing up blood		Cramps		Epilepsy	
Night Sweats		Emphysema		Deformity		Fainting spells	
Poor Appetite		Lung disease		Fibromyalgia		Headaches	
Weakness		Pneumonia		Limited motion		Hearing issues	
Weight Gain		Pulmonary embolism		Locking/catching		Un-consciousness	
Weight Loss		Shortness of breath		Loss of limb		Palsy	
		Tuberculosis		Lupus		Paralysis	
<b>CARDIOVASCULAR</b>		Wheezing		Mass		Parkinson	
Chest pain (angina)		<b>GENITOURINARY</b>		Muscular disorder		Seizures	
Congestive heart failure		Blood in urine		Numbness		Stroke	
Coronary artery disease		Frequent urination		Osteoporosis		T.I.A.	
Elevated cholesterol		Kidney disease		Pain		<b>BLOOD</b>	
Heart Attack		Kidney stone pain		Popping		Aids/HIV	
Heart Murmur		Wake up to urinate		Psoriasis		Anemia	
High blood pressure		Painful urination		Redness		Bleeding Disorder	
Irregular heartbeat		Discharge		Stiffness		Blood Transfusion	
Low blood pressure		Prostate		Swelling		Leukemia	
Pacemaker		Urgent urination		Tingling		Sickle Cell	
Palpitations		<b>HEAD/EARS/NOSE/THROAT</b>		Weakness		<b>GASTROINTESTINAL</b>	
Phlebitis/clots in legs		Hay fever		<b>PSYCHIATRIC</b>		Abdominal pain	
Rheumatic fever		Hoarseness		Anxiety		Black stools	
Shortness of breath		Neck stiffness/pain		Depression		Constipation	
Swelling of feet		Nose bleeds		Schizophrenia		Diarrhea	
Swollen ankles		Postnasal drip		Bipolar Disorder		Gas	
<b>SKIN</b>		Visual problems		Alcoholism		Hemorrhoids	
Hives		<b>ENDOCRINE</b>		Drug Addiction		Hepatitis	
Lesions		Cold intolerance		<b>LYMPHATICS</b>		Hernia	
Melanoma		Diabetes		Lymph node swelling		Indigestion	
Psoriasis		Easy bleeding		Node Tenderness		Jaundice/Yellow	
Rash		Excessive appetite		<b>CANER</b>		Nausea	
Tumor/growth/cyst		Excessive thirst		List Type of Cancer Below:		Pancreatitis	
<b>OTHER</b>		Excessive urination				Rectal bleeding	
Venereal disease		Gout				Ulcer – gastric	
		Heat intolerance				Ulcer – peptic	
		Thyroid disease				Vomiting	
		Hair loss				Vomiting blood	

Patient Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_