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NEW PATIENT INFORMATION FORM

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and accurately as you can, you will facilitate your therapeutic plan. We request that you answer these questions prior to seeing the doctor so that the actual consulting time can be used to deal with the current problem.

Date: _______________

I. Name:____Age:_______________

Please describe the reason for your visit today:
____
____

Have you previously consulted anyone about this problem? YES NO

If yes, whom did you consult: ____

II. Please check all of the following that you have experienced recently:

_____ Persistent sadness
_____ Excessive sleep
_____ Diarrhea
_____ Blurred vision
_____ Irritability
_____ Nervousness
_____ Headaches
_____ Recurring fears or worries
_____ Suicidal thinking/attempts
_____ Sexual problems
_____ Dreams/nightmares
_____ Constipation
_____ Change in appetite
_____ Drowsiness
_____ Muscle stiffness
_____ Dizziness
_____ Problems sleeping
_____ Nausea/vomiting
_____ Weight gain/loss
_____ Low or High energy
_____ Poor memory
_____ Tremors/jitters
_____ Dry mouth
_____ Periods of rapid heart beat

Describe any other recent symptoms:
____
____

III. MEDICAL INFORMATION
Date of last physical exam: ______________________

List operations and/or injuries: ____
____

How would you rate your overall health?

Poor _____ Fair _____ Good _____ Excellent _____

Have YOU ever had:		Has any of YOUR FAMILY had:	
Y/N	Tumor or cancer	Y/N	Tumor or cancer
Y/N	Heart trouble	Y/N	Heart trouble
Y/N	High blood pressure	Y/N	High blood pressure
Y/N	Thyroid trouble	Y/N	Thyroid trouble
Y/N	Diabetes	Y/N	Diabetes
Y/N	Asthma, Allergies	Y/N	Asthma, Allergies
Y/N	Nervous breakdown	Y/N	Nervous breakdown
Y/N	Arthritis	Y/N	Arthritis
Y/N	Kidney or bladder trouble	Y/N	Kidney or bladder trouble
Y/N	Stroke, fits, seizures	Y/N	Stroke, fits, seizures
Y/N	Tendency to bleed easily	Y/N	Tendency to bleed easily
Y/N	Ulcer	Y/N	Ulcer
Y/N	Jaundice or liver problems	Y/N	Jaundice or liver problems
Y/N	Depression	Y/N	Depression
Y/N	Alcohol, drug problems	Y/N	Alcohol, drug problems

IV. MEDICATIONS:

Please list all medications and dosages that you now take (including over the counter medications):

____
____
____
____

List any other medications, drugs, or herbs which you use:

____
____

How much alcohol do you drink? ______________________

Have you felt a need to cut down on your drinking? YES NO

WOMEN ONLY Menstrual History:

Do you have regular cycles? YES NO Cycle length:_________

Date of last period: __________________ Do you use birth control pills? YES NO