NEW PATIENT INFORMATION FORM

Patient's First Name:_____Last Name:_____

Home Address:_____

City:_____State:_____Zip Code:_____

Home Phone_____Work/Cell Phone_____

Email Address:_____

Date of Birth:_____ Social Security #:_____

How did you hear about Dr. Bravo?_____

Relationship Status (circle): Single Married Partnered Separated Divorced Widowed

Occupation:_____

Employer:_____Work Hours:_____

Have you been in therapy before?:_____ If so, when?_____

Have you ever been evaluated by a psychiatrist for medication?_____

Please list any medications you are currently taking (including over-the-counter meds):

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever been hospitalized for mental health issues?_____

If so, when?_____Where?_____How long?_____

BACKGROUND INFORMATION QUESTIONNAIRE

Why are you seeking the evaluation at this time:

_____
_____
_____
_____
_____
_____

What do you hope to gain from this evaluation?

_____
_____
_____
_____
_____

Who referred you?

_____
_____

With whom do you live:_____

How long in current living situation: _____

Are you bilingual? If so, what language(s): _____

What is your current level of education: _____

School(s) attended (Grade, Middle, High, Technical/Vocational, and College):

_____
_____
_____
_____
_____

Did you do well in school? What grades did you earn?

_____
_____
_____

Are you currently employed? If so, what do you do? How many hours a week do you work?

_____
_____
_____
On average, how many hours a night do you sleep? _____

Have you ever been hospitalized for medical or psychiatric complications? If so, please explain:

_____
_____
_____
_____
_____
_____

Please check any prior illnesses and approximate age experienced:

[ ] Measles: _____
[ ] Mumps: _____
[ ] Chicken Pox: _____
[ ] Tuberculosis: _____
[ ] Whooping Cough: _____
[ ] Scarlet Fever: _____
[ ] Rheumatic Fever: _____
[ ] Diptheria: _____
[ ] Meningitis: _____
[ ] Encephalitis : _____
[ ] Anemia: _____
[ ] Fever above 104 degrees: _____
[ ] Broken bones: _____
[ ] Head injury (provide details) :_____
[ ] Coma or loss of consciousness: (provide details) : _____
[ ] Sustained high fever (provide details) : _____

Please indicate any additional past or present medical concerns:

_____
_____
_____
_____
_____
_____

Have you ever experienced the following (if so, please check box and provide details):

[ ] Seizures/Convulsions: _____
[ ] Speech deficits: _____
[ ] Hearing difficulties/deficits:_____
[ ] Vision problems (need glasses/contacts):_____
[ ] Allergies: _____

Do you do any of the following? If so, how often?

[ ] Consume caffeine (coffee, soda, energy drinks): _____
[ ] Smoke cigarettes: _____
[ ] Inhale toxic substances: _____
[ ] Use illegaldrugs:_____
[ ] Chew tobacco:_____
[ ] Drink alcohol (beer, liquor, wine): _____

Name of Physician: _____ Telephone: _____

Date of last physical examination: _____

Have you ever attended counseling/psychotherapy? If so, when, with whom and how long did you attend?

_____
_____
_____

In the past, why did you seek counseling?

_____
_____
_____

Did you enjoy psychotherapy? Did it work? Why or why not?

_____
_____
_____

Have you ever participated in a psychological or psychiatric examination? If so, why was this done?

_____
_____
_____

Where any diagnoses given to you during the course of psychotherapy or the examination? If so, please indicate the diagnosis/diagnoses:

_____
_____
_____
_____
_____
_____

Are you now experiencing or have you ever experienced suicidal thoughts, behaviors, or attempted suicide? If so, please provide details:

_____
_____
_____
_____

Was your mother under a physician's care during her pregnancy? _____

Were there any complications during her pregnancy? If so, please describe:

_____
_____
_____

Did she take any medications, nonprescription drugs, smoke cigarettes, or consume alcohol during pregnancy? If so, please specify:

_____
_____
_____

Did you meet developmental milestones within normal ranges (sitting, crawling, walking, first words, short phrases, toilet training)? _____

Race of each parent: _____

Languages spoken at home: _____

Siblings/Step-siblings and birth order:

_____
_____
_____

Marital status (past and present): _____

Do you have any children? If so, how old: _____

Marital status of parents: _____

If your parents are divorced, how old were you when they got divorced?

_____
_____
_____

Have any family members had any of the following conditions (if so, please check box and provide details):

[ ] Cancer:_____
[ ] Cystic Fibrosis:_____
[ ] Diabetes:_____
[ ] Heart Disease:_____
[ ] Physical Handicap:_____
[ ] Stroke:_____
[ ] Tuberculosis::_____
[ ] Alzheimer's Disease:_____
[ ] Hemophilia:_____
[ ] Huntington's Chorea:_____
[ ] Muscular Distrohpy:_____
[ ] Parkinson's Disease:_____
[ ] Sickle-Cell Anemia:_____
[ ] Tay-Sachs Disease:_____
[ ] Tourette's Syndrome:_____
[ ] Birth Defect:_____
[ ] Cerebral Palsy:_____
[ ] High Blood Pressure:_____
[ ] Kidney Disease:_____
[ ] Migraine Headaches:_____
[ ] Multiple Sclerosis:_____
[ ] Alcohol/ Drug Abuse:_____
[ ] Behavior Disorder:_____
[ ] Emotional Disturbance:_____
[ ] Mental Illness:_____
[ ] Depression/ Bipolar disorder: _____
[ ] Mental Retardation:_____
[ ] Sexually Transmitted Disease:_____
[ ]Seizures/Epilepsy:_____
[ ] Reading Difficulties:_____
[ ] ADD/ADHD: _____
[ ] Other Learning Disabilities:_____
[ ] Speech or Language Problem:_____
[ ] Food Allergies:_____
[ ] Head Injury:_____

[ ] Other (please describe):
_____
_____
_____

Describe your father's current health:
_____
_____
_____

Describe your mother's current health:
_____
_____
_____

Has anyone in the family ever been in special education? _____

If yes, with whom and where?
_____
_____
_____

Do you have difficulties relating to peers? If yes, please describe why:
_____
_____
_____
_____

Do you have friends?
_____
_____
_____

Do you have difficulties making friends? If yes, please describe why:
_____
_____
_____

Do you have a good relationship with your family members? If not, why:
_____
_____
_____

Do you fight frequently with peers or family members? If yes, please describe why:

_____
_____
_____

Do you prefer to be alone? If yes, please describe why:

_____
_____
_____

What do you do in your free time (sports, hobbies, etc)?

_____
_____
_____

Has your interest in hobbies or pleasurable activities declined recently? If so, please describe how:

_____
_____
_____

What are your personal strengths?

_____
_____
_____

What are your personal weaknesses?

_____
_____
_____

ADDITIONAL COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____

THANK YOU FOR THE CANDOR AND ENERGY SPENT COMPLETING THIS QUESTIONNAIRE.