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New Patient Intake Form

Please fill out the following form to the best of your ability. Some sections may not apply to you. We will discuss your responses in greater detail during your first appointment.

1. Patient Demographics

First Name **Middle Name** **Last Name**

DOB - Month **DOB - Day** **DOB - Year** **Age**

Marital Status:

Single Married Partnered
Divorced Separated Widowed

Sex:

Male Female Non-binary Other

If Other, please specify

Race/Ethnicity

2. Address & Contact Information

Billing Street Address

City **State**

Postal Code **Country**

Email **Direct Telephone**

3. Preferred Pharmacy Information

Pharmacy Name / Address

City **State**

Postal Code **Country**

Direct Telephone

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4. Current / Referring Providers

Current Psychiatrist (if any)

Name / Address / Phone

Current Therapist (if any)

Name / Address / Phone

Primary Care Physician (PCP)

Name / Address / Phone

5. Reason for Seeking Treatment

Reason(s) for seeking treatment at this time:

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6. Current Symptoms (Psychiatric)

Check all that apply:

- No problems or concerns
- Unable to enjoy activities
- Loss of interest
- Excessive guilt
- Decreased libido
- Fatigue / Low energy
- Violent thoughts
- Impulsivity
- Increased libido
- Excessive energy
- Crying spells
- Memory problems
- Flashbacks
- Nervousness, tension
- Fears, phobias
- Hallucinations
- Disorganized / illogical thoughts
- Attention problems
- Depressed mood
- Sleep pattern disturbance
- Change in appetite
- Concentration / forgetfulness
- Suicidal thoughts
- Low self esteem
- Racing thoughts
- Increased risky behavior
- Decreased need for sleep
- Increased irritability
- Pain
- Stress
- Nightmares
- Anxiety or panic attacks
- Obsessions / compulsions
- Suspiciousness
- Anger / temper problems
- Avoidance

Other symptoms/concerns

7. Symptom Duration & Treatment Goals

How long have these symptoms been present?

What are your treatment goals?

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8. Recent Stressful Life Events

Check any of the following events that have occurred during the last 2 years:

- Married
- Child left home
- Miscarriage
- Legal problems
- Arguments / conflicts
- Infertility
- Lost or changed job, retired
- Separated
- Loss of a child
- Sexual difficulties
- Divorced
- Adoption
- Problems or changes at work/school
- Engaged
- Death of spouse, significant other
- Injury or significant illness
- Financial difficulties
- Breakup of important relationship
- Pregnancy
- Changed residence

Other

9. Past Medical History

Medication Allergies

Other Allergies

Current Weight

Height

Date & Location of Last Physical Exam

Have you had a recent EKG? Yes No

If Yes, was the EKG Normal Abnormal

When? (EKG date)

Please list all current medical problems:

Have you had any non-psychiatric hospitalizations or surgeries? Please describe:

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10. Personal & Family Medical History

Please check all medical problems that you or a family member has had in the past:

Condition	You	Family	Which Family Member?
Thyroid Disease			
Stroke			
Osteoarthritis			
Eating Disorders			
Anemia			
Liver Disease			
Chronic Fatigue			
Kidney Disease			
Diabetes			
Prediabetes			
Asthma / Respiratory Problems			
Stomach or Intestinal Problems (IBD, GERD, Celiac)			
Gallbladder Disease			
Cancer (type)			
Fibromyalgia			
Heart Disease			
Autoimmune Disorders (lupus, MS)			
Seizures			
Chronic Pain			
High Cholesterol			
High Blood Pressure			
Dyslipidemia			
Head Trauma			
Genetic Disorder (e.g. sickle cell, cystic fibrosis)			
Migraines			
Skin Problems (eczema, psoriasis)			
Sleep Apnea			
PCOS			
Psychiatric Conditions (type)			
Other (please list)			

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11. Review of Systems

Gastrointestinal

Problems with a sensitive stomach, reflux, diarrhea, constipation, or ulcers?	Yes	No
Any history of ulcers?	Yes	No
Problems with high or low blood sugar?	Yes	No

Hormonal

Problems with weight gain, dry skin, or sluggishness?	Yes	No
Did you develop normally into adolescence?	Yes	No
For women: do you have normal menstrual cycles?	Yes	No

Immune

Do you get sick and catch colds easily or frequently?	Yes	No
Have you taken a lot of antibiotics in your life?	Yes	No
Do you have problems with seasonal or food allergies?	Yes	No

Musculoskeletal

Do you have any problems with achy muscles or joints?	Yes	No
Weak bones?	Yes	No

Genitourinary

Do you experience problems with urination, water balance?	Yes	No
Any problems with libido and/or sexual function?	Yes	No
Any history of bladder or kidney infections?	Yes	No

For Women Only

Date of Last Menstrual Period

Are you currently pregnant or think you might be pregnant?	Yes	No
Are you planning to get pregnant in the near future?	Yes	No

Birth Control Method

How Many Times Pregnant? **Full Term Births** **Preterm Births**

Abortions / Miscarriages **Living Children**

Have You Gone Through Menopause? **When?**

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12. Weight Management & GLP-1 Therapy

For weight loss and wellness patients only. This section supports the initial assessment of patients seeking obesity-related medical care, including consideration for GLP-1 receptor agonist therapy (e.g., semaglutide, liraglutide, dulaglutide, tirzepatide).

Chief Concern & Goals

Reason for Visit: (check all that apply)

- Weight Loss
- Weight Maintenance
- Management of Obesity-related Conditions (e.g., T2DM,
- GLP-1 Therapy Consideration
- Pregnancy Planning / Contraception Advice
- Other

If Other, please specify

Weight-related Goals (e.g., % weight loss, BMI target, health outcomes)

Interest in GLP-1 Receptor Agonist Therapy?

- Yes
- No
- Undecided

Desired Timeframe to Achieve Goals (weeks/months)

Previous Trials of Weight Loss Medications?

Current Symptoms & Body Metrics

Height **Weight** **Target Weight**

Waist Circumference **BMI**

Obesity-related Symptoms:

- Fatigue
- Breathlessness
- Joint Pain
- Sleep Disturbances
- Digestive Changes

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Lifestyle & Treatment Preferences

Typical Diet:

Physical Activity Level:

Sedentary Light Moderate High

Average Sleep (hours/night)

Stress Management Techniques:

GLP-1 Therapy Preferences

Preferred Agent (if known):

Semaglutide Other

If Other, please specify agent

Preferred Administration:

Injection Oral

13. Current Medications

Please list your current medications (include prescription, over the counter, supplements and herbs):

Medication	Dosage & Frequency	Reason for Medication	Is it helpful?

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14. Past Psychiatric History

Have you had outpatient psychiatric treatment in the past?

Reason	Dates	Treated By Whom	Nature of Treatment

Have you ever been hospitalized for psychiatric reasons? Yes No

If Yes, please explain

Have you ever had thoughts about death or wanting to die, or ever threatened to hurt yourself? Yes No

Please explain

History of suicide attempts or suicidal gestures? Yes No

Please explain

History of self-harm (e.g. cutting)? Yes No

Please explain

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15. Past Psychiatric Medications

If you have ever taken any of the following medications, please indicate the dates, dosage, and whether they were helpful (as best you are able to remember).

Antidepressants

Medication	Taken?	Dates / Dosage / Was it helpful?
Anafranil (clomipramine)		
Celexa (citalopram)		
Cymbalta (duloxetine)		
Effexor (venlafaxine)		
Elavil (amitriptyline)		
Fetzima (levomilnacipran)		
Lexapro (escitalopram)		
Luvox (fluvoxamine)		
Pamelor (nortriptyline)		
Paxil (paroxetine)		
Pristiq (desvenlafaxine)		
Prozac (fluoxetine)		
Remeron (mirtazapine)		
Serzone (nefazodone)		
Trintellix / Brintellix (vortioxetine)		
Viibryd (vilazodone)		
Wellbutrin / Zyban (bupropion)		
Zoloft (sertraline)		
Other:		

Anti-Anxiety

Medication	Taken?	Dates / Dosage / Was it helpful?
Ativan (lorazepam)		
Buspar (buspirone)		
Klonopin (clonazepam)		
Inderal (propranolol)		
Librium (chlordiazepoxide)		
Valium (diazepam)		
Vistaril (hydroxyzine)		
Xanax (alprazolam)		
Other:		

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Mood Stabilizers / Anti-Epileptics

Medication	Taken?	Dates / Dosage / Was it helpful?
Depakote (valproate)		
Dilantin (phenytoin)		
Eskalith / Lithobid (lithium)		
Keppra (levetiracetam)		
Lamictal (lamotrigine)		
Neurontin (gabapentin)		
Tegretol (carbamazepine)		
Topamax (topiramate)		
Trileptal (oxcarbazepine)		
Other:		

Antipsychotics

Medication	Taken?	Dates / Dosage / Was it helpful?
Abilify (aripiprazole)		
Fanapt (iloperidone)		
Geodon (ziprasidone)		
Haldol (haloperidol)		
Invega (paliperidone)		
Latuda (lurasidone)		
Risperdal (risperidone)		
Saphris (asenapine)		
Seroquel (quetiapine)		
Zyprexa (olanzapine)		
Other:		

Stimulants / ADHD Medications

Medication	Taken?	Dates / Dosage / Was it helpful?
Adderall (amphetamine mixture)		
Dexedrine (dextroamphetamine)		
Focalin (dexmethylphenidate)		
Intuniv / Tenex (guanfacine)		
Nuvigil (armodafinil)		
Provigil (modafinil)		
Ritalin / Concerta (methylphenidate)		
Strattera (atomoxetine)		
Vyvanse (lisdexamfetamine)		
Other:		

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Sleep Aids

Medication	Taken?	Dates / Dosage / Was it helpful?
Ambien (zolpidem)		
Belsomra (suvorexant)		
Desyrel (trazodone)		
Lunesta (eszopiclone)		
Restoril (temazepam)		
Rozerem (ramelteon)		
Sinequan (doxepin)		
Sonata (zaleplon)		
Other:		

Natural Supplements / Medical Foods

Medication	Taken?	Dates / Dosage / Was it helpful?
5-Hydroxytryptophan (5-HTP)		
Deplin (L-methylfolate)		
Melatonin		
Omega-3 Fatty Acids		
S-Adenosyl Methionine (SAM-e)		
St. John's Wort		
Valerian		
Vayarin		
Other:		

16. Treatment-Resistant / Neuromodulation Treatments

Electroconvulsive Therapy (ECT)

Have you ever undergone Electroconvulsive Therapy (ECT)? Yes No

How Many Treatments? **Location / Institution?** **Response?**

Repetitive Transcranial Magnetic Stimulation (rTMS)

Have you ever undergone repetitive Transcranial Magnetic Stimulation (rTMS)? Yes No

How Many Treatments? **Location / Institution?** **Response?**

Ketamine

Have you ever undergone ketamine treatment? Yes No

How Many Treatments? **Location / Institution?** **Response?**

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17. Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live?	Yes	No
Do you currently feel that you don't want to live?	Yes	No

If you answered Yes above, please answer the following. If No, please skip to the next section.

1) How often do you have these thoughts?

2) When was the last time you had thoughts of dying?

3) Has anything happened recently to make you feel this way?	Yes	No

4) On a scale of 1 to 10 (10 being the strongest), how strong is your desire to kill yourself currently?

5) Would anything make it better?	Yes	No
6) Have you ever thought about how you would kill yourself?	Yes	No
7) Is the method you would use readily available?	Yes	No
8) Have you planned a time for this?	Yes	No
9) Is there anything that would stop you from killing yourself?	Yes	No
10) Do you feel hopeless and/or worthless?	Yes	No
11) Have you ever tried to kill or harm yourself before?	Yes	No
12) Do you have access to guns? If Yes, please explain.	Yes	No

If Yes, please explain

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18. Family Psychiatric History

Has anyone in your family been diagnosed with or treated for the following?

Condition	Yes	No
Bipolar Disorder		
Depression		
Anxiety		
Anger		
Suicide		
Schizophrenia		
Post-traumatic Stress		
Alcohol Use		
Other Substance Use		
Violence		

If yes, who had each problem?

What type of treatment (e.g. medications) did they receive, and was it effective?

19. Substance Use History

Please describe your current use of drugs and alcohol:

Has using drugs or alcohol ever caused problems for you (legal, family, medical)? Yes No

Have you ever been treated for drug or alcohol problems in the past? Yes No

Please explain

Have you ever abused prescription medication? Yes No

Please explain

Do you smoke tobacco? Yes No

How many cigarettes per day?

How many caffeinated beverages do you drink per day?

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20. Family Background & Childhood History

Were you adopted? Yes No

Where did you grow up?

List your siblings and their ages:

Father's Occupation **Mother's Occupation**

Did your parents divorce? Yes No

If Yes, how old were you?

Who did you live with growing up?

How is your relationship with your family?

Have there been any deaths in your immediate family? If so, who?

When your mother was pregnant with you, are you aware of any complications during the pregnancy or birth?

Were you born premature? (Yes/No) **How were you delivered?**

Were you breastfed or bottle fed as an infant?

Did you have any significant injuries or illnesses as a child?

Do you have a history of being abused emotionally, sexually, physically, or by neglect? Yes No

If Yes, please describe:

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21. Education / Employment History

Education

Highest Degree Completed **Area of Study**

Spouse's Education (if applicable)

Highest Degree Completed **Area of Study**

History of learning disorder/difficulties? Please describe:

Employment

Occupation **Place of Employment**

Spouse's Employment (if applicable)

Occupation **Place of Employment**

Please describe any current difficulties you are experiencing at work:

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22. Relationship History & Current Family

Are you currently:

Married	Partnered	Divorced
Single	Widowed	

How long?

If not married, are you currently in a relationship? Yes No

If Yes, how long?

Are you sexually active? Yes No

How would you identify your sexual orientation?

Straight / Heterosexual	Lesbian / Gay / Homosexual
Bisexual	Transsexual
Unsure / Questioning	Asexual
Prefer Not to Answer	Other

If Other, please specify

Describe your relationship with your spouse or significant other:

Have you had any prior marriages? Yes No

If Yes, how many?

How long?

Do you have children? Yes No

If yes, list ages and gender:

Describe your relationship with your children:

List everyone who currently lives with you:

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23. Legal History

Have you ever been arrested? Yes No

Details:

Do you have any pending legal problems? Yes No

Details:

24. Exercise / Fitness History

Please describe your type and level of activity of exercise:

25. Nutritional History

What do you like to eat?

What would a typical day look like with respect to breakfast, lunch, dinner, and snacks?

Do you crave certain foods?

Do particular foods make you tired?

Do you have a dairy or wheat allergy/sensitivity?

26. Spiritual History

Please describe your spiritual and religious background and beliefs:

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27. Anything Else We Should Know

Is there anything else I should know that doesn't appear on this form or other forms, but that is or might be important?

28. Signature

My signature below indicates that I have voluntarily and accurately completed the New Patient Intake Form.

Patient Name **Signature** **Date**