New Patient Information

Date: _____ Appointment Scheduled With: _____

Name: _____

(last) (first) (middle)

Address:_____

Phone #s:_____

Employer: _____

Occupation: _____

Social Security #: _____- _____- _____ Date of Birth: _____ Age: _____

Gender: _____

Marital Status: Single Married Widowed Separated Divorced Domestic Partners

Children (Names & Ages): _____

Any Family Member with Mental Health or Substance Use Problems? (If yes, please include relationship, condition, and treatment if known):_____

_____

_____

Contact Person: Can we contact this person if we need to reach you? Yes No

Name:_____

Address:_____

Phone #s:_____

Relationship:_____

Reason for Visit:_____

_____

_____

_____

Referral Source:_____

Primary Care Physician: _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure-- Adult

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly Every day
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4
	2. Feeling down, depressed or hopeless?	0	1	2	3	4
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
	5. Starting lots ore projects than usual or doing more risky things than usual?	0	1	2	3	4
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
	7. Feeling panic or being frightened?	0	1	2	3	4
	8. Avoiding situations that make you anxious?	0	1	2	3	4
V.	9. Unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?	0	1	2	3	4
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
VIII.	14. Problems with sleep that affected your sleep quality overall?	0	1	2	3	4
IX.	15. Problems with memory (e.g. learning new information) or with location (e.g. finding your way home)?	0	1	2	3	4
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4
	20. Not feeling close to other people or enjoying your relationship with them?	0	1	2	3	4
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly Every day
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4

Additional Concerns/Problems: _____

_____

_____

MEDICAL HISTORY

	YES	**NO**	**If yes, explain**
Heart Disease			
High Blood Pressure			
Stroke			
Lung Problems			
Snoring/Sleep Apnea			
Allergies (food/seasonal)			
High Cholesterol			
Thyroid Disease			
Diabetes			
Digestive Problems			
Muscle Pain/Stiffness			
Skin Problems			
Hot Flashes			
Migraines			
Tremors			
Numbness in arms/legs			
Seizures			
Seizures			
Cancer			
Pregnancy			
Menopause			
Other			

Do you have allergies to medications? YES NO (If yes, list drug and reaction): _____

_____

_____

Current Medications (Dose, Start Date, and Prescribing Doctor):_____

_____

_____

_____

Past Psychiatric Medication (Include Dose, Duration, and any side effects): _____

_____

_____

_____

Prior Hospitalizations/Surgeries (Include Date, Reason, and Location for both medical and psychiatric): _____

_____

_____

What is your current Height: _____inches and **Weight**:_____lbs

What is your CURRENT Sleep Pattern? (Time to bed, hours of sleep, interruptions):

_____

_____

What is your NORMAL Sleep Pattern? (Time to bed, hours of sleep, interruptions):

_____

_____

Privacy and Patient Responsibility Agreements

Privacy Policy: I acknowledge that I have been given the opportunity to review and ask questions about the "Privacy Practices of Triangle Psychiatric Services, PA." I understand that TPS may use or disclose information relating to me for purposes of treatment, payment and health operations as disclosed in the notice. _____ (Initials)

Insurance Payments: (We are happy to file claims to your insurance company as a courtesy to you, but will need your permission.) I hereby authorize Triangle Psychiatric Services, PA to release all information necessary to facilitate the insurance processing of all claims relating to my health care. I understand I am responsible for all charges whether or not paid by my insurance company. I authorize use of this signature on all my insurance submissions. _____ (Initials)

Co-payments: Co-payments are expected at the end of each session. _____ (Initials)

No Show/Late Cancellation Policy: I acknowledge that TPS reserves the right to charge a $50 fee for missed appointments and requires 24 hours notice to cancel or reschedule without being charged. _____ (Initials)

E-Mail: I understand E-mail privacy cannot be guaranteed because of the possibility of hackers. Nevertheless, I appreciate that accuracy and efficiency may outweigh this risk. Accordingly, I agree to exchange e-mail of a non-personal nature regarding my treatment with TPS (for example, medication questions and answers or schedule changes). _____ (Initials)
My E-mail Address: _____

Patient Signature: _____
Printed Name: _____
Date: _____
Witness Signature: _____
Date: _____