# NEW PATIENT INFORMATION

Triangle Psychiatric Services, PA
2501 Atrium Drive, Suite 250 | Raleigh, NC 27607
(919) 845-1555

Date: _____ Appointment scheduled with: _____

Name: _____
*last* *first* *middle*

Legal name (if different): _____

Preferred name: _____ Pronouns: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Date of birth: _____ Age: _____ Gender identity: _____

Sex assigned at birth (optional): _____ Occupation: _____

Relationship status: [ ] Single [ ] Married/partnered [ ] Separated [ ] Divorced [ ] Widowed [ ] Other

Children (names and ages): _____

## FAMILY MENTAL HEALTH AND SUBSTANCE USE HISTORY

Include relationship, condition, and treatment if known.

_____

_____

## EMERGENCY / SUPPORT CONTACT

Name: _____ Relationship: _____

Phone: _____ May we contact this person if we cannot reach you or in an emergency? [ ] Yes [ ] No

*Listing a contact does not authorize routine disclosure of clinical information. A separate authorization may be needed.*

## REASON FOR VISIT

_____

_____

_____

_____

Referral source: _____

Primary care clinician: _____

Preferred pharmacy and location: _____

## 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 more 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 |

| | **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 |
|---|---|---|---|---|---|---|
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 |
| | 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 | | | |
| 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

Triangle Psychiatric Services, PA | 2501 Atrium Drive, Suite 250 | Raleigh, NC 27607 | (919) 845-1555

**Acknowledgment of Receipt of Notice of Privacy Practices**
I acknowledge that I received the Triangle Psychiatric Services, PA Notice of Privacy Practices, effective August 18, 2026. My initials confirm receipt only; they do not indicate agreement with the Notice or authorize any use or disclosure beyond what is otherwise permitted or required by law. I may request a paper or electronic copy at any time. **Initials:** _____

**Insurance Billing and Assignment of Benefits**
I authorize TPS to submit claims to my health plan and to receive payment directly for covered services. I understand TPS may use and disclose protected health information for payment as permitted by law. This paragraph is not an authorization for a use or disclosure that otherwise requires my written authorization. I remain responsible for charges not paid by insurance, subject to applicable contracts and law. **Initials:** _____

**Co-payments and Patient Balances**
Co-payments and other amounts due from me are expected at the end of each session unless another arrangement has been made. **Initials:** _____

**No-show / Late Cancellation Policy**
TPS reserves the right to charge a $75 fee for a missed appointment or for cancellation or rescheduling with less than 24 hours notice, except when waived by the practice or prohibited by applicable law or contract. **Initials:** _____

**Electronic Communications**
I request and consent to communicating with TPS by email at the address below for scheduling, billing, and limited clinical messages. I understand that ordinary email may not be fully secure, that messages may become part of my medical record, and that I may withdraw this request by notifying TPS. Email is not monitored continuously and must not be used for urgent or emergency concerns. For an emergency, call 911 or 988 or go to the nearest emergency department. **Initials:** _____

Email address for communication: _____

By signing below, I confirm that I have reviewed the agreements above and had an opportunity to ask questions.

Patient name (printed): _____ Date of birth: _____

Signature of patient or personal representative: _____ Date: _____

Personal representative name (if applicable): _____

Relationship/authority: _____

**Practice use only if the NPP acknowledgment is not obtained**
Notice provided: [ ] paper [ ] electronically Date provided: _____
Reason not obtained: [ ] declined [ ] unable [ ] sent but not returned [ ] other: _____
Good-faith effort / notes: _____
Staff name and signature: _____ Date: _____