



New Patient Form

Personal Information

Name* _____

First

Middle

Last

Gender* _____ Date of Birth (MM/DD/YYYY) _____

Address _____ City* _____ State* _____ Zip Code* _____

Cell Phone* _____ Work Phone _____ Home Phone _____

Email* _____ Alternate Email _____

Family Members Living at Home (age and relationship with patient)

Emergency Contact: Name* _____

Emergency Contact: Phone* _____

Guarantor Information

Is The Guarantor Same as Patient? Yes No

(If Yes, Please Skip the Guarantor's Section)

Guarantor's Name _____

First

Last

Guarantor's Birthdate (MM/DD/YYYY) _____

Guarantor's Address _____

Guarantor's City _____ Guarantor's State _____ Zip Code _____

Guarantor's Phone Number _____ Guarantor's Alternate Phone _____

Guarantor's Email- Id _____

Guarantor's Relationship with Patient _____



Insurance Information

Insurance Company Name* _____

Insurance Company Address* _____

Insurance Company City* _____ Insurance Company State* _____

Insurance Company Zip Code* _____

Insurance Company Phone* _____

Insurance Holder's ID Number* _____

Insurance Holder's Group Number _____

Secondary Insurance Information

Does the Insured have a Secondary Insurance? Yes No

(If No, please skip the secondary insurance section.)

Subscriber's Name (Primary on Insurance)

Relationship with Patient _____

Secondary Insurance Company Name _____

Secondary Insurance Company Address _____

Secondary Insurance Company City _____ Secondary Insurance Company State _____

Zip Code _____

Secondary Insurance Company Phone Number _____

Secondary Insurance Holder's ID Number _____

Secondary Insurance Holder's Group Number _____

Pharmacy Information

Current Pharmacy* _____

Pharmacy's Address* _____

Pharmacy's Zip Code* _____ Pharmacy's Phone number* _____



Medical Information

Visit Information: Referred by: _____

Principal Reason(s) for Requesting a Treatment/Consultation*:

Area of Concern (Academic/Work)

- Difficulty with peers Difficulty with authority Behavioural problems
 Learning disability Difficulty with focus and concentration
 Language / speech delay History of current academic/work problems

Areas of Concern (Personal)

- Unduly sad Suicidal thoughts/ behaviour Temper tantrums
 Withdrawn / shy Uncontrollable habits / mannerism Strange/bizarre behaviour
 Overly anxious Homicidal thought /behaviour Risk taking behaviour
 Perceptual/visual disturbance Problem with self-care (eating, bathing, toileting)

Areas of Concern (family)

- Parent child problem Sibling conflict Marital conflict or co-parenting problems
 Recent family changes Recent trauma/loss Domestic violence/abuse

* Elaborate (Family changes/trauma/loss/violence/abuse)

Current Medical Illnesses* (Enter NA if none):

Prior Psychiatric Diagnosis/Treatment:



Medication Allergies and Reactions* (Enter NA if none)

Prior/Current Primary Care Physician _____

Prior/Current Primary Care Therapist _____

Prior/Current Mental Health Provider Psychiatrist _____

Past Treatment History:

Partial Hospitalisation

Intensive Outpatient Programs Hospitalisation None

Month/Year and Reason for Hospitalization _____

Has the Patient Ever had Psychological Testing? Yes No

If yes, then please email test results to info@int-psy.com

Family Psychiatric History:

List Past/Current Psychiatric Medications Including Maximum Dosages and Frequency:
