New Patient History

Ministry of Counseling & Enrichment

When considering medications to be prescribed a complete and accurate patient history is required to minimize risk and to give the clinician a comprehensive picture of your current and past circumstances and care. Please complete all the information requested below to provide as clear a history as possible for the clinician to be fully informed when considering your case.

CLIENT INFORMATION Date: __________________

First Name: ____________________________ MI: ______ Home PH: _______________
Last Name: _______________________________________ Work PH: _______________
Address: _______________________________________ Cell PH: _______________
_______________________________________ ____ Male ____ Female
City: ______________________ State: _____ Zip: __________ SSN: _____ - _____ - _____
DOB: _____ /_____ /_____ Age: _____

Do you want Ministry of Counseling & Enrichment to file on your Medical Insurance? ____ Yes ____ No

If your answer is "YES", please fill out the below information AND the upper portion of the attached insurance form and sign in both places

Insurance Company Information

Insurance Co. Name: ____
Insurance Co. Address: ____
____
City: ______________________ State: _____ Zip: ____________

POLICY HOLDER

First Name: ________________________ MI: ______ ID #: __________________
Last Name: ___________________________________ Policy #: _______________
Address: ___________________________________ Group #: _______________
____
City: _________________ ST: _____ Zip: _________
Home PH: __________________ Work PH: _______________
DOB: ____ / ____ / ____ ____ Male ____ Female

Status (TRICARE claims): ____ Active Duty ____ Retired ____ Deceased ____ Other
What is your relationship to the insured? ____ Spouse ____ Child ____ Self ____ Other
Are you under your employer's Health Plan? ____ Yes ____ No
Employer's Name: ________________________________
Insurance Plan Name: ____________________________
Is your signature on file? ____ Yes ____ No

(*If there is another Health Benefit Plan, Please fill out another Insurance Form and write "Secondary Insurer" on the top of the form*)

GENERAL INSURANCE INFORMATION

Marital Status:
____ Single
____ Married
____ Other: ___________________________

Employment Status:
____ Employed
____ Full Time Student
____ Part Time Student

Briefly describe your reason for the clinical visit: ____

____

Current Symptoms (check all that apply):

- ☐ Poor appetite
- ☐ Weight gain
- ☐ Weight loss
- ☐ Irritable
- ☐ Poor academic performance
- ☐ Poor bladder control
- ☐ Suicidal thoughts
- ☐ Delusions (believing things to be true others do not)
- ☐ Other: ____
- ☐ Overeating
- ☐ Anxiety
- ☐ Tearful
- ☐ Anger
- ☐ Hyperactivity
- ☐ Poor bowel control
- ☐ Suicide attempt
- ☐ Insomnia
- ☐ Isolating
- ☐ Affect not matching mood
- ☐ Verbal aggression
- ☐ Poor attention span
- ☐ Loss of interest in activities
- ☐ Hallucinations
- ☐ Purposeful self-injury (cutting, scratching, burning self)
- ☐ Hypersomnia
- ☐ Poor impulse control
- ☐ Frustrated often
- ☐ Physical aggression
- ☐ Alcohol/drug abuse
- ☐ Running away

Circle the above symptoms that have persisted for at least the last 3 months.

MEDICAL HISTORY

Current Medications

Medication	Dosage	Frequency		Medication	Dosage	Frequency

Past Medications (within the last year)

Medication	Dosage	Frequency	Last taken

Check and briefly describe all that apply

	Condition	Description
	Medical hospitalization	
	Surgery	
	Serious accidents	
	Head injury with unconsciousness	
	Neurological problems	
	Cardiovascular problems	
	Respiratory problems	
	Diabetes	
	Thyroid disorder	
	Liver disease	
	Gastrointestinal disorder	
	Musculoskeletal disorder	
	Chronic pain	
	Skin problems	
	Genitourinary/kidney problems	
	Sexually transmitted disease	
	Sexual dysfunction	
	Reproductive problems	
	Cancer	
	Vision problems	
	Hearing problems	
	Speech problems	
	Seizures	
	Physical activity limited by health	

Any previous *psychiatric* hospitalizations? ☐ YES ☐ NO

If "yes" please complete the following information:

How many previous psychiatric hospitalizations? ________

Briefly list below the reason for hospitalization, approximate date, and timeframe of your hospitalization (i.e. March 2013 for 2 weeks)

Reason for hospitalization	Approx. Date	Timeframe	Facility

Below list all medical doctors of record for you in the last two years beginning with your current primary care physician:

Doctor Name	Phone	Last seen (approx.)

Which local pharmacy is your preferred pharmacy? Please specify which location if more than one exists ______________________

____

SOCIAL HISTORY

List all persons living in the home:

Name	Age	Sex	Relationship to you

Current home atmosphere (check all that apply):

- ☐ Loving
- ☐ Chaotic
- ☐ Comfortable
- ☐ Abusive
- ☐ Supportive
- ☐ Other

Current Support Systems (check all that apply):

- ☐ Family support and involvement
- ☐ Boy/girlfriend
- ☐ Community Involvement
- ☐ Involvement in school activities
- ☐ Job
- ☐ Other support groups
- ☐ None
- ☐ Spouse support and involvement
- ☐ Support of friends
- ☐ Church/Religious community
- ☐ Participation in organized sports
- ☐ 12 Step program
- ☐ Counselor
- ☐ Pets

MARITAL INFORMATION: ____ Single ____ Married ____ Widowed ____ Divorced

Previously married: ____ Yes ____ No (if “yes” # of times ____)

Spouse name: ____ DOB: ____ / ____ / ____

Spouse’s occupation and employer: ____

WORK/LEISURE INFORMATION:

Occupation: ____ How long: ______________

Place of Employment: ____

Satisfied with this job? ☐ YES ☐ NO

Please explain: ____

____

Hobbies: ____

Goals: ____

EDUCATION: (Circle highest grade completed)

	Elementary	Jr. High	High School	College
Grade:	1 2 3 4 5	6 7 8	9 10 11 12	1 2 3 4

Other Education or Training: ____

Are you currently being seen by a mental health counselor/therapist/psychologist? ☐ YES ☐ NO

If “YES”, please complete the information below.

Clinician Information.:

Name: ____

Address: ____

Phone: ____

How long have you been seeing this clinician?

For what reason have you been in counseling?