NEW PATIENT INFORMATION SHEET

Name:______________________ (Marital) (Relationship) Phone: H:______________________
(Family) Therapy W:______________________
Date:______________________ Cell:______________________

1. Describe the problems you are experiencing that you would like to change through therapy?

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2. MEDICAL PROBLEM LIST
Circle all those that you have been diagnosed as having problems with and/or treated for in the past 5 years.

NERVOUS SYSTEM: Cerebral Confusion___ Epilepsy___Headaches (Cluster, Migraines)___ Meningitis___Neuropathy___Chronic Pain___Palsy___Parkinsons___Multiple Sclerosis___Other___

CIRCULATORY SYSTEM: Heart (Angina, Cardiac Arrest, Congestive Heart Failure, Dysrhythmia, Fibrillation, Tachycardia, Mitra l Valve)___Veins/ Arteries Block___Coronary___Atherosclerosis___Hypertension___ Hypotension___Myocardinal Infarction___Other___

RESPRITORY SYSTEM: Asthyma___Bronchitis___COPD___Pneumonia___Other___

NEOPLASMS (CANCER): Leukemia___Multiple Myeloma ____ Neoplasm___Please Specify ________________
____

ENDOCRINE: Adrenal Fatigue___Diabetes___Hyperparathyroidism___Hypothyroidism___Testicular Dysfunction___Other___

NUTRITIONAL DISEASES: Mineral Deficiency___Vitamin Deficiency___

DIGESTIVE SYSTEM: Cirrhosis___Colitis___Crohn's___Diarrhea___Diverticulitis___Hepatitis___Irritable Bowel Syndrome___Pancreatitis___Ulcer___Other ____

GENITOURINARY SYSTEM: Cystitis___Dysmenorrhea___Endometriosis___Renal Failure___Fibroid of Uterus___Infertility___Menopausal___Menstruation (abnormal Bleeding)___ Genital Prolapse___ Prostatitis___Urinary Tract Infection (UTI)___Other___

BLOOD: Anemia___Coagulation Defects___Other___

EYES, EARS, NOSE, THROAT: Cataract___Glaucoma___Detached Retina___Hearing Loss___Laryngitis___ Rhinitis___Allergic___Sinusitis___Tinnitus___

MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: Arthritis___Bruxisim___Disc Disorder___Osteoarthritis___Scleroderma___Scoliosis___Other___

SKIN: Alopecia___Dermatitis___Psoriasis___Allergic Urticaria___Other___

INFECTIOUS: Candidiasis___Hepatitus (A,B,C,)___Herpes___HIV Infection___Lyme___Malaria___Mononucleosis___Trichinosis___Other___

3. List any current medical or psychological problems for which you are taking medication. Identify the medication taken for each problem, the dosage and the problem.

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4. Have you experienced any significant negative drug side effects/interactions in the past 5 years. If so please identify the drugs.____

5. List any non-prescription drugs or health products you use on a regular basis, e.g., Vitamin C, MSM, Glucosamine, etc.

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6. **PSYCHOLOGICAL PROBLEM LIST**

Check all those that you have been diagnosed as having problems with and/or treated for in the past 5 years.

Memory | Cognition/thinking | Concentration | Not Completing Tasks

Depressed (more than 2 weeks) | Suicidal Thoughts | Reoccurring Nightmares

Unusually energetic | Chronic Anger | Elevated mood | Controlling Your Thoughts

Anxious or panicky | Obsessions | Compulsions | Eating Problems

Frightening or dangerous experience (accident, natural disaster, personal attack, forced sexual experience, etc.) that continues to bother you long after it is over

Sleep problems | Insomnia | Hypersomnia (sleepy/drowsy all the time) | Sleepwalking

7. Alcoholic beverages; amount consumed per day_______, week_______
Tobacco products daily use____

8. What kind of exercise do you engage in?____________________How Often?__________

9. Are you/will you be involved in any legal proceeding related to your seeking outpatient assessment and treatment? _____Y _____N

If yes, please explain____
____
____

10. Name of your family or personal physician____
Office location (city/county)____________________________Phone__________
Date of your most recent physical exam/checkup____
How did you hear of/who referred you to Williamsburg Centre For Therapy?____________________
____

PROFESSIONAL CONTACTS

1.

a) I (do/do not) want my primary care physician to be notified that I am receiving therapy at Williamsburg Centre For Therapy.

______________________________	______________________________
Signature	Date

b) If so, do you want your therapist to coordinate treatment with ______________________________ ______________________________M.D. by verbal or written communication? (Yes _____ No _____)

c) If yes, please sign the authorization for release of information after it has been filled out by your therapist or his/her designee.

2.

a) I (do/do not) want my therapist to contact and thank my professional referral source (e.g., therapist, clergy) for referring me to therapy/counseling and to let him/her know that I have begun to work on changing myself/life.

______________________________	______________________________
Signature	Date
Therapist name______________________________	Phone______________________________

b) If yes, please sign the authorization for release of information after it has been filled out by your therapist or his/her designee.