New Beginnings Therapy Services, LLC

616 Harrison Street ~ Princeton, WV 24740

Patient Intake/Medical History

All Patient Information Is Confidential (to be completed by the patient)

Please Print - Black Ink Only (Do not leave any blanks. If it does not pertain to you write N/A)

Date: _____

Name: _____ Birthdate: _____ Age: _____

Social Security #_____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Do you prefer to receive calls ☐ Home ☐ Cell ☐ Either

Are you: ☐ Married ☐ Divorced ☐ Single ☐ Separated

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Employers Name: _____ Occupation: _____

Employers Address: _____

City: _____ State: _____ Zip: _____

If you are a student, name of college: _____

City: _____ State: _____ Zip: _____

PATIENT NAME_____ DOB_____

Patient Intake/Medical History:

Emergency Contact: _____

Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Date of Last Physical: _____ Date of last EKG: _____

List all Current or Past Medical Conditions: (check all that apply) If there is a family member with any of these illnesses please mark "F" beside it

- ☐ Asthma/Respiratory
- ☐ Hypertension
- ☐ Head Trauma
- ☐ Liver
- ☐ STD's
- ☐ Cardiovascular
- ☐ Epilepsy
- ☐ HIV/Aids
- ☐ Pancreatic Problems
- ☐ Abnormal Pap Smears
- ☐ GI Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Nutritional Deficiency

Any others not listed please describe below:

_____

_____

Is there any Family History of anything not noted:

_____

_____

Have you ever had any surgeries or been hospitalized:

_____

_____

Patient Name:_____DOB:_____

Childhood Illnesses:

☐ Measles ☐ Mumps ☐ Chicken Pox

Have you or a family member ever been diagnosed with a psychiatric or mental disorder: (please describe)

_____

_____

_____

Have you ever taken antidepressants: _____ Date of Use: _____

Name of Medication Used: _____

For what reason were you taking it: _____

Date Stopped: _____ Why Stopped: _____

Please list all current prescribed medication, dose and how often you take them:

_____

_____

Please list all herbal medications, vitamin supplements, etc. and how often you take them:

_____

_____

Please list any allergies you may have:

_____

_____

Patient Name:_____ DOB:_____

Current tobacco use: ☐ Yes ☐ No If so, What: _____

How much per day on the average: _____ How long: _____

Have you ever been treated for substance misuse ☐ Yes ☐ No

If yes, please describe when, where, and how long you attended:_____

Substance	No	Yes Now/Past	Route	How Much	Date/Time Of last use	How much
Alcohol						
Caffeine						
Cocaine						
Crystal Methamphetamines						
Heroin						
Inhalants						
LSD or Hallucinates						
Marijuana						
Methadone						
Pain Killers						
PCP						
Stimulants (pills)						
Tranquilizers (sleeping pills)						
Ecstasy						

Have you ever stopped using any of the above because of becoming dependent:

☐ Yes ☐ No

If yes, please list:_____

Patient Name_____DOB_____

Patient Clinical History and Physical Form:

Name: _____ Date: _____

Birthdate: _____ Age: _____

Check one: Race: ☐Caucasian ☐African American ☐Asian ☐Hispanic ☐Multi-Racial ☐Other

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Divorced ☐ Widowed

Family Physician: _____ Referring Physician: _____

Medical History:

☐ None
☐ Heart Disease
☐ High Blood Pressure
☐ Stroke/TIA
☐ Hypothyroid
☐ Hyperthyroid
☐ Asthma
☐ Depression
☐ Anxiety
☐ Bleeding Disorders
☐ Hepatitis: A B C
☐ HIV
☐ Obstructive Sleep Apnea
☐ Coronary Artery Disease
☐ Diabetes
☐ High Cholesterol
☐ Seizure Disorders
☐ Loss of Consciousness
☐ Arthritis
☐ Tuberculosis
☐ Allergies
☐ Emphysema
☐ Osteoporosis
☐ Cancer:
Type/Treatment_____

Past Surgical History:

1. _____
2. _____
3. _____
4. _____
5. _____

Patient Name:_____ DOB:_____

Patient Clinical History and Physical Form:

Do you have any religious beliefs that would affect your medical treatment?

☐ Yes ☐ No

What was your highest level of education:

☐ High School/GED ☐ College ☐ Post Grad ☐ Vocational

Occupational History:

Employer: _____ Job Title: _____

Has your job altered as the result of the problem you are being seen for today?

☐ Yes ☐ No

If yes, please explain:

_____

If you are currently off work as a result of why you are here today, how long have you been off? _____

Patient Name:_____DOB:_____

Father	Living Deceased	Age:	High Blood Pressure Diabetes Cholesterol Cancer: Type _____ Other: _____
Mother	Living Deceased	Age:	High Blood Pressure Diabetes Cholesterol Cancer: Type _____ Other: _____
Sister	Living Deceased	Age:	High Blood Pressure Diabetes Cholesterol Cancer: Type _____ Other: _____
Brother	Living Deceased	Age:	High Blood Pressure Diabetes Cholesterol Cancer: Type _____ Other: _____

For Females: Are you Pregnant: ☐ Yes ☐ No Are you Breast Feeding? ☐ Yes ☐ No

Number of Pregnancies: _____ Type of Birth Control: _____

Age of first menstrual cycle: _____ Date of last menstrual cycle _____

Last mammogram: _____ Last Pap: _____ Last bone density: _____

For Males: Do you ever experience impotency? _____

Do you have issues with erectile problems? _____

Date of last immunizations: Flu _____ Pneumonia _____ Tetanus _____