DRS. GAULT, FISHBEIN, & ASSOCIATES

NEW PATIENT INFORMATION SHEET

DATE: _____

(FAMILY DEMOGRAPHICS)

PATIENT:

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

FOR PATIENTS UNDER AGE 18:

MOTHER'S NAME: _____ AGE: _____ BIRTHDATE: _____

MOTHER'S PHONE: (H) _____ (C) _____ (W) _____

EMAIL: _____ OCCUPATION: _____

FATHER'S NAME: _____ AGE: _____ BIRTHDATE: _____

FATHER'S PHONE: (H) _____ (C) _____ (W) _____

EMAIL: _____ OCCUPATION: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SIBLINGS:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

(FAMILY DEMOGRAPHICS CONT.)

MARITAL STATUS OF PARENTS: (Circle One) Married Separated **Divorced*** Widowed

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***If Divorced:** Custody: _____

Visitation: _____

Child's Main Residence: _____

Divorce Agreement: _____

(EDUCATION)

SCHOOL: _____ GRADE: _____ PHONE: _____

ADVISOR NAME: _____ DEAN'S NAME: _____

SCHOOLS ATTENDED:

ELEMENTARY: _____

MIDDLE: _____

HIGH: _____

COLLEGE: _____

IS THERE A 504 PLAN IN PLACE? YES NO IS THERE AN IEP IN PLACE? YES NO

HAS YOUR CHILD EVER HAD PSYCHOLOGICAL OR PSYCHOEDUCATIONAL TESTING? YES NO

ANY DIAGNOSES FROM THAT TESTING SUCH AS LD/ADHD, ETC…?

_____

_____

_____

_____

_____

ANY PROBLEMS AT SCHOOL OUTSIDE OF ACADEMIC SUCH AS BEHAVIORAL OR SOCIAL?

_____

_____

_____

_____

_____

_____

(FAMILY MEDICAL HISTORY)

DOES THE PATIENT HAVE HISTORY OF…OR IS THERE ANY FAMILY HISTORY OF? (PLEASE NOTE RELATIONSHIP TO THE PATIENT IF THERE IS A FAMILY HISTORY):

DEPRESSION: □ YES □NO _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: □ YES □NO _____

ANXIETY: □ YES □NO _____

ADHD: □ YES □NO _____

AUTISM: □ YES □NO _____

DEVELOPMENTAL DELAYS: □ YES □NO _____

SELF-INJURY: □ YES □NO _____

ATTEMPTED/COMPLETED SUICIDE: □ YES □NO _____

ALCOHOLISM/SUBSTANCE ABUSE: □ YES □NO _____

LEARNING DISABILITIES: □ YES □NO _____

PSYCHIATRIC HOSPITALIZATION: □ YES □NO _____

HEAD INJURY: □ YES □NO _____

CONCUSSIONS: □ YES □NO _____

CARDIAC ARRHYTHMIA: □ YES □NO _____

OTHER HEART PROBLEMS: □ YES □NO _____

DIABETES: □ YES □NO _____

SEIZURE: □ YES □NO _____

SUDDEN DEATH: □ YES □NO _____

HIGH BLOOD PRESSURE: □ YES □NO _____

OTHER SIGNIFICANT FAMILY HISTORY: _____

_____

_____

_____

_____

(FAMILY MEDICAL HISTORY CONT.)

1) OTHER THERAPIST OR OTHER MENTAL HEALTH PROVIDER OUTSIDE DRS. GF&A
May I contact this person for the purposes of care coordination? □ YES □NO

NAME: _____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

2) PRIMARY CARE PHYSICIAN/PEDIATRICIAN
May I contact this person for the purposes of care coordination? □ YES □NO

NAME:_____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

3) CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)

MEDICATION NAME	DOSAGE	SCHEDULE (e.g AM, PM)	REASON

4) ALLERGIES: _____

(DEVELOPMENTAL HISTORY)

A) PREGNANCY: NUMBER OF PREGNANCIES? _____ MISCARRIAGES? _____

B) ANY COMPLICATIONS DURING PREGANCY/LABOR/DELIVERY? _____

_____

_____

(DEVELOPMENTAL HISTORY CONT.)

C) WAS ALCOHOL OR OTHER SUBSTANCES USED DURING PREGANCY? _____

_____

D) WHAT WAS THE STATE OF INFANT'S HEALTH AT BIRTH? _____

_____

E) WERE THERE ANY DEVELOPMENTAL MILESTONES DELAYED? (MOTOR, LANGUAGE, SPEECH)

_____

_____

(ADDITIONAL COMMENTS)

Is there anything else you would like to share about yourself/your child that relate to why you are seeking out treatment at this time?

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_____

(REFERRAL SOURCE)

REFERRAL SOURCE:_____ PHONE:_____