# NEW ADULT PATIENT INFORMATION

## PATIENT INFORMATION

| PATIENT'S FULL LEGAL NAME (LAST, FIRST, MIDDLE) | | | | EMAIL ADDRESS |
|---|---|---|---|---|
| SEX | AGE | DATE OF BIRTH | SOCIAL SECURITY NUMBER | |
| MAILING ADDRESS | CITY/STATE | ZIP | | MARITAL STATUS |
| HOME PHONE | CELL PHONE | BUSINESS PHONE | | OCCUPATION |

## INSURANCE INFORMATION

| PRIMARY INSURANCE COMPANY NAME | POLICY EFFECTIVE DATE | POLICY NUMBER | GROUP NUMBER |
|---|---|---|---|
| SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE) | SEX | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
| RELATIONSHIP TO PATIENT | EMPLOYER | | |
| SECONDARY INSURANCE COMPANY NAME | POLICY EFFECTIVE DATE | POLICY NUMBER | GROUP NUMBER |
| SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE) | SEX | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
| RELATIONSHIP TO PATIENT | EMPLOYER | | |

| PRIMARY CARE PHYSICIAN | PHONE NUMBER |
|---|---|
| | |

## ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR INFORMATION RELEASE

I hereby assign, transfer, and set over to Central Louisiana Medical Psychology Clinic all of my rights, titles, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information to determine these benefits. This authorization shall remain valid until written notice is given by me revoking this authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____

Patient Signature Date


Date: _____ Birthdate:_____

Name: _____
Last First M. I.

Age:_____ Sex: _____

Ethnicity:_____

Who referred you here?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you had psychotherapy or counseling before?

Drug allergies:

| CURRENT MEDICATIONS | | |
|---|---|---|
| **Name of drug:** | **Dose (include strength & number of pills per day):** | **How long have you been taking ?** |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
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| 13. | | |
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| 15. | | |
| 16. | | |
| 17. | | |
| 18. | | |
| 19. | | |
| 20. | | |
| | | |

## PAST MEDICAL HISTORY

Do you now or have you ever had: Mark (Y) YES or (N) NO

Diabetes: _____

High blood pressure: _____

High cholesterol: _____

Hypothyroidism: _____

Goiter: _____

Cancer: _____

Leukemia: _____

Psoriasis: _____

Angina: _____

Heart problems: _____

Crohn's: _____

Colitis: _____

Liver disease:_____

Anemia:_____

Jaundice: _____

Hepatitis: _____

Heart murmur: _____

Pneumonia: _____

Pulmonary embolism: _____

Asthma: _____

Emphysema: _____

Stroke: _____

Epilepsy (seizures) : _____

Cataracts: _____

Kidney disease: _____

Kidney stones: _____

Stomach or peptic ulcer: _____

Rheumatic fever: _____

Tuberculosis: _____

HIV/AIDS:_____

Covid:_____

STD:_____

Other medical conditions:

Surgical history:

## FAMILY HISTORY

| | IF LIVING | | IF DECEASED | |
|---|---|---|---|---|
| | Age (s) | Health & Psychiatric | Age(s) at death | Cause |
| Father | | | | |
| Mother | | | | |
| Siblings | | | | |
| Children | | | | |

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

**SOCIAL HISTORY**

Do you regularly exercise? _____ If yes, how often?: _____

Do you smoke cigarettes? _____ If yes, how many per day? _____

Do you smoke marijuana? _____ If yes, how much per day? _____

What is your highest level of education?

Are you currently working?

What is your current or past occupation?

Do you currently receive disability or SSI?

Do you have a history of drug or alcohol abuse?

Do you have a legal history?

Religion:

How many children do you have?

How many grandchildren to you have?

What are your hobbies?

**WOMENS REPRODUCTIVE HISTORY**

Age of first menstrual cycle:

Do you have regular periods?

Number of pregnancies:

Number of Miscarriages:

Number of Abortions:

Have you reached menopause and at what age?

OB/GYN Provider:

**SYSTEMS REVIEW**

**In the past month, have you had any of the following problems? Mark (Y) for yes or (N) for no**

**GENERAL**
____Recent weight gain
____Recent weight loss
____Fatigue
____Weakness
____Fever
____Night sweats

**MUSCLE/JOINTS/BONES**
_____ Numbness
_____ Joint pain
_____ Muscle weakness
_____ Joint swelling

**EARS**
_____ Ringing in ears
_____Loss of hearing

**EYES**
_____Pain
_____ Redness
_____ Loss of vision
_____Double or blurred vision
_____ Dryness

**THROAT**
_____ Frequent sore throats
_____ Hoarseness
_____ Difficulty in swallowing
_____ Pain in jaw

**HEART AND LUNGS**
_____ Chest pain
_____ Palpitations
_____ Shortness of breath
_____ Fainting
_____Swollen legs or feet
_____ Cough

**NERVOUS SYSTEM**
_____Headaches
_____Dizziness
_____Fainting or loss of consciousness
_____ Numbness or tingling
_____Memory loss

**STOMACH AND INTESTINES**
_____ Nausea
_____ Heartburn
_____ Stomach pain
_____ Vomiting
_____ Yellow jaundice
_____Increasing constipation
_____ Persistent diarrhea
_____ Blood in stools
_____Black stools

**SKIN**
_____Redness
_____Rash
_____Nodules/bumps
_____Hair loss
_____Color changes of hands or feet

**BLOOD**
_____ Anemia
_____Clots

**KIDNEY/URINE/BLADDER**
_____ Frequent or painful urination
_____Blood in urine

**Women Only:**
_____Abnormal Pap smear
_____Irregular periods
_____ Bleeding between periods
_____PMS

**PSYCHIATRIC**
_____Depression
_____ Excessive worries
_____ Difficulty falling asleep
_____ Difficulty staying asleep
_____ Difficulties with sexual arousal
_____ Poor appetite
_____ Food cravings
_____ Frequent crying
_____ Sensitivity
_____Thoughts of suicide / attempts
_____Stress
_____ Irritability
_____Poor concentration
_____ Racing thoughts
_____ Hallucinations
_____Rapid speech
_____Guilty thoughts
_____Paranoia
_____ Mood swings
_____ Anxiety
_____ Risky behavior

**OTHER PROBLEMS:**

**Men Only:**
_____Prostate issues
_____Erectile dysfunction
_____Low testosterone

Please save and email form to: NewPatient@centrallamedpsych.com