New Patient Evaluation Form

Name____ Today's Date: _____________________

Please list your **current** medications. Include names and dosages of over the counter vitamins and supplements. If you need more space, please include your list on a separate piece of paper.

Medication	Dosage	How many times a day do you take this medicine?

Please list **ALL** previous medications tried for depression, mania, anxiety, sleep, etc. This would include medications such as Zoloft, Lithium, Abilify, Ambien, Xanax, etc.

Medication	**Dosage**	**Year taken**	**What side effects did you have, if any?**	**Did it help?**

Please list previous psychiatrists and therapists you have seen:

Psychiatrist or Therapist	Year seen	How long did you see them for?

Please list previous psychiatric hospitalizations:

Year	Hospital	Reason for admission

Please list previous suicide attempts:

Please list your primary care physician and any other specialists you see:

Specialty	**Name of physician**	**Phone number**	**Fax number (if known)**
Primary Care Physician			

Please list any medical hospitalizations or surgeries you have had:

Year of hospitalization or surgery	**What was hospitalization or surgery for?**

What medical and psychiatric illnesses run in your family? Please include alcohol/drug dependence and suicide.

Family member	**Name of family member**	**Condition**	**How old are they? If they have passed away, how old were they when they died?**
Mother			
Mother’s side			
Father			
Father’s side			
Siblings			

Children			

What substances do you use?

Substance	**Age at first use**	**How much do you use?**	**How often do you use?**
Caffeine			
Tobacco			
Alcohol			
Marijuana			
Cocaine			
Pain pills			
Heroin			
Ecstasy			
Other			

What year did you last have labwork or an EKG? Where they normal or abnormal?

Do you have any medication allergies?

Please list what you are allergic to:	Reaction?