MEDICAL AND COUNSELING ASSOCIATES, INC.

NEW PATIENT INFORMATION

Print Name_____ Confidential Telephone #:_____

Briefly describe your reason(s) for seeking help _____
_____
_____
_____
_____
_____

When were you last examined by a physician? _____
_____

Note major illnesses, hospitalizations, surgeries and injuries_____
_____
_____
_____

Have you experienced any recent life style changes, such as weight loss/gain, exercise, energy level, sleeping and change in short/long term memory?_____
_____
_____

List any major medical health problems for which you have had or currently receive treatment such as

_____ COPD (Chronic Obstructive Pulmonary Disease)
_____ CAD (Coronary Artery Disease)
_____ CHF (Coronary Heart Failure)
_____ Asthma
_____ Diabetes
_____ Other _____
_____
_____

Has anyone in your family received treatment for or been diagnosed as having a mental disease, disorder, alcohol or drug problem? _____
_____
_____

Note significant developmental issues (e.g. Developmental Milestones? Walk early? Talk late?)
_____
_____
_____

Note significant problems/issues in educational history, give dates, graduation and or degrees conferred
_____
_____
_____

Primary Care Physician:_____ Phone:_____
Address/Location:_____

Current Medication	Dosage	Doctor Prescribing
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who referred you to our practice? _____

Have you received counseling, psychological, or psychiatric services in the past? Yes No
If yes, please provide professional's name and the date that treatment began and ended

Name of Professional	Date Began	Date Ended
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any of these that have been a problem in the past six months:

_____ Anxiety
_____ Excessive Worrying
_____ Panic Attacks
_____ Extreme Fears
_____ Unhappiness
_____ Depressed Mood
_____ Suicidal Thoughts
_____ Sleep Problems
_____ Lack of Energy
_____ Lack of Motivation
_____ Irritable Mood
_____ Anger Problems
_____ Lack of Self-Control
_____ Excessive Energy
_____ Undue Stress
_____ Recent Trauma
_____ Concentration Problems

_____ Memory Problems
_____ Work/Career Problems
_____ Educational Problems
_____ Alcohol Use/Abuse
_____ Substance Use/Abuse
_____ Legal Problems
_____ Problems with Children
_____ Marital/Relationship Problems
_____ Domestic Violence
_____ Separation/Divorce
_____ Death of Family Member/Friend
_____ Gay/Lesbian Issues
_____ Financial Problems
_____ Eating Problem/Eating Disorder
_____ Health Problems/Major Illness

_____ School Pressure
_____ Bullying past or present
_____ Family
_____ Social Network
_____ Other _____
_____
_____
_____

List the members of your family and all others in your home:

Name(s)	Age/Birth Date	Relationship	Occupation

Please add any information which you may feel may be useful to us:

_____
_____
_____
_____
_____
_____

Signature:_____ Date:_____
Clinician Signature:_____ Date:_____