New Patient Information **Maggie Hope, LPC, MHSP**

2323 21st Ave. S. Nashville, TN 37212 **615-417-9707**

Please provide the following confidential information. Please Print.

Today's Date: _____________

Client Name____ **Preferred Name**_____________________
First Middle Last

Date of Birth____________________________ **Age**_____________

Sex: F M Other or Gender Identity:_____________________________ (Specify if comfortable doing so)

Race/Ethnicity____ **Country of Origin**__________________

Disability Status (if applicable)____

Religious Affiliation or Spiritual Practice (if applicable) ____

Employer____**Job Title/Occupation**_________________

Primary Care Physician_____________________________________ **Date of Last Exam**___________________

Psychiatrist (if applicable)_____________________________________ **Date of Last Appointment**__________

Relational Status: Single Partnered Married Committed Separated Divorced Widowed
Other: ____________________________________

Length of Current Relationship______________

Dates of Previous Marriage(s)/Committed Relationship(s):____
____
____

Dependent(s) Names/ Age(s) ____
____
____

How were you referred to my practice?:____

Do You Have Any Medical Problems or History of Medical Problems? Yes No If Yes, Please Explain:
____
____
____
____
____
____

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Current Medications & Dosage (Prescription/Herbal/Other): **Prescribed by:**

____
____
____
____
____
____

Listing of Prior Treatment

Beginning with the most recent, please list all professionals (psychologists, psychiatrists, counselors, social workers, pastoral counselors, etc.) and facilities (hospitals, alcohol and drug programs, clinics, etc.) that have provided psychological evaluation and/or treatment.

Patient Initials	Type of Service (counseling, hospitalization, etc)	Provider	Dates of Service

Has anyone in your family (blood relatives) ever been diagnosed with a mental illness?___________________

____
____
____
____

Has anyone in your family ever attempted suicide?____

____
____
____
____

My symptoms include (Circle all that apply):

sadness irritability insomnia crying spells suicidal thoughts

no pleasure no energy trouble sitting still trouble concentrating fear

changes in appetite sleeping too much low self-esteem troubling thoughts

feeling paranoid feeling out of control thoughts of harming others

confused or forgetful alcohol abuse hopelessness helplessness

excessive or inappropriate guilt excessive or inappropriate anger worrying

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panic attacks indecisiveness impulsivity racing thoughts

irritability relationship difficulties physical symptoms________________________________

Others:____

Briefly Describe the Main Problems/Reasons That Bring You Here:

____

____

____

____

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____

What Would You Like To Achieve and/or See Happen By Coming Here For Care?

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____

What kinds of physical activity do you get?

____

____

Do you try to restrict your eating in any way? ____No ____Yes If Yes, how? ___________________________

____

____

Do you have any problems getting enough sleep? ____No ____Yes If Yes, what problems?

____

____

How many cups of regular coffee do you drink each day? _____ **How many cups of tea?** ____

How many sodas with caffeine? ____ **How many "energy drinks"?** ____ **How often do you use caffeine pills?** _______ **How much tobacco do you smoke or chew each week?** _____________________________ **How much beer, wine, or hard liquor do you consume each week, on average?** _____________________

____

Have you ever felt the need to cut down on your drinking? ____No ____Yes

Have you ever felt annoyed by criticism of your drinking? ____No ____Yes

Have you ever felt guilty about your drinking? ____No ____Yes

Have you ever felt you needed a drink first thing in the morning to steady your nerves or get rid of a hangover? ____No ____Yes

Have you ever had a DUI? ____No ____Yes If yes, when and where? _________________________________

Have you ever had an alcohol or drug-related arrest? ____No ____Yes If yes, when, and what was the charge?: ____

Which drugs (not medications prescribed for you) have you used in the last 10 years? Note how often you have used, their effects, and so forth.

____

____

____

____

Have you ever been exposed to or witnessed any of the following: actual or threatened death, actual or threatened serious injury, or actual or threatened sexual violence? ____No ____Yes If yes, please explain:

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____

____

Have you ever been abused in any way? ____No ____Yes If yes, ___Emotional ____Physical ____Sexual

When and by whom: ____

____

How did/do your parents/caregivers get along with each other?

____

____

____

How were/are your relationships with parents/caregivers? ______________________________

____

____

How many siblings do you have? How did/do you get along?

____

____

____

Did anyone in your family abuse alcohol or drugs, experience mental or emotional difficulties, or have serious medical concerns? ____No ____Yes If yes, please explain: ______________________________

____

____

Has anyone in your family been diagnosed with a mental illness? ____No ____Yes If yes, please explain:

____

____

Has anyone in your family ever attempted suicide? ____No _____Yes If yes, please explain: ______________

____

____

How do you get along with friends? Are you satisfied with your social support? __________________

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____

____

How do you get along with your current spouse or partner? ____

____

____

How do you get along with your children? ____

____

____

Are you presently suing anyone or thinking of suing anyone? ____No ____Yes If yes, please explain:

____

Is your reason for coming to see me related to an accident or injury? ____No ____Yes If yes, please explain:

____

Are you required by a court, the police, or a probation/parole officer to have this appointment? ____No ____Yes If yes, please explain: ____

Do you have past or current domestic violence charges or convictions? ____No ____Yes If yes, when, where, and nature of the charge(s)/conviction(s): ____

5. **Do you have any past or current felony convictions? ____No ____Yes If yes,** when, where, and the nature of the conviction(s):

____

6. **Are there any other legal involvements I should know about?** ______________________________________

____

L. Is there any other information you think I should know about your health or history?