Adult New Patient Assessment

Demographic Information
Date:_____
Patient Name:_____
Name of person completing form:_____
Relationship to Patient if other than patient:_____
Patient Date of Birth:_____ Age:_____
Patient Social Security Number:_____
Home Address: _____
_____
Phone: _____ (home)
_____ (cell)
_____ (work)
Email: _____ (Patient)

Referred by:_____

Insurance/Billing Information
Insurance Company Name:_____
Policy or ID number:_____
Group or Account number:_____
Name of Policy Holder:_____
Address and Phone Number of Policy Holder (if different from above):
_____
_____
Social Security Number of Policy Holder:_____
Policy Holder's Date of Birth:_____

Emergency Information
Name of Emergency Contact: _____
Relationship to Patient: _____
Daytime phone number(s) for contact: _____
Evening phone number (s) for contact: _____

Authorization
My signature below attests to the fact that the above information is true to the best of my knowledge. I approve payment be made to Summit Mental Health Services for services that I receive. I understand that I may be responsible for payment in the event that my benefits do not cover the services provided. I authorize Summit Mental Health Services to release required information to my insurance company to justify services being covered by my insurance provider.

_____ _____
Signature Date

Summit
MENTAL HEALTH SERVICES

Name: _____
Date of Birth: _____
Place of Birth: _____
Ethnicity: _____
Age: _____

Please list the reason for today's appointment: _____
_____
_____
_____

How long has this been an issue? _____
Please list the ways you have attempted to alleviate the issue so far: _____
_____

Social History

Please name the people who live in your home, their ages, and occupation:

Name	Age	Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any children not living in the home:_____

Who raised you? _____
Number of sisters? _____ brothers? _____
How would you describe your relationships with your family of origin? _____
_____

Did you suffer abuse as a child? Yes No
If so, what kind? Physical Sexual Neglect Please describe: _____
_____
_____

Is there a history of domestic violence in your current or any of your past relationships? Yes No

Please circle the appropriate description of your identified sexuality below:
Heterosexual Homosexual Bisexual Transgender

Has anyone in your family been diagnosed with a mental health issue in the past? Please list the family member and the diagnosis below:

_____

_____

If you are married or have children, how would you describe your relationship with you spouse and/or children? _____

What are the three biggest stressors in your life?

1. _____
2. _____
3. _____

How would you describe your network of friends or relationships with members of your community?

_____

_____

Please list the extracurricular activities that you currently enjoy: _____

Employment History

Please list your past three employers and your duration of employment at each.

Employer	Duration of Employment
_____	_____
_____	_____
_____	_____

Are you satisfied with your current employment situation?	Yes	No
Do you have satisfactory relationships with coworkers?	Yes	No
Is your relationship with your boss positive?	Yes	No

Description of current job duties: _____

_____

Educational History

Highest grade level achieved: _____

High School attended: _____

College attended and area of study:_____

Postgraduate education: _____

History of academic problems?	Yes	No
History of behavioral problems?	Yes	No
History of any type of learning issues (i.e. learning disabilities)?	Yes	No

Marital and Legal History

Currently married? If so, please list your spouse's name and duration of the marriage to date:
Name _____ Duration_____

Previous marriages? If so, please list the duration of the marriages, spouse name, and reason the marriage ended:

From	To	Spouse name	Reason marriage ended
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been arrested? Yes No
Describe: _____
Have you ever served crime for a criminal conviction? Yes No
Describe: _____
Have you ever been involved in legal proceedings for any reason other than an arrest?
Yes No Please Describe: _____

Medical History

Please list all past medical issues and state their status today:

Diagnosis	Date diagnosed	Current status
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications (include vitamins and supplements):

Medicine name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

What time do you typically go to bed? _____
Wake in the morning? _____
How many hours of sleep do you usually get? _____

Psychiatric History

Please list all previous psychiatric/behavioral health providers, both inpatient and outpatient. List the provider's name and the dates of treatment to the best of your ability.

Provider name /Treatment facility	Diagnosis	Dates of service
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever attempted suicide in the past? Yes No

If yes, please describe the situation: _____

_____

Are you currently having suicidal thoughts? Yes No

If yes, please describe the thoughts: _____

_____

Current psychiatric medications

Medicine name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

Please list any past psychiatric medications and dosages:

_____

_____

My mood is usually (circle all that apply): Stable Happy Sad Tense

Unstable Angry

In the past thirty days have you had trouble with (Circle all that apply):

Falling asleep	Staying asleep	Concentrating	Completing tasks	low sex drive
Weight gain	Feeling worthless	Loss of interest in preferred activities	Appetite changes	Feeling excessively tired
Weight loss	Irritability	Social isolation	Aches and pains	Crying episodes
Feelings of being invincible	Excessive energy	Mood swings	Recurrent, unwanted thoughts	Focusing on one thing
Overwhelming need to complete rituals	Excessive fears	Excessive focus on weight or body parts	Visual hallucinations	Auditory hallucinations
Excessive concerns about health	Poor self esteem	Missing work/school	Aggression/Explosive Anger	sexual performance issues
Shortness of breath	Dizziness	Memory loss	Work related performance issues	Conflict with loved one
Chest pain	Sweating	Nausea	Risk taking	self injury

Substance Abuse History

Have you ever been treated for a substance abuse issue? Yes No

If yes, please describe: _____

Please state your current use of the following substances:

Substance	Use per week
Alcohol	_____
Cigarettes	_____
Caffeine	_____
Marijuana	_____
Cocaine	_____
Prescription pills	_____
Meth Amphetamine	_____

Are you seeking substance abuse treatment at this time? Yes No