Marni L. Jacob, Ph.D.
New Adult Patient Information Form

Patient's Name: _____ Date: _____

Age: _____ DOB: _____/_____/_____ Sex: _____ Race: _____

Address: _____ Phone (H): _____

_____ Phone (C): _____

_____

Who referred you for this evaluation? _____

Briefly describe the reason for your visit: _____

_____

_____

_____

What are your goals for treatment? _____

_____

_____

_____

Marital Status: ☐

1 = Single
2 = In a relationship
3 = Married
4 = Divorced
5 = Widowed
6 = Other (specify):_____

Living Situation: ☐

1 = Lives alone
2 = Lives with spouse
3 = Lives with significant other
4 = Lives with roommates
5 = Lives with parents
6 = Other (specify):_____

Do you have children? ☐ NO ☐ YES

If YES, please indicate the following information:

Name (or initials)	Age	Does s/he reside with you?	Biological? Step-Child? Adopted?

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Are you currently attending school? ☐ NO ☐ YES

If YES, (specify school/degree): _____

Patient's highest education received: ☐

1 = Some high school
2 = High school graduate
3 = Obtained GED
4 = Some college
5 = University/College Graduate
6 = Graduate School (MA/MS/PhD/MD/etc)

Current Occupation: _____

Length of Time in Current Job: _____

Family Information

Are your parents/caregivers currently living? ☐ NO ☐ YES ☐ OTHER

If NO/OTHER, please specify: _____

Names (or initials) and Ages of Siblings (including adopted/step/half-siblings): _____

_____

How well do you get along with:

siblings ☐ excellent ☐ well ☐ fair ☐ poor ☐ terrible ☐ n/a

parents ☐ excellent ☐ well ☐ fair ☐ poor ☐ terrible ☐ n/a

relatives ☐ excellent ☐ well ☐ fair ☐ poor ☐ terrible ☐ n/a

Has anyone in your family had a mental, emotional, or behavioral problem? ☐ NO ☐ YES

If YES, please fill in the chart below.

Relationship to Patient	Father's Side	Mother's Side	Diagnosis

Medical History

Have you previously participated in therapy for an emotional/psychiatric/behavioral problem? ☐ NO ☐ YES

If YES, please complete the following:

Diagnosis/Purpose of Treatment	Therapist Name, Location	Dates of Treatment	Response to Therapy/ Reason for Stopping

Have you ever been hospitalized for an emotional/psychiatric/behavioral problem? ☐ NO ☐ YES

If YES, please complete the following:

Diagnosis/Purpose of Treatment	Hospital Name, Location	Dates of Treatment	Response to Treatment/ Reason for Stopping

Have you previously taken psychiatric medication for an emotional/psychiatric/behavioral problem? ☐ NO ☐ YES

If YES, please complete the following:

Medication and dose	Diagnosis/Reason Prescribed	Prescribing Physician, Location	Dates on Medication	Response / Any side effects?

Do you have a history of physical, sexual, or emotional abuse, or any significant trauma? ☐ NO ☐ YES

If YES, please specify: _____

_____

_____

Do you have a history of any significant medical illnesses, surgeries, or hospitalizations? ☐ NO ☐ YES

If YES, please specify: _____

_____

_____

Do you currently have problems with sleep? ☐ NO ☐ YES

If YES, please specify: _____

_____

Do you currently have problems with appetite, or have you exhibited significant recent weight changes? ☐ NO ☐ YES

If YES, please specify: _____

_____

Are you currently taking any <u>other</u> medications (besides those for psychiatric purposes)? ☐ NO ☐ YES

If YES, please complete the following:

Medication and dose	Diagnosis/Reason Prescribed	Prescribing Physician, Location	Dates on Medication	Response / Any side effects?

How much caffeine do you typically drink? _____

How much alcohol do you drink? (Note: a drink is 1 beer, 1 glass of wine, or a mixed drink with 1.5 oz of liquor in it)

- ☐ None
- ☐ Up to 2 drinks in a week
- ☐ Up to 7 drinks in a week
- ☐ Two to five drinks daily
- ☐ Over 5 drinks daily
- ☐ Other _____

Do you currently smoke cigarettes? ☐ No ☐ Yes If so, how much? _____

Do you currently use recreational drugs, or excessively use prescription or non-prescription drugs? ☐ NO ☐ YES

If YES, please specify: _____

_____

Has anyone ever told you that you have a problem with drugs or alcohol? ☐ NO ☐ YES

If YES, please specify: _____

_____

How many **close** friends do you have? ☐ None ☐ 1-2 close friends ☐ Several close friends

Do you feel that you currently have a good social support network? ☐ NO ☐ YES

Please specify: _____

_____

_____

Do you currently engage in any enjoyable activities or hobbies? ☐ NO ☐ YES

If YES, please specify: _____

_____

Are you currently involved in any legal matters? ☐ NO ☐ YES

If YES, (specify): _____

_____

_____

Are you currently applying for disability or planning to apply within the next 6 months? ☐ NO ☐ YES

If YES, (please explain why): _____

_____

_____

Is there anything else in particular that is important for me to know? If so, please specify: _____

_____

_____

_____

_____

_____