DRS. GAULT, FISHBEIN, & ASSOCIATES

NEW PATIENT INFORMATION SHEET

DATE: _____

(FAMILY DEMOGRAPHICS)

PATIENT:

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

FOR PATIENTS UNDER AGE 18:

MOTHER'S NAME: _____ AGE: _____

MOTHER'S PHONE: (H) _____ (C) _____

MOTHER'S EMAIL: _____ OCCUPATION: _____

FATHER'S NAME: _____ AGE: _____

FATHER'S PHONE: (H) _____ (C) _____

FATHER'S EMAIL: _____ OCCUPATION: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SIBLINGS:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

(FAMILY DEMOGRAPHICS CONT.)

MARITAL STATUS OF PARENTS: (Circle One) Married Separated **Divorced*** Widowed

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***If Divorced:** Custody: _____

Visitation: _____

Child's Main Residence: _____

Divorce Agreement: _____

(EDUCATION)

SCHOOL: _____ GRADE: _____ PHONE: _____

ADVISOR NAME: _____ DEAN'S NAME: _____

SCHOOLS ATTENDED:
ELEMENTARY SCHOOL: _____
MIDDLE SCHOOL: _____
HIGH SCHOOL: _____
COLLEGE: _____

IS THERE A 504 PLAN IN PLACE? YES☐ NO☐ IS THERE AN IEP IN PLACE? YES☐ NO☐

HAS YOUR CHILD EVER HAD PSYCHOLOGICAL OR PSYCHOEDUCATIONAL TESTING? YES☐ NO☐

WEREN ANY DIAGNOSES YIELDED FROM THAT TESTING SUCH AS LD/ADHD, ETC…?

_____
_____
_____
_____
_____

ANY PROBLEMS AT SCHOOL OUTSIDE OF ACADEMIC SUCH AS BEHAVIORAL OR SOCIAL?

_____
_____
_____
_____
_____
_____

(FAMILY MEDICAL HISTORY)

DOES THE PATIENT HAVE HISTORY OF…OR IS THERE ANY FAMILY HISTORY OF? (PLEASE NOTE RELATIONSHIP TO THE PATIENT IF THERE IS A FAMILY HISTORY):

DEPRESSION: □ YES □NO _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: □ YES □NO _____

ANXIETY: □ YES □NO _____

ADHD: □ YES □NO _____

AUTISM: □ YES □NO _____

DEVELOPMENTAL DELAYS: □ YES □NO _____

SELF-INJURY: □ YES □NO _____

ATTEMPTED/COMPLETED SUICIDE: □ YES □NO _____

ALCOHOLISM/SUBSTANCE ABUSE: □ YES □NO _____

LEARNING DISABILITIES: □ YES □NO _____

PSYCHIATRIC HOSPITALIZATION: □ YES □NO _____

HEAD INJURY: □ YES □NO _____

CONCUSSIONS: □ YES □NO _____

CARDIAC ARRHYTHMIA: □ YES □NO _____

OTHER HEART PROBLEMS: □ YES □NO _____

DIABETES: □ YES □NO _____

SEIZURE: □ YES □NO _____

SUDDEN DEATH: □ YES □NO _____

HIGH BLOOD PRESSURE: □ YES □NO _____

OTHER SIGNIFICANT FAMILY HISTORY: _____

_____

_____

_____

(FAMILY MEDICAL HISTORY CONT.)

1) OTHER THERAPIST OR OTHER MENTAL HEALTH PROVIDER OUTSIDE DRS. GF&A
May I contact this person for the purposes of care coordination? □ YES □NO

NAME: _____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

2) PRIMARY CARE PHYSICIAN/PEDIATRICIAN
May I contact this person for the purposes of care coordination? □ YES □NO

NAME:_____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

3) CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)

MEDICATION NAME	DOSAGE	SCHEDULE (e.g. AM, PM)	REASON

4) ALLERGIES: _____

(DEVELOPMENTAL HISTORY)

A) PREGNANCY: NUMBER OF PREGNANCIES? _____ MISCARRIAGES? _____

B) ANY COMPLICATIONS DURING PREGANCY/LABOR/DELIVERY? _____

(DEVELOPMENTAL HISTORY CONT.)

C) WAS ALCOHOL OR OTHER SUBSTANCES USED DURING PREGANCY? _____

_____

D) WHAT WAS THE STATE OF INFANT'S HEALTH AT BIRTH? _____

_____

E) WERE THERE ANY DEVELOPMENTAL MILESTONES DELAYED? (MOTOR, LANGUAGE, SPEECH)

_____

_____

(ADDITIONAL COMMENTS)

Is there anything else you would like to share about yourself/your child that relate to why you are seeking out treatment at this time?

_____
_____
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_____
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_____

(REFERRAL SOURCE)

REFERRAL SOURCE:_____ PHONE:_____