

**CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA**

**New Patient History**

Name \_\_\_\_\_ Date \_\_\_\_\_

Name of person completing form if different from patient \_\_\_\_\_

Referred by \_\_\_\_\_

Reason for appointment \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and phone number for any current mental health provider \_\_\_\_\_  
\_\_\_\_\_

Previous Treatments (Please list therapists, psychiatrists, medications, hospitalizations and approximate dates. Include substance abuse treatment.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please have records forwarded to our office.)

Current Medications (prescription and over the counter)

Name	Dose	When started	Side Effects	Prescribed by
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medication Allergies \_\_\_\_\_  
\_\_\_\_\_

Primary Care Provider (name, address, phone, fax) \_\_\_\_\_  
\_\_\_\_\_

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**For women only** – Please inform your provider if there is any chance you are, or will become pregnant, now or at any time during treatment. **Psychiatric meds are not proven safe in pregnancy.** Abruptly discontinuing medication and/or psychiatric illness may also pose a risk to a pregnancy.

I am not pregnant and, if sexually active, am using reliable birth control to prevent pregnancy. I will contact my mental health provider and advise them of any pregnancy or plan to become pregnant so that risks and benefits may be discussed. Initials\_\_\_\_\_

Medical and Neurologic History (Please list any significant illnesses or injury.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Substance Use History

Alcohol - How much do you drink? \_\_\_\_\_

Do you have, or have you had, a problem with alcohol? \_\_\_\_\_

Have family or friends ever been concerned about your use of alcohol? \_\_\_\_\_

Caffeine – How much caffeine do you have on an average day? \_\_\_\_\_

Cigarettes – Do you smoke and if so how much? \_\_\_\_\_

Street Drugs – Do you or have you used any street drugs? (Please state what and how much.) \_\_\_\_\_

Over the counter and prescription medications - Do you, or have you, ever used more than the prescribed dosage or for longer than recommended? \_\_\_\_\_

Developmental History (Please list any problems, complications or delays in development from pre-birth through early childhood.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Education History (Please list any problems you had in school and your highest level of education.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Work History (Please list your current or most recent employment and any employment problems that may be related to mental health concerns.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychosocial History (Please list recurrent or current interpersonal problems, marriage history and any history of verbal, physical or emotional abuse.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family and Family Psychiatric History (Please list first names, ages and medical or mental health history of family members. Please indicate if there is any adoption history including your own.)

Spouse \_\_\_\_\_  
\_\_\_\_\_

Children \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parents \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Extended Family Members (if relevant) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other information you would like us to know \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_