CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

New Patient History

Name_____Date_____

Preferred name if different: _____

Legal gender: _____ Gender identity if different: _____

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 have records forwarded to our office.)

Please list therapists, psychiatrists, hospitalizations and approximate dates. Please include substance abuse treatment.) _____

_____

_____

_____

Previous medications (Please indicate if you think they helped and if they caused side-effects.)

_____

_____

_____

Current Medications, Vitamins, and Supplements (List both prescription and over the counter medications and all vitamins and supplements)

_____

_____

_____

_____

_____

_____

Medication Allergies _____

_____

Primary Care Provider (Please include office phone number) _____

_____

610 Jones Ferry Road Suite 208
Carrboro, NC 27510-6113

Phone: 919.636.5695
Fax: 919.442.1105

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New Patient History con't

For women only – Psychiatric meds are not proven safe in 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 all current diagnoses and any significant illnesses or injury.)

_____

_____

_____

Cardiac Screen: Do you have a history of: Heart disease or heart problems? _____ Fainting without explanation and possibly without warning? _____ An abnormal EKG or Long QTc? _____ A very slow heart rate (less than 50 beats per minutes)? _____ Low potassium, magnesium or calcium in your blood? _____ Has anyone in your biologic family died from a heart attack before age 40? _____

Sleep Screen: Do you have a known sleep disorder such as: Obstructive Sleep Apnea? _____, Restless Leg Syndrome? _____ Narcolepsy? _____ Other (please list) _____

Do you feel rested most mornings? _____ Frequently feel tired during the day? _____ Snore? _____ Sometimes have a strange feeling in your legs, or have to move them, especially at night? _____

Substance Use History

Alcohol - How much alcohol 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?_____

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.) _____

_____

_____

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

_____

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

Family Members and Family Medical and 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/Significant other

Children

Parents

Extended Family Members (if relevant)

Other information you would like us to know

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