BRANCHES COUNSELING CENTER
Recovering Hope • Restoring Lives

MENTAL HEALTH MEDICATION MANAGEMENT NEW PATIENT INFORMATION FORM

General

Name: _____ DOB: _____ Age: _____ Gender: M or F

Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Home Phone: _____ Which is preferred? Cell or Home

If necessary, may voicemails with possible confidential information be left with your preferred number? Y or N

Email address: _____ May I contact you by email? Y or N

How did you hear about us?: _____

Emergency Contact: Name: _____ Relationship: _____ Number: _____

Reason for Visit

Describe your reason(s) for making this appointment: _____

_____

Medical History

Please indicate if you have any of the following mental health diagnoses:

	Alcohol / Drug abuse		Eating Disorder (Anorexia/Bulimia/ Binge Eating Disorder)		Panic Attacks
	Anxiety		History of Hospitalization due to Mental Health		PTSD
	Attention Deficit Disorder		History of Suicide Attempt		Schizophrenia
	Bipolar Disorder		History of Self Harm		Other: _____
	Depression		History of Trauma (Physical/Sexual/ Emotional)		Other: _____

Please list all medications you are currently taking:

Drug	Dose	Frequency	Prescribing Physician

___ check here if additional space is required for medications and write the medications on the back of this page

Primary Care Provider: _____ Phone: _____ Fax: _____

Allergies to Medications: _____

Please indicate if you have any of the following:

	Asthma		Dementia		Diabetes
	Fibromyalgia / Chronic Pain		Hepatitis		Hypertension
	Irregular Heart Rate		Pregnant or Breast Feeding		Seizures / Epilepsy
	Stroke		Thyroid Problems		Sexually Transmitted Disease

Please list and describe any other condition or problem that you think your provider should know about:

_____

Family History

Please indicate if anyone in your family has or had any of the following conditions:

	Alcohol / Drug abuse		Bipolar Disorder		History of Suicide Attempt
	Hospitalization due to Mental Health		Other: _____		Other: _____

If yes, please indicate your relationship (mother, brother, etc) and details of their condition:

_____

Social History

Are you currently married or in a committed relationship? Y / N If so, for how long? _____

Are you currently employed? Y / N If so, who is your current employer? _____

Please describe your religious/spiritual background: _____

Do you exercise regularly? If so, please describe the nature of your exercising and how often: _____

_____

How would you describe your diet/eating habits? _____

_____

Please describe the outcome you are hoping for from this visit and future visits: _____

_____

_____ _____

Patient Signature **Date**