New Patient Information

Contact Information:

Client Name:________________________________ Age:_________

Home Phone:________________________________ Is it ok to leave a message?: yes no

Cell Phone:__________________________________ Is it ok to leave a message?: yes no

E-mail Address:____ Is it ok to send a message?: yes no

Living Situation:

Please identify those living in your household.

Name	Age	Relationship

Who will be participating in therapy? ____

How were you referred to me? ____

Medical Information:

Primary Care Physician:____

Date of last physical: ____

Are you currently prescribed any medication? If yes, please describe: ______________________________

____

Medical History (Hospitalization, surgery, chronic pain):____

____

Tele-Health Only
PO Box 711442
Herndon, VA 20171
www.malekawalters.com
703-474-7410

Psychiatric History

Have you ever seen a psychiatrist, counselor, or social worker in the past? If yes, please describe:______

____

____

Have you ever been prescribed psychotropic medication? If yes, please describe:__________________

____

Have you ever experienced any of the following?: Please check.

Suicidal Thoughts Suicidal attempt Homicidal Thought Homicidal actions

Violent Relationship Physical Abuse Sexual Abuse Neglect

Emotional Abuse Rape Traumatic Event

Substance Abuse History:

Have you ever used (currently or in the past)?: Please check.

Cigarettes Alcohol Marijuana Cocaine

Street Drugs Prescription Drugs for recreational use

Have you ever received treatment for substance abuse? If yes, describe:______________________________

____

Current Concerns and Reason for Treatment:

____

____

____

____

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