Roz Davidovich, PsyD
900 Walt Whitman Rd., Suite 302
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New Patient Information Form

Name: _____ Date: _____

Date of Birth: _____ Place of Birth: _____ Sex: M / F

Address: _____

Insurance Information

Primary Health Insurance: _____ ID number: _____

Subscriber Name: _____ Relationship to Subscriber: _____

Subscriber Date of Birth: _____

Contact Telephone Numbers

	Phone Messages okay?	Primary Contact Number?
CELL: (___) _____	☐ Yes ☐ No	☐
HOME: (___) _____	☐ Yes ☐ No	☐
WORK: (___) _____	☐ Yes ☐ No	☐

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____ Phone # _____

Marital Status

☐ Single ☐ Married (___ years) ☐ Divorced (___ years) ☐ Other _____

Spouse's/Partner's Name: _____

If I can't reach you, is it okay to contact your spouse/partner? ☐ Yes ☐ No ☐ N/A

If yes, spouse/partner's phone number: (___) _____

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Household composition

Name	Relationship	Age

How many of years of school did you complete? _____

Employment Status:

Are you employed? ☐ No ☐ Yes → **Occupation:** _____

If unemployed, for how long? _____

Are you unemployed due to a disability? ☐ No ☐ Yes → _____

_____

_____

Name of Primary Care Physician: _____ Phone**:** _____

_____

Do you have any current physical illnesses or medical problems? ☐ No ☐ Yes ⇩

_____

_____

_____

Please describe the primary concern that led to this appointment: _____

_____

_____

_____

_____

_____

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Have you ever received psychological or psychiatric services before? ☐ No ☐ Yes ⇩

When (approx.)?	From Whom?	For What?	With What Results?

Have you ever taken medications for mood/anxiety/emotional difficulties? ☐ No ☐ Yes ⇩

Name of Med	When (approx.)?	From Whom?	For What?	With What Result?

Substance Use:

1. Have you ever felt the need to cut down on your drinking (or other substance)? ☐ No ☐ Yes
2. Have you ever felt annoyed by criticisms of your drinking (or other substance)? ☐ No ☐ Yes
3. Have you ever felt guilty about your drinking (or other substance)? ☐ No ☐ Yes
4. Have you ever taken a morning "eye-opener?" ☐ No ☐ Yes
5. How much beer, wine, or hard liquor do you consume each week, on average?_____
6. How much tobacco do you smoke each week, on average_____
7. What drugs (**not** medications prescribed for you) have your used?

What Substance?	Current or past use?	Age(s)?	How often?

Please indicate if you've ever had:

☐ Blackouts ☐ Withdrawal symptoms ☐ An overdose(s) ☐ Detox (in hospital)

☐ Rehab (in hospital/outpatient setting) ☐ None of these

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Please describe/answer the following:

- Your parents' relationship with each other when you were a child (verbal/physical fights, etc):
- Your parents' physical health, substance use or emotional difficulties when you were a child:
- Your relationship with your parents when you were a child:
- Your current relationship with each parent:
- Your relationship with your siblings in the past and present:
- Were you raised by anyone other than your parents? If yes, please elaborate:
- Is there anything significant that I need to know about your childhood that may be related to current or past mental health concerns: