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Dedicated secure fax line: 562 595 7703

New Patient History/Intake Information

Please complete all of the information on this form and send, fax or bring it to the first visit. The form is quite detailed but we want to be well informed to be able to provide the best help. Many of the questions require only a check, so it will go quickly. You may need to ask family members for some information. If there is something that you are still not certain how to answer or don't feel comfortable putting it on paper now, you may discuss it with us in person during your visit. Thank you very much!

Referred by _____ Phone/Address _____
<input type="checkbox"/> Self <input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Specialist <input type="checkbox"/> Psychologist/Psychotherapist <input type="checkbox"/> Family <input type="checkbox"/> Friend

1. Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** ____ **Gender:** M F **SS#** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (____) _____ **Cell:** (____) _____ **Work:** (____) _____

May we contact you at home? YES NO

May we contact you on your cell? YES NO

May we contact you at work? YES NO

E-Mail: _____

Race and Ethnicity – please forgive the format but our electronic medical record requires it this way

Ethnicity: [] Non-Hispanic [] Hispanic [] Not Specified

Race: [] African or African-American [] Asian or Asian-American [] Caucasian or European

[] Native American or Alaska Native [] Native Hawaiian [] Pacific Islander

[] Other: _____

How did you hear about us? _____

Person financially responsible, if not yourself? _____

Relation: _____ **Phone:** (____) _____

Address: _____

Emergency Contact Info

Name: _____

Relation: _____ **Phone:** (____) _____

Address: _____

Reason for your visit - what can we help you with?

2. Current Care Providers

Specialty	Name (with credentials)	Phone #
Primary Care Physician		
Psychotherapist		
Other		

3. Psychiatric History:

Regarding the current issue, when was the last time you were functioning at your usual emotional baseline? _____

Looking back at your life, at what age do you think you were emotionally different than your peers? _____

What is the earliest age that you saw a psychotherapist, counselor or a psychiatrist? _____

What diagnosis, if any, was given? _____

Any history of suicidal attempts? [] Yes [] No

If yes, please provide approximate dates, means, and other details: _____

4. Previous Psychiatric Treatment (may use separate page if necessary)

Form of Treatment	Purpose of Treatment	Provider(s) Facility(ies)	Location(s)	Approximate Dates
Psychiatric Hospital	Number of admissions: - Voluntary: _____ - Involuntary: _____			
Electro-Convulsive				
Residential				
Partial Hospitalization or Intensive Outpatient (IOP)				
Outpatient Psychotherapy or Counseling				
Family/Couples Therapy				
Therapeutic Groups				
Other				

6. Psychotropic medications used (Please underline meds with “good” response and circle meds with “bad” reactions): _____

7. Medical History:

If you have never received a diagnosis of cancer, other malignancies or oncologic problems, please go to the next page.

Any history of Cancer, Oncologic Diagnosis or Other Malignancy:

Approximate date of the original diagnosis:

Location: _____ Pathology/Receptor Status _____

If cancer has recurred, please specify the approximate date(s) and location(s) of recurrence

Forms of treatment to date:

Surgery (approximate dates, types): _____

Chemotherapy (who administered it?) _____

Radiation (approximate dates, area of the body irradiated, in what facility) _____

Hormonal therapy _____

Other (including Complementary/Alternative): _____

Forms of support:

Beat the Odds; Peer Mentorship; Oncology Coach; Support Group(s); Other: _____

Oncologist(s) names and phone numbers:

Do you have any questions to your doctors about your diagnosis or treatment? If yes, please list them here: _____

How would you like your doctors to communicate “bad news” to you?

Did you receive your Survivorship Care Plan? Yes No

- If yes, please bring a copy with you for your next appointment.

Please check all of the following which you now have or have had in the past:

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> COPD | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fainting/Dizziness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent/Severe Headaches |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Carpal Tunnel Syndrome |

Other illnesses or injuries not specified above:

Please list **surgeries** that you have undergone and approximate dates (exclude oncology if listed above):

Please list **alternative or complementary** treatments that you have used or are using:

Pain:

Do you have any pain associated with your disease? Yes No

If so, please indicate the level of your pain on the scale from 0 to 10, where 0 is no pain and 10 is the worst pain that you have ever experienced: 1 2 3 4 5 6 7 8 9 10

8. Substance Use

Alcohol Yes No Age when you began using: _____

Quantity/Frequency: _____ Most Recent Use: _____

Cigarettes Yes No Age when you began using: _____

Quantity/Frequency: _____ Most Recent Use: _____

Pipe, cigars, or chewing tobacco Yes No Age when you began using: _____

Quantity/Frequency: _____ Most Recent Use: _____

9. Illicit Drug Use History [] Yes [] No

Age when you began using: _____

Substance _____

Quantity/Frequency: _____ Most Recent Use: _____

Substance _____

Quantity/Frequency: _____ Most Recent Use: _____

Substance _____

Quantity/Frequency: _____ Most Recent Use: _____

Substance _____

Quantity/Frequency: _____ Most Recent Use: _____

History of Substance Abuse Treatment [] Yes [] No

Detox [] Yes [] No

Residential [] Yes [] No

Explain: _____

10. List Allergies To Foods Or Medications:

Medication or Food	Reaction	Affected Organs	Severity of Reaction
		<input type="checkbox"/> Skin <input type="checkbox"/> Nose <input type="checkbox"/> Lungs <input type="checkbox"/> GI <input type="checkbox"/> Generalized <input type="checkbox"/> Other _____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Anaphylactic Shock
		<input type="checkbox"/> Skin <input type="checkbox"/> Nose <input type="checkbox"/> Lungs <input type="checkbox"/> GI <input type="checkbox"/> Generalized <input type="checkbox"/> Other _____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Anaphylactic Shock
		<input type="checkbox"/> Skin <input type="checkbox"/> Nose <input type="checkbox"/> Lungs <input type="checkbox"/> GI <input type="checkbox"/> Generalized <input type="checkbox"/> Other _____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Anaphylactic Shock
		<input type="checkbox"/> Skin <input type="checkbox"/> Nose <input type="checkbox"/> Lungs <input type="checkbox"/> GI <input type="checkbox"/> Generalized <input type="checkbox"/> Other _____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Anaphylactic Shock
		<input type="checkbox"/> Skin <input type="checkbox"/> Nose <input type="checkbox"/> Lungs <input type="checkbox"/> GI <input type="checkbox"/> Generalized <input type="checkbox"/> Other _____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Anaphylactic Shock

11. Lifestyle and Health Behaviors:

I. Nutrition:

a. Any recent changes in weight or eating habits? [] Yes [] No

If yes, please describe: _____

b. How many meals do you usually eat per day? _____

c. In the last week, how many times did you eat sitting in front of TV? _____

d. In the last week, how many servings of fruits and vegetables did you eat every day? _____

e. Are you engaging in any unhealthy food related behaviors like bingeing, purging, and restricting?

[] Yes [] No

If yes, please explain what behaviors and how many times per month _____

f. Did you notice any obstacles or challenges in healthy eating? [] Yes [] No What were they?

II. Physical Activity:

In the **past week** on average:

- How many times were you physically active for more than 7 minutes at a time? _____
- How many times did you break into sweat from physical activity? _____
- How many times did you intentionally increase your normal activity (by for example taking stairs instead of the elevator/escalator or walking instead of driving)? _____
- How many times did you need to talk yourself against resistance to engage in physical activity? _____
 - How many times did you overcome this resistance? _____
- Did you notice any obstacles or challenges to physical activity? What were they?

III. Sleep:

Do you have difficulty falling or staying asleep? [] Yes [] No
If yes, please describe your difficulties?

Do you wake up rested? [] Yes [] No

In the **past week** on average:

- How many hours did you sleep per each 24 hours? _____
- Did you have any nightmares? [] Yes [] No
- On average, what was the quality of your sleep?

Very good	Good	Fair	Not so good	Bad	Very bad
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- What did you do, to assure good quality of your sleep?

- Did you notice any obstacles or challenges in healthy sleeping? What were they?

IV. List below your own 2 behaviors, that you know are unhealthy but you keep engaging in them.

- Unhealthy Behavior 1:** _____

- In the past week, how many times did you engage in this behavior? _____
- What would be a healthier behavior?

- Did you notice any obstacles or challenges in engaging in a healthier instead of unhealthy behavior? What were they?

- Unhealthy Behavior 2:** _____

- In the past week, how many times did you engage in this behavior? _____
- What would be a healthier behavior?

- Did you notice any obstacles or challenges in engaging in a healthier instead of unhealthy behavior? What were they?

12. Family History:

	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Anxiety	[]	[]	[]	[]	[]
Insomnia/Sleep problems	[]	[]	[]	[]	[]
Depression	[]	[]	[]	[]	[]
Suicide Attempts/Thoughts	[]	[]	[]	[]	[]
Current Suicidal Thoughts/Plans	[]	[]	[]	[]	[]
Alcoholism	[]	[]	[]	[]	[]
Drug Problems	[]	[]	[]	[]	[]
Mental/Emotional Problems	[]	[]	[]	[]	[]
Eating Problems	[]	[]	[]	[]	[]
Psychiatric Hospitalizations	[]	[]	[]	[]	[]
Extreme Mood Swings	[]	[]	[]	[]	[]
Dementia/Alzheimer Disease	[]	[]	[]	[]	[]
Heart Disease	[]	[]	[]	[]	[]
Cancer	[]	[]	[]	[]	[]
Diabetes	[]	[]	[]	[]	[]
High Blood Pressure	[]	[]	[]	[]	[]
Stroke	[]	[]	[]	[]	[]
Other: _____	[]	[]	[]	[]	[]

13. Current Medications: Instead of copying them to this form, you can give us the list of these medications on a separate sheet (*including prescriptions, over-the-counter medicine, vitamins and herbal supplements*)

Medication	Dosage	Frequency	Began Taking	Prescribed By

Social History:

14. Family Background and Childhood History:

Were you adopted? [] Yes [] No

Where were you born? _____

Where did you grow up? _____

Please list the ages of your brothers and sisters:

What was your father's occupation?

What was your mother's occupation?

Did your parents divorce? []Yes; []No; If yes, how old were you when they divorced? _____

If your parents divorced, who did you live with afterwards? _____

Describe your relationship with your father:

Describe your relationship with your mother:

How old were you when you left home?

Has anyone in your immediate family died? []Yes; []No;

Who and when?

15. Relationship Status

[]Single []Dating []Partnered/Common Law []Married []Divorced []Separated []Widowed

Duration of Current Relationship: _____

Level of satisfaction with the relationship: 1 2 3 4 5 6 7 8 9 10
Not Satisfied Very Satisfied

What is/was the occupation of your spouse/partner?

If married before, list number of your marriages and how long they lasted:

Names, Sex, and Ages of Children: _____

#1 M F Age ___ Name _____ #2 M F Age ___ Name _____ #3 M F Age ___ Name _____
#4 M F Age ___ Name _____ #5 M F Age ___ Name _____

Children still residing with you: _____

16. Educational History:

Highest grade level completed: _____ Degree: _____ Field of Study: _____

History of Learning Disability? []Yes []No If yes, explain: _____

17. Vocational History/Economical:

Are you currently: [] Working [] Student [] Unemployed [] Disabled [] Retired

Current job: _____

Level of satisfaction with job: 1 2 3 4 5 6 7 8 9 10
Not Satisfied Very Satisfied

Previous jobs: _____

How many people depend on your income? _____

Level of stress related to financial situation: 1 2 3 4 5 6 7 8 9 10
No Stress Very High Stress

18. Military History:

Have you ever served in the military? [] Yes [] No

If yes, what branch and when? _____

Have you ever been in combat? _____

If yes, where and when? _____

Honorable discharge [] Yes [] No

Other type discharge _____

19. Legal History:

Have you ever been arrested/incarcerated [] Yes [] No

If yes, when and how many times? _____

Do you have any pending legal problems? _____

20. Religion/Spirituality:

In what, if any, religion or spiritual tradition were you raised?

Are you practicing any form of spirituality or religion? [] Yes [] No

If yes, please say more about it:

21. Social Support System:

List people you can count on for practical help and/or emotional support in the time of need:

22. List 5 or more activities that bring you joy:

Is there any more information that you want to share with us?

Patient Signature

Date

Thank you very much for completing this form!