MindHope of Oviedo
We Specialize in Psychiatric Evaluations and Treatment of Adults 21 and older

Today's Date:_____
Insurance ID#_____
Mobile Number: ( )
Home Phone Number: ( )
Email:

NEW PATIENT INFORMATION

All questions contained in this form(s) are strictly confidential and will become part of your medical record.

Name:	**Last Name:**	**Gender** ☐ **M** ☐ **F**	**DOB:**
Address Number:	**Street Name**	**City:**	**State:** **Zip:**
Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**			
Primary doctor:_____ **Phone Number:( )**	**Previous Psychiatrist or Referring doctor:**_____ **Phone Number:**	**Name of Psychotherapist:** _____ **Phone Number:**	
In case of Emergency, who should be notified?		**Phone Number:**	**Relation to Patient:**

HEALTH HISTORY/MENTAL HEALTH HISTORY

MEDICAL REVIEW: PLEASE CHECK BELOW IF YOU HAVE HAD OR HAVE ANY OF THE FOLLOWING

☐ Arthritis	☐Kidney problems	☐ Heart attack	☐Cancer	☐ Skin
☐ Ulcers	☐Diabetes	☐ High blood pressure	☐Chronic headaches	☐Head/Neck
☐ Thyroid problems	☐Chest Pain	☐ Low blood pressure	☐Colitis	☐ Lungs
☐Back	☐Intestinal	☐Circulation	☐Bladder	☐Other:

☐ Flu	☐ E.*Coli*	☐ Confusion
☐ COPD	☐ Schizophrenia	☐ Fibromyalgia
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Zika Virus	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Menopause symptoms	☐ Circulation	☐ MS symptoms

List any medical problems that other doctors have diagnosed:

Have you ever had a blood transfusion? Yes___ No____ When:_____

Surgeries

Year	Reason	Hospital

Name of Patient (please print): _____

Other hospitalizations		
Year	Reason	Hospital

Patients Name:		**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**
Medication Name	Strength	Frequency Taken

Allergies to medications	
Name the Medication	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
	Have you experience any Trauma? Briefly explain				☐ Yes	☐ No

Name of Patient (please print): _____

	Have you been physically/verbally abuse?	☐ Yes	☐ No
		☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

HISTORY OF MENTAL HEALTH PROBLEMS IN YOUR FAMILY

	AGE	PROBLEM/DIAGNOSIS
Father		
Mother		
Sibling	☐ M ☐ F	**Other:**

Is stress a major problem for you?	Yes☐	☐No
What stresses you the most?		
Do you feel depressed? How long have you been feeling depressed? _____	Yes☐	☐No
Do you panic when stressed?	Yes☐	☐No
Do you dislike yourself?	Yes☐	☐No
If you feel angry, do you tend to keep quiet about it initially, but later erupt and really lose your temper?	Yes☐	☐No
Have you experienced repeated or unexpected "attack" during which you suddenly are overcome by fear for no apparent reason	Yes☐	☐No
Do you have upsetting or distressing thoughts, impulses, or images that happen in your mind over and over again?	Yes☐	☐No
Do you have a hard time stopping yourself from doing certain things repeatedly, such as: checking things, washing your hands, re-arranging objects, repeating things until it feels "right", collecting useless objects, and or repeating words silently?	Yes☐	☐No
Has there ever been a period of time when you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	Yes☐	☐No
Have you ever spent money on things you didn't need and got your or your family into trouble?	Yes☐	☐No
Do you have feelings of guilt or remorse after overeating?	Yes☐	☐No
Do you cry frequently?	Yes☐	☐No
Have you ever attempted suicide? How long ago_____ Was this your first time____ If No how many other times have you attempted suicide?____ What made you change your mind?	Yes☐	☐No
Have you ever seriously thought about hurting yourself? Please explain. Have you ever thought of hurting someone else? Any mental health hospitalization or Rehabilitation? ___Yes ___No How long ago?_____	Yes☐	☐No
Do you have trouble sleeping?	Yes☐	☐No
Have you ever been to a counselor? How long ago?	Yes☐	☐No

Name of Patient (please print): _____

Please use this page to write any additional information you may feel is important.

"Where Transformation begins
By changing lives forever"

Note: Please make sure that your name appears in each page

Name of Patient (please print): _____

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Please check all that apply to you:

- ❍ Depressed
- ❍ Sadness
- ❍ Crying Spells
- ❍ Loss of Interest
- ❍ Anxiety
- ❍ Panic Attack
- ❍ Irritability
- ❍ Rages
- ❍ Fearfulness
- ❍ Feelings of hopelessness
- ❍ Feelings of helplessness
- ❍ Insomnia
- ❍ Hypersomnia
- ❍ Fatigue
- ❍ Forgetfulness
- ❍ Poor concentration
- ❍ Headaches
- ❍ Blurred vision
- ❍ Constipation
- ❍ Diarrhea
- ❍ No appetite
- ❍ Increased appetite
- ❍ Bingeing
- ❍ Thoughts of Suicide
- ❍ Purging Nausea
- ❍ Vomiting
- ❍ Low energy
- ❍ Excessive Energy
- ❍ Risky Activity
- ❍ Weight loss
- ❍ Weight gain
- ❍ Muscle aches
- ❍ Stomach pain
- ❍ Sexual dysfunction
- ❍ Hallucinations
- ❍ Paranoid thinking
- ❍ Obsessive Worry/Habits
- ❍ Guilt
- ❍ Impulsivity
- ❍ Sleep changes
- ❍ Avoidance
- ❍ Racing Thoughts
- ❍ Suspiciousness

Name of Patient (please print): _____