New Patient Information Form
CBT-DBT, LLC
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Name _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

e-mail address _____

What is your preferred way for us to contact you? ☐ (H) ☐ (W) ☐ (C) ☐ (E-mail)

Date of Birth _____ Marital Status _____ ☐ Male ☐ Female ☐ Other

Employer or School _____ ☐ Full time ☐ Part time

Referred by _____ Phone _____

May we contact this person for relevant information? ☐ yes ☐ no

In case of an emergency, whom should we contact? _____

Relationship _____ Phone # (H) _____ (W) _____

Current living situation ☐ alone ☐ spouse/partner ☐ family ☐ other

Names, ages and occupations or other relevant information about those living with you:

Spouse/partner _____

Children/other _____

_____

What is the main problem that led you to contact us? _____

_____

_____

_____

What should we know about the history of this problem?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What is the most important thing you would like to get from this treatment?

_____

_____

_____

_____

_____

_____

Current Medications	Dose	Purpose

Who prescribes them? _____ ☐ MD ☐ APRN

What other psychiatric medication have been prescribed for you in the past?

Medications	Dose	Was it helpful?	Why did you stop?

Past treatment for psychological, behavioral or emotional difficulties:

Inpatient Hospital Treatment (name, date, reason and length of stay)

_____

_____

_____

Outpatient Treatment (therapist's name, date, was it helpful?)

_____

_____

_____

_____

_____

Medical History: Date of last physical examination _____

Do you have current medical problems for which you are receiving treatment?

☐ yes ☐ no If yes, what? _____

Current primary care provider _____

Intoxicant Use History: In the past month, what intoxicants have you used?

	Yes or No	**Amount**	**Form**	**Alone or Socially**	**Did you think it was excessive?**	**Did anyone else think it was excessive? who?**	**Earlier History?**
Alcohol							
Cannabis/Pot							
Cocaine							
Ecstasy, LSD							
Opiates							
Amphetamines							
Other							

Has the quality of your life ever been reduced by your substance use? ☐ yes ☐ no

Did you ever tried to stop or reduce your on your own? ☐ yes ☐ no

Have you ever received treatment for substance abuse? ☐ yes ☐ no

If yes, when? _____

Social and Developmental History: Is there anything we should be aware of regarding your childhood development, including but not limited to:

physical developmental issues_____

verbal abuse_____ physical abuse_____ sexual abuse _____

learning or school difficulties_____

stressful separations/deaths/divorces_____

parent or sibling with serious illness, alcohol/drug use_____

accidents, fires, assaults_____

other_____

Education: Highest grade completed _____ College _____

How would you describe yourself as a student? _____

Occupational History:

☐ employed ☐ unemployed ☐ student ☐ homemaker ☐ retired ☐ disabled

Current employer _____

How do you spend your days? _____

Family History:

Names	Age	Health or alcohol/drug abuse difficulties	Briefly describe present and past relationship
Mother			
Father			
Other parent figure			
Sibling			
Sibling			
Sibling			
Sibling			

Other important current relationships_____

Religious practice_____

Financial stress_____

Legal concerns_____

Any other information you'd like to share_____

_____