SUMMIT PSYCHOLOGICAL SERVICES

NEW/UPDATED PATIENT DEMOGRAPHICS

Personal Information		
First Name:	Last Name:	Today's Date:
DOB:		Sex:
Address:		
Email:		Phone:
Insurance:		Policy #:

Current Work Situation:

☐ Full-Time	☐ Part-Time	☐ Student	☐ Unemployed	☐ Disabled	☐ Retired
Active Military? ☐ Yes ☐ No			If yes, for how long?		

Emergency Contact Name:	Relationship:	Phone:

Is there anyone (family member, loved one, close friend, etc.) who you would like to allow to access your information from our practice (such as appointment dates and times, the ability to talk to your provider(s), etc.)?

Name:	Relationship:	Phone:

If you are over the age of 14, is there anyone legally designated as your Power of Attorney or Legal Guardian?

Authorized Representative's Name:	Relationship:
Authority to Act on Behalf of Patient:	Phone:

Medical and Psychiatric History		
Height:	Weight:	BMI:
Allergies:		
When was the last time that you had your blood pressure and blood work taken?		
Do you monitor your blood pressure and blood sugar regularly at home? ☐ Yes ☐ No		

Please check any of the following that apply to you:

☐ Personal history of cardiovascular disease	Managed by a PCP/doctor?	☐ Yes ☐ No
☐ Personal history of diabetes	Managed by a PCP/doctor?	☐ Yes ☐ No
☐ Personal history of high cholesterol	Managed by a PCP/doctor?	☐ Yes ☐ No
☐ Personal history of high blood pressure	Managed by a PCP/doctor?	☐ Yes ☐ No
☐ Personal history of obesity	Managed by a PCP/doctor?	☐ Yes ☐ No

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Other Current Providers:

Practitioner Name	Profession (Therapist/Counselor, Psychiatrist, PCP, etc.)	May we exchange information with this provider?

Past Mental Health Treatments/Programs and Dates:

Office/Facility/Practitioner	Date(s) Attended

Past Mental Health Diagnoses:

Name of Condition	Date Diagnosed

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Current Psychiatric Medications:

Medication Name	How long have you been taking this medicine for?	Do you feel that this medication works?	Do you take this medication regularly as directed?	What, if any, significant side effects do/have you experienced?

Past Psychiatric Medications:

Medication Name	Why did you stop this medication?	How long did you take this medicine for?	Did the medicine seem to work for you?	Did you take this medication regularly as directed?	What, if any, significant side effects did you experience?

Please use the back of this page to add any additional providers, treatments, diagnoses, or medications that were not able to fit into the above sections.

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Family History of Mental Health Conditions

Were you adopted? ☐Yes ☐No	If yes, at what age?

Please list any mental health illnesses experienced by the below family members (if known):

Relationship	Treated with Medication?	If yes, which medications?
Mother:		
Father:		
Siblings:		
Maternal Grandparents:		
Paternal Grandparents:		

Please check any of the following that apply to your family:

☐Family history of cardiovascular disease	Which member(s)?
☐Family history of diabetes	Which member(s)?
☐Family history of high cholesterol	Which member(s)?
☐Family history of high blood pressure	Which member(s)?
☐Family history of obesity	Which member(s)?

Chief Complaint and Current Symptoms

What is your major complaint/why are you seeking services?

_____

_____

_____

Check all current symptoms that you are experiencing:

☐Anxiety	☐Depression	☐Weight Loss/Gain	☐Homicidal Thoughts	☐Alcohol Use
☐Panic Attacks	☐Fatigue	☐Change in Libido	☐Excessive Energy	☐Substance Use
☐Irritability	☐Crying Spells	☐Loss of Interest	☐Impulsive Behavior	☐Hallucinations
☐Racing Thoughts	☐Sleep or Appetite Issues	☐Self-Harm	☐Difficulty Concentrating	☐Other: _____
☐Mood Swings	☐Loss of Energy	☐Suicidal Thoughts	☐Risky Activity	

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Please check any of the below that you have tried or are currently using:			
☐ Alcohol	☐ Marijuana	☐ K2	☐ Ecstasy
☐ Tobacco	☐ Cocaine	☐ Tranquilizers	☐ LSD/Hallucinogens
☐ Juul	☐ Opiates/Stimulants (Pills)	☐ Methamphetamines	☐ Methadone
☐ Kratom	☐ Pain Killers	☐ Heroin	☐ Suboxone
If you checked any of the above, please list how often you use each:			

Have you ever abused prescription drugs? ☐ Yes ☐ No	If yes, which ones?	
Have you ever been treated for drug or alcohol abuse? ☐ Yes ☐ No	If yes, when?	
Do you smoke cigarettes/vape or use another form of tobacco? ☐ Yes ☐ No	If yes, which type and how many times per day?	
Do you drink caffeinated beverages? ☐ Yes ☐ No	If yes, how many per day?	
*Would you like for your practitioner to provide a referral to help with quitting? ☐ Yes ☐ No		

Have you at any time in the past or are your currently experiencing any of the below?

Abuse or Trauma		Details
Physical Abuse or Neglect	☐ Yes ☐ No	
Sexual Abuse or Neglect	☐ Yes ☐ No	
Psychological Abuse or Neglect	☐ Yes ☐ No	
Been a Victim of Domestic Violence	☐ Yes ☐ No	
Witnessed Domestic Violence	☐ Yes ☐ No	
Traumatic Loss	☐ Yes ☐ No	
Victimization	☐ Yes ☐ No	
Community Violence	☐ Yes ☐ No	
Medical Trauma	☐ Yes ☐ No	
Terrorism	☐ Yes ☐ No	
Natural Disaster	☐ Yes ☐ No	
Migration Trauma (Refugees, Asylum Seekers)	☐ Yes ☐ No	
Other:		
*Would you like for your practitioner to provide a referral to a specialist to focus more on this abuse/trauma? ☐ Yes ☐ No		

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Are you currently struggling with any of the following hardships that might make it hard for you to get help?

Problem		Details
Transportation Issues (no car, limited access to a ride etc.)	☐Yes ☐No	
Financial Issues (trouble making copays, no money for the bus, etc.)	☐Yes ☐No	
Lack of Support from Friends or Family	☐Yes ☐No	
Lack of Support in the Community	☐Yes ☐No	
Other:		
*Would you like for your practitioner to provide a referral that can potentially help with this hardship? ☐Yes ☐No		

Is there anything else that you would like your provider to know?

_____

_____

_____

_____

Signature of Patient (14 years of age or older) *Date*

_____

Signature of Parent (if under the age of 14), Legal Guardian, or Authorized Representative *Printed Name* *Date*

Oral Authorization (for persons physically unable to sign): I witness that the patient understood the nature of this form, and freely gave all information as well permission for a staff member of Summit Psychological Services to fill out this form on their behalf.

_____

Signature of Witness/Staff Member *Printed Name* *Date*

Office Use Only:				
☐Copies of legal docs obtained (POAs, etc.)	☐ROIs completed & signed	☐Release info entered into Kareo	☐Ht & Wt entered into Kareo, BMI recorded here	☐Note made in chart of any referrals needed
Staff Initials:			Date Completed:	
Notes:				