

NEW PATIENTS

Please call to schedule an appointment.

PLEASE FILL IN AND BRING THIS WITH YOU TO THE FIRST VISIT. IF YOU PREFER, YOU CAN EMAIL IT TO maryannmcdonnell@yahoo.com OR FAX IT TO 781-735-0457 PRIOR TO YOUR APPOINTMENT.

NAME:

DATE OF BIRTH:

ADDRESS:

CELL PHONE:

EMAIL:

PARENT OR GUARDIAN (IF MINOR) OR EMERGENCY CONTACT:

IF USING INSURANCE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF INSURANCE COMPANY:

ID NUMBER:

GROUP NUMBER:

NAME OF SUBSCRIBER TO INSURANCE:

SUBSCRIBER'S ADDRESS AND PHONE #:

SUBSCRIBER'S DATE OF BIRTH:

PLEASE BRING COPY OF INSURANCE CARD TO FIRST VISIT!!

Have you ever had suicidal thoughts or attempted suicide? Yes ___ No___

Have you ever had homicidal thoughts or violent behavior? Yes ___ No___

Have you ever been hospitalized for emotional or behavioral problems?

If so, please list the following:

Name of Hospital Dates of hospitalization Reason for hospitalization

FAMILY HISTORY OF PSYCHIATRIC DISORDERS:

FAMILY MEMBER DIAGNOSIS

MOTHER:

FATHER:

GRANDPARENTS:

SISTERS:

BROTHERS:

CHILDREN:

COUSINS:

AUNTS OR UNCLES:

OTHER RELATIVE:

Have you ever abused drugs or alcohol? Yes ___ No___

Has anyone ever been concerned about your alcohol use? Yes ___ No___

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LIST OF CURRENT MEDICATIONS:

<u>NAME OF MEDICATION</u>	<u>DOSE</u>	<u>TIMES TAKEN PER DAY</u>	<u>REASON FOR TAKING IT</u>

MEDICAL HISTORY

PLEASE LIST ANY PAST OR CURRENT MEDICAL PROBLEMS: PLEASE CHECK YES OR NO

	YES	NO		YES	NO
CONCUSSION			ASTHMA		
TRAUMATIC BRAIN INJURY			HEART PROBLEMS		
SEIZURES			LUNG PROBLEMS		
BLOOD CLOTS			GLAUCOMA		
ABNORMAL BLEEDING			LIVER PROBLEMS		
STOMACH PROBLEMS			KIDNEY PROBLEMS		

ANY OTHER MEDICAL PROBLEMS? PLEASE DESCRIBE:

IS THERE ANY CHANCE THAT YOU COULD BE PREGNANT? YES___ NO___

WHEN WAS YOUR LAST PHYSICAL?

WHEN WAS THE LAST TIME YOU HAD BLOOD DRAWN?

****If you have had neuropsychological testing done, please bring a copy with you to your visit.**