WC PSYCHNET | TELEVATECOMP CARE

Connecting Minds Raising Awareness

New Patient Paperwork

Demographics

Full Name: _____ Date of Birth: ____/____/_____
FIRST MI LAST SUFFIX MM DD YYYY

Address Line#1:_____ Sex Assigned at Birth: Female____ Male____

Address Line#2:_____ City:_____ State_____ Zip:_____

Email: _____ Phone:_____

SSN #:_____ Race:_____ Ethnicity:_____

Pronouns: She/her☐ He/him☐ They/them☐

Sexuality: Heterosexual☐ Homosexual☐ Bisexual☐ Pansexual☐

Marital Status: Married☐ Separated☐ Divorced☐ Widowed☐ Single_____

Previous Marriages: _____ # Previous Divorces: _____ Relationship Status: _____

Biological Children _____ Ages: _____

Stepchildren_____ Ages: _____

Emergency Contact

Full Name: _____ Relationship to Contact: _____
FIRST MI LAST SUFFIX

Phone Number: _____ Email: _____

Address Line#1: _____ Address Line#2:_____

City: _____ State: _____ Zip code:_____

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Social History

Place of Birth:_____ Where did you grow up(City, State):_____

Where do you currently live?
House____ Apartment_____ Trailer_____ Townhouse_____ Camper_____ Car_____
Assisted Living_____ Homeless_____

With whom? _____

Do you currently smoke any type of cigarette or e-tobacco product? Yes____ No_____

Previous use? Yes____ No____

If yes, how many years? _____ When did you stop? _____ How many packs or how much per day or week? _____

Have you ever had a DUI? Yes____ No____

Do you have a military history? Yes ___ No____ Service:_____ Rank_____ MOS:_____

Were you ever deployed overseas? Yes____ No____ Do you have an honorable discharge? Yes___ No____

History of Trauma? Yes___ No___ If yes, Physical ___ Mental____ Sexual ____

Have you ever had any suicidal ideation or attempts? Yes____ No____

Have you ever had outpatient mental health treatment? Yes ___ No____

Have you ever been admitted voluntarily or involuntarily to a mental hospital? Yes___ No☐

If so, when and where _____

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Family History

Do any blood relatives have any mental or nervous conditions? Yes___ No___

Do any blood relatives have any substance abuse conditions? Yes___ No___

Do any blood relatives have a history of violence? Yes____ No____

Mother
Living ☐ Yes ☐ No If no, age when deceased ____ Highest level of education ___ # marriages____

Did mom work when you were a child if so, what occupation?_____

What do you remember the most about your mom? _____

Father
Living ☐ Yes ☐ No If no, age when deceased ____ Highest level of education ___ # marriages____

Did dad work when you were a child if so, what occupation?_____

What do you remember the most about your dad? _____

Siblings
# of brothers ____ # of half-brothers ____ # of sisters___ # of half-sisters____

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Education

Did you have any trouble meeting year developmental milestones, like walking, talking, throwing the ball, making friends, toilet training, or separating from your parents? Yes____ No____

Any trouble with stuttering? Yes____ No____

Any special education, or IEPs in school? Yes____ No____

Did you ever get pushed forward a grade or held back a grade? Yes____ No____

Did you ever have juvenile behaviors such as cruelty to animals, fire setting, lying, stealing fighting, truancy, destruction of property, drugs or alcohol, arrest, sexual behaviors, forgery, bullying, or being bullied? Yes____ No____

Have you ever had in-school or out-of-school detention or been expelled from school? Yes____ No____

What is your highest level of education? _____

Degree	**School /location**	**Year Awarded**

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Occupational History

Please list all your employment since high school starting with your most recent

Date From -To	Employer	Job Title

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Medical History

Please list any chronic conditions:

Date Diagnosed	Condition	Current Doctor

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Have you ever been on any medication for mental or nervous conditions? Yes____ No____

List all medication (including supplements):

Name	Dose	Doctor	Started When

Allergies to Medications? Yes____ No____

Medication	Reaction

Please list all surgeries:

Date	Surgery	Provider	Body Part (left right)

Specific Conditions	Yes/No	Date
Have you had Glaucoma		
Seizure		
Head Injury		
Loss of consciousness		
Times in your life where you could go for days without needing sleep		
Seeing things or hearing things that others do not		
Need for order that others find difficult to manage		
Perfectionistic qualities		
Cleaning routines that are hard to manage		
Worry about worry		
Nightmares		
Trouble making and keeping friends		
Food issues		
Have you ever been arrested		
Have you ever been suspended from school or expelled		
Did you have an IEP in school		

Any history of substance use? Yes____ No_____

Have you had any substance use treatment? Yes_____ No_____

If yes, please complete below:

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Substance	Date Started	Date Stopped if stopped	Quantity Per Day	Route (oral, nasal, inhale, inject, etc)
Caffeine				
Alcohol				
Marijuana				
LSD				
Methamphetamine				
Cocaine				
Crack				
Kratom				
PCP				
Methadone				
Psilocybin				
Mushrooms				
Heroin				
Prescription Drugs not prescribed				
Xanax, or other benzodiazepines not prescribed				
Adderall or other stimulants not prescribed				
Other				

I hereby confirm that I have diligently completed all necessary paperwork, providing accurate and truthful information. I fully understand that this information will be utilized by the healthcare provider for the purpose of my treatment, ensuring the best possible care based on my medical history and needs.

Patient Name:_____ Patient Signature: _____ Date:_____