Dayspring Psychological Services
13-15 East Deer Park Drive, Suite 103D
Gaithersburg, MD 20877
(240) 686-6885

NEW PATIENT INFORMATION FORM

Patient Name:_____ Date of First Session: _____

Primary Complaints (Check all that apply):

___ Alcohol/Substance Abuse
___ Adjustment to a new situation
___ Anxiety
___ Depression
___ Divorce
___ Domestic Violence
___ Eating Disorders
___ Grief and Loss
___ Job Dissatisfaction
___ Medical Issues
___ Obsessive thoughts/Behaviors
___ Panic Attacks
___ Post Traumatic Stress
___ Relationship Issues
___ Schizophrenia
___ Sexual Abuse
___ Sexual Dysfunction
___ Suicide/Homicidal Thoughts
___ Other: _____

Please feel free to share specific details as to what brings you to therapy: _____

_____

_____

_____

Background Information

Relationship Status (circle): Single Married Partnered Separated Divorced Widowed

If married/significant relationship, name of spouse/partner: _____

How long married/together? _____

Names and ages of children: _____

_____

Where were you born? _____ Where were you raised? _____

Names of parents and ages: Mother_____ Father_____

Sibling(s) names and ages: _____

_____

Is there anyone in the family who has been diagnosed with a mental health/psychiatric condition? Yes No

If yes, list name and condition: _____

_____

Occupation:_____How many years? _____

Employer:_____

Highest grade/degree attained _____ From what program/school?_____

If currently unemployed, when was the last day you worked? _____

If retired, when did you retire?_____

From what occupation?_____

If student, name of school:_____ Grade/Year:_____

If disabled, what caused it?_____ When? _____

Do you receive disability benefits? Yes No If yes, when did you start receiving benefits? _____

Have you been in therapy before? Yes No If yes, when?_____

For what issues/concerns/diagnoses?_____

Have you ever been evaluated by a psychiatrist for medication? Yes No If yes, when? _____

Do you have any medical/physical conditions or diagnoses? _____

_____

Please list any medications and dosages you are currently taking (including over-the-counter meds):

_____ _____

_____ _____

_____ _____

Have you ever been hospitalized for mental health issues? Yes No If yes, when? _____

Where?_____ How long?_____

Do you smoke cigarettes? Yes No If yes, how much per day? _____

Do you drink alcohol? Yes No If yes, how much per day or week or month? _____

Have you ever been in treatment for alcohol-related problems? Yes No

If yes, when, where and for how long? _____

Have you ever used illicit drugs? Yes No If yes, which one(s)? _____

And when did you last use? _____

Any legal history or history of arrests? Yes No If yes, please describe briefly the circumstances: _____

_____

Experiences of Trauma: Without going into too much detail, please list dates and significant events in your life which you may consider traumatic or outside the norm of your regular experience (e.g., accidents, natural events, abuse, difficult transitions, loss). _____

_____

_____

_____

What are your hobbies or interests?_____

_____

_____