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All Things New Therapy Services, Inc.
111 Arizona Ave. NW
Orange City, IA 51041
P: 712.737.9444
F: 712.737.9445
office@allthingsnewtherapy.org
www.allthingsnewtherapy.org

New Patient Information - Adult

To help your clinician understand your concerns, please answer the questions on this form and bring it with you to your first appointment. Please print using black or blue ink.

Patient's Legal Name: ______________________________ Date of birth: ____________

Form completed by: ______________________________ Today's date:____________

Did anyone refer you to All Things New? ______________

PRESENTING PROBLEM/REASON FOR TREATMENT

What is your primary reason for coming to All Things New? ______________________________

____

____

Please check any concerns you may have in the boxes below :

☐ Loss of interests/not enjoying things ☐ Guilt ☐ Decreased energy ☐ Concentration difficulty ☐ Loss of appetite ☐ Sleep difficulties ☐ Thoughts of suicide or self-harm	☐ Easily distracted ☐ Taking risks ☐ Feeling overly important ☐ Racing thoughts ☐ Talkative ☐ Little need for sleep ☐ Very active/on the go all the time	☐ Anxiety worry ☐ Panic attacks ☐ Avoid going places ☐ Avoid being with others ☐ Checking things repeatedly ☐ Perfectionist ☐ Fears
☐ Depression ☐ Feeling helpless/hopeless ☐ Episodes of crying ☐ Moody ☐ Feeling empty inside ☐ Afraid of rejection ☐ Angry/easily irritable	☐ Stomach aches ☐ Headaches ☐ Backaches ☐ Eating difficulties ☐ Body image difficulties ☐ Sexual difficulties ☐ Sexual addictions	☐ Concerns with drinking alcohol ☐ Concerns with drug use ☐ Past alcohol/drug use ☐ Recreational drug use ☐ Thoughts of hurting others ☐ Legal problems ☐ Work problems
☐ Difficulty remembering ☐ Confusion ☐ Getting lost more often ☐ Difficulty making decisions	☐ Feeling suspicious at times ☐ Having strange experiences ☐ Hearing voices ☐ Seeing things	☐ Financial problems ☐ Learning problems ☐ Relationship problems ☐ Gambling

Are there other concerns (not listed above) that you want to discuss? ______________________________

____

How have these concerns impacted your daily life?______________________________

____

What do you consider to be your strengths? ______________________________

What do you consider to be your weaknesses? ______________________________

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New Patient Information - Adult

RACE & ETHNICITY

RACE: (Optional) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Two or more races ☐ White

SEXUAL ORIENTATION: (Optional) ☐ Heterosexual ☐ Gay/Lesbian ☐ Bisexual

FAMILY AND SUPPORTIVE RELATIONSHIPS

Marital Status:

☐ Married ☐ Never Married ☐ Divorced ☐ Annulled ☐ Domestic Partner ☐ Legally Separated ☐ Widowed

Name	Age	Relationship (e.g. Husband, Wife, Son, Friend)	Quality of Relationship	Living with you?
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No

EDUCATION/EMPLOYMENT INFORMATION

Highest (or current) Grade Level Achieved: ____________________

Current Employer: ____________________ How Long? __________

Employment Status: ☐ Full Time (30 or more hours) ☐ Part TIme (Less than 30 hours) ☐ Unemployed
☐ Volunteer or internship ☐ Retired

CURRENT/PAST MILITARY HISTORY

Are you currently serving or have you served in the military? ☐ Yes ☐ No

If yes, please explain (when/how long/branch): ____________________

TRAUMA HISTORY

Have you had a history of trauma, abuse or neglect? ☐ Yes ☐ No

If yes, what type of abuse or trauma occurred?

____ Physical ____ Sexual ____Emotional ____Neglect ____Verbal

MENTAL HEALTH TREATMENT HISTORY

Have you ever received inpatient or outpatient mental health services? ☐ Yes ☐ No

When? Where?

____________________ ____________________
____________________ ____________________
____________________ ____________________

ALL THINGS NEW
THERAPY SERVICES, INC.

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New Patient Information - Adult

MEDICAL INFORMATION

Please check all **medical issues** for which you have had treatment:

___ **Allergies**
(e.g., allergic reactions, seasonal allergies, etc)

___ **Bone disease**
(e.g., osteoporosis, arthritis, broken bones, etc)

___ **Endocrine disease**
(e.g., diabetes, hypothyroid, low testosterone, etc)

___ **Head and brain illness or injury**
(e.g., fainting, concussion, seizures, dementia, etc)

___ **Immune disease**
(e.g., serious infections, MRSA, Rheumatoid Arthritis, etc)

___ **Mouth and teeth disease**
(e.g., gum disease, cold sores, canker sores, etc)

___ **Poisoning & chemical exposure**
(e.g., overdose, lead exposure, work fumes, etc)

___ **Blood disease**
(e.g., anemia, bleeding disorders, etc)

___ **Digestive system disease**
(e.g., ulcers, heartburn, Celiac Disease, IBS, etc)

___ **Genetic disease**
(e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc)

___ **Heart/cardiovascular disease**
(e.g., heart arrhythmia, heart attack, high blood pressure)

___ **Lungs and breathing disease**
(e.g., asthma, COPD, emphysema, etc)

___ **Muscle and movement disease**
(e.g., tremors, tics, Restless Legs, Parkinson's, etc)

___ **Serious injuries and wounds**
(e.g., burns, cuts, stabs, crushed limbs, etc)

___ **Other** ____

Check all areas where you have had past **surgeries**:

___ **Cancer**
(e.g., procedures for cancer treatment)

___ **Ear, Nose, Throat**
(e.g., tonsillectomy, thyroidectomy, etc)

___ **Obstetrics & Gynecology**
(e.g., hysterectomy, c-section, abortion, etc)

___ **Plastic surgery**
(e.g., reduction, implant, reconstruction, etc)

___ **Urology**
(e.g., kidney stones, hypospadias, erectile dysfunction, etc)

___ **Weight loss**
(e.g., gastric bypass, band, sleeve, etc)

___ **Cardiac / Vascular**
(e.g., procedures for heart, blood clot, stroke)

___ **Gastroenterology (digestive system)**
(e.g., stomach, gall bladder, liver, etc)

___ **Orthopedic**
(e.g., joint replacement, bones, spinal fusion, etc)

___ **Neurosurgery**
(e.g., brain surgery, spinal fusion, etc)

___ **Vision**
(e.g., LASIK, eye muscle correction, etc)

___ **Other:**
____

Comments: ____

____

Do you have any current or ongoing medical concerns? ______________________________

____

Do you have problems with pain? ☐ Yes ☐ No

Severity of your pain? (low) 1 2 3 4 5 6 7 8 9 10 (high)
Location of your pain?____

Have your medical concerns interfered with your ability to work, relate to others, or be involved in activities outside of your home? ☐ Yes ☐ No
If yes, please explain ____

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New Patient Information - Adult

Please list all current medications/supplements you are taking: (attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

Has you ever had an allergic reaction to medication(s)? ☐ Yes ☐ No

Name of medication ______________________ Explain reaction ______________________

______________________ ______________________

SUBSTANCE USE

Do you drink alcohol? ☐ Daily use ☐ Occasional Use ☐ None

Do you use tobacco? ☐ Daily use ☐ Occasional Use ☐ None

Do you use drugs? ☐ Daily use ☐ Occasional Use ☐ None

Has alcohol/drug use interfered with family, work, health, or interpersonal life? ☐ Yes ☐ No

If yes, please explain: ______________________

Have others viewed your use as a problem? ☐ Yes ☐ No

Have you ever tried to cut down on your alcohol or drug use or quit using? ☐ Yes ☐ No

If yes, please explain: ______________________

Have you had any prior substance abuse treatment? ☐ Yes ☐ No

When? ______________________ Where? ______________________

______________________ ______________________

LEGAL HISTORY

Involved with the legal system, Friend of the Court or Child Protective Services? ☐ Yes ☐ No

If yes, explain ______________________

Do you currently have a probation or parole officer? ☐ Yes ☐ No

If yes, name ______________________

Have you been involved with the legal system in the past? ☐ Yes ☐ No

If yes, explain: ______________________

SPIRITUAL

What is your present religious affiliation, if any? ______________________

Do you have any spiritual concerns you want to address in treatment? ______________________

In your experience, how important are spiritual matters? ______________________

Patient signature: ______________________ Date: ______________________

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PRE-TREATMENT MEDICATION CHECKLIST

Please indicate all the medications you have ever been prescribed, include comments on effectiveness and reasons for discontinuing the medication.

ANTIDEPRESSANTS

☐ Anafranil (Clomipramine) ____________________
☐ Celexa (Citalopram) ____________________
☐ Cymbalta (Duloxetine) ____________________
☐ Desyrel (Trazodone) ____________________
☐ Effexor, (Venlafaxine) ____________________
☐ Elavil (Amitriptyline) ____________________
☐ ENSAM Transdermal Patch (Selegiline) ______________
☐ Lexapro (Escitalopram) ____________________
☐ Luvox, (Fluvoxamine) ____________________
☐ Nardil (Phenelzine) ____________________
☐ Norpramin (Desipramine) ____________________
☐ Pamelor (Nortriptyline) ____________________
☐ Parnate (Tranylcypromine) ____________________
☐ Paxil, (Paroxetine) ____________________
☐ Pristiq (Desvenlafaxine) ____________________
☐ Prozac; Sarafem (Fluoxetine) ____________________
☐ Remeron, (Mirtazapine) ____________________
☐ Serzone (Nefazodone) ____________________
☐ Sinequan (Doxepin) ____________________
☐ Surmontil (Trimipramine) ____________________
☐ Tofranil (Imipramine) ____________________
☐ Vivactil (Protriptyline) ____________________
☐ Wellbutrin, (Bupropion)/Zyban ____________________
☐ Zoloft (Sertraline) ____________________

ANTI-ANXIETY and INSOMNIA MEDICATIONS

☐ Ambien, (Zolpidem) ____________________
☐ Ativan (Lorazepam) ____________________
☐ Benadryl (Diphenhydramine) ____________________
☐ BuSpar (Buspirone) ____________________
☐ Dalmane (Flurazepam) ____________________
☐ Halcion (Triazolam) ____________________
☐ Klonopin (Clonazepam) ____________________
☐ Librium (Chlordiazepoxide) ____________________
☐ Lunesta (Eszopiclone) ____________________
☐ Noctec (Chloral hydrate) ____________________
☐ ProSom (Estazolam) ____________________
☐ Restoril (Temazepam) ____________________
☐ Rozerem (Ramelteon) ____________________
☐ Serax (Oxazepam) ____________________
☐ Sonata (Zaleplon) ____________________
☐ Tranxene (Clorazepate) ____________________
☐ Unisom (Doxylamine) ____________________
☐ Valium (Diazepam) ____________________
☐ Vistaril, Atarax (Hydroxyzine) ____________________
☐ Xanax (Alprazolam) ____________________

OTHER MEDICATIONS NOT LISTED ABOVE

____
____
____

STIMULANT MEDICATIONS

☐ Adderall ____________________
☐ Concerta, Daytrana TD Patch, Metadate,
Ritalin (Methylphenidate) ____________________
☐ Dexedrine (Dextroamphetamine) ____________________
☐ Focalin (Dexmethylphenidate) ____________________
☐ Provigil ____________________
☐ Strattera (Atomoxetine) ____________________
☐ Tenex (Guanfacine) ____________________
☐ Vyvanse (Lisdexamfetamine) ____________________

MEDICATIONS FOR SIDE EFFECTS

☐ Artane (Trihexyphenidyl) ____________________
☐ Benadryl (Diphenhydramine) ____________________
☐ Cogentin (Benztropine) ____________________
☐ Inderal (Propranolol) ____________________
☐ Parlodel (Bromocriptine) ____________________

MOOD STABILIZERS

☐ Carbatrol, Equetro, Tegretol (Carbamazepine)
____
☐ Depakote, (Divalproic Acid) ____________________
☐ Eskalith, Lithobid (Lithium) ____________________
☐ Lamictal (Lamotrigine) ____________________
☐ Topamax (Topiramate) ____________________
☐ Trileptal (Oxcarbazepine) ____________________

ANTIPSYCHOTICS

☐ Abilify, (Aripiprazole) ____________________
☐ Clozaril, Fazaclo (Clozapine) ____________________
☐ Geodon, (Ziprasidone) ____________________
☐ Haldol (Haloperidol) ____________________
☐ Invega (Paliperidone) ____________________
☐ Loxitane (Loxapine) ____________________
☐ Mellaril (Thioridazine) ____________________
☐ Moban (Molindone) ____________________
☐ Navane (Thiothixene) ____________________
☐ Prolixin (Fluphenazine) ____________________
☐ Risperdal, (Risperidone) ____________________
☐ Serentil (Mesoridazine) ____________________
☐ Seroquel, (Quetiapine) ____________________
☐ Stelazine (Trifluoperazine) ____________________
☐ Thorazine (Chlorpromazine) ____________________
☐ Trilafon (Perphenazine) ____________________
☐ Zyprexa, (Olanzapine) ____________________

MEMORY

☐ Aricept (Donepezil) ____________________
☐ Exelon (Rivastigmine) ____________________
☐ Namenda (Memantine) ____________________
☐ Reminyl (Galantamine) ____________________