KRISTIE JEWITT MS, LMFT

New Patient Information

CONTACT INFORMATION	
CLIENT NAME	**DATE**
STREET ADDRESS	**CITY, STATE, ZIP**
PHONE OK TO LEAVE MESSAGE ☐ **YES** ☐ **NO**	**EMAIL ADDRESS** OK TO SEND MESSAGE ☐ **YES** ☐ **NO**
EMPLOYER/OCCUPATION	**WORK PHONE** OK TO LEAVE MESSAGE ☐ **YES** ☐ **NO**
EMERGENCY CONTACT NAME	**EMERGENCY CONTACT RELATIONSHIP**
EMERGENCY CONTACT PHONE	**MARITAL STATUS**
PRONOUNS	**DATE OF BIRTH**
☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:	
GENDER IDENTITY (CHECK ALL THAT APPLY)	**SEXUAL ORIENTATION** (CHECK ALL THAT APPLY)
☐ Male ☐ Transgender Male/Transman/FTM ☐ Female ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer/Gender Nonconforming ☐ Other: ☐ Decline to Answer	☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Queer, Pansexual, and/or Questioning ☐ Don't Know ☐ Other: ☐ Decline to Answer

LIVING SITUATION (PLEASE IDENTIFY THOSE LIVING IN YOUR HOUSEHOLD CURRENTLY)			
	NAME	**AGE**	**RELATIONSHIP**
1			
2			
3			
4			

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MEDICAL BACKGROUND		
PRIMARY CARE DOCTOR (PCP)		**DATE OF LAST PHYSICAL EXAM**
OTHER DOCTORS/SPECIALISTS NAME		**SPECIALTY**
1		
2		
3		
PREVIOUS OR REFERRING DOCTOR		**HOW DID YOU HEAR ABOUT THIS PRACTICE?**

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITIONS? (IF YES, PLEASE DESCRIBE)
☐ No ☐ Yes:
ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATION? (IF YES, PLEASE DESCRIBE)
☐ No ☐ Yes:
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (IF YES, PLEASE DESCRIBE)
☐ Chronic Pain Condition(s):
☐ Difficulty Maintaining a Healthy Weight:
☐ Head Injury/TBI:
☐ Seizure Disorder:
☐ Childhood Development Issues:
☐ Childhood Learning Problems:

PSYCHIATRIC HISTORY		
HAVE YOU EVER SEEN A PROVIDER PSYCHIATRIST, THERAPIST, COUNSELOR, PSYCHIATRIC NURSE PRACTITIONER OR SOCIAL WORKER PREVIOUSLY?		
☐ No ☐ Yes (If yes, please list the name of provider and the dates of treatment)		
NAME OF PROVIDER		**DATES OF TREATMENT** (FOR EXAMPLE, MAY 2020–MAY 2021)
1		
2		
3		

HAVE YOU EVER BEEN GIVEN A MENTAL HEALTH DIAGNOSIS IN THE PAST FROM A MENTAL HEALTH PROFESSIONAL? (IF YES, PLEASE DESCRIBE)
☐ No ☐ Yes
HAVE YOU EVER BEEN PRESCRIBED PSYCHOTROPIC (ANTIDEPRESSANTS, ANTI-ANXIETY, SLEEP AIDS) MEDICATIONS IN THE PAST?
☐ No ☐ Yes (If yes, please describe)

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATION? (IF YES, PLEASE DESCRIBE)			
☐ No ☐ Yes:			
MEDICATION NAME		**DATES PRESCRIBED**	**DID YOU FIND IT HELPFUL**
1			
2			
3			

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? (IF YES, PLEASE DESCRIBE)
☐ No ☐ Yes:
HAVE YOU EVER ATTENDED A PARTIAL HOSPITALIZATION PROGRAM? (IF YES, PLEASE DESCRIBE)
☐ No ☐ Yes:
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (IF YES, PLEASE DESCRIBE)
☐ Suicidal thoughts or attempts in the past:
☐ Homicidal thoughts or actions in the past:
☐ Been in a violent relationship:
☐ Been the recipient of physical abuse:
☐ Been the recipient of verbal or emotional abuse:
☐ Been the recipient of sexual abuse as a child:
☐ Been the recipient of unwanted sexual advances as an adult:
☐ Been the witness of a traumatic event:
☐ Known someone who has committed suicide:

SUBSTANCE ABUSE HISTORY
HAVE YOU EVER USED (CURRENTLY OR IN THE PAST)? (IF YES, PLEASE DESCRIBE)
☐ Cigarettes:
☐ Alcohol:
☐ Marijuana:
☐ Cocaine:
☐ Opioids:
☐ Other street drugs:
☐ Prescription drugs recreationally:
HAVE YOU EVER WONDERED IF YOU HAVE A PROBLEM WITH DRUGS OR ALCOHOL?
☐ No ☐ Yes
HAVE ANYONE SUGGESTED TO YOU THAT YOU MIGHT HAVE A PROBLEM WITH DRUGS OR ALCOHOL?
☐ No ☐ Yes

HAVE YOU EVER BEEN FORMALLY TREATED FOR A DRUG OR ALCOHOL PROBLEM? (IF YES, LIST DATES OF TREATMENT)
☐ No ☐ Yes:

CURRENT CONCERNS
DESCRIBE YOUR MAIN REASON FOR SEEKING THERAPY AT THIS TIME
HAVE YOU HAD THERAPY IN THE PAST FOR THIS SAME ISSUE?
☐ No ☐ Yes
PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING

☐ Anger/Rage	☐ Hypersomnia (Too Much Sleep)	☐ Nightmares
☐ Anxiety	☐ Insomnia	☐ Obsessive Thoughts
☐ Alcohol Use	☐ Job Loss	☐ Panic Attacks
☐ Appetite Changes	☐ Legal Issues	☐ Physical Symptoms/Discomfort
☐ Arguing	☐ Loneliness	☐ Restlessness
☐ Compulsive Behaviors	☐ Low Motivation	☐ Self-Harming Behaviors
☐ Depression/Sadness	☐ Low Self Esteem	☐ Sexual Dysfunction
☐ Distractibility	☐ Marital Infidelity	☐ Social Withdrawal
☐ Fatigue	☐ Marital Conflict	☐ Stress
☐ Financial Problems	☐ Mood Swings	☐ Suicidal Thoughts/Behaviors
☐ Other:		

FOR WOMEN ONLY	
GYNECOLOGIST'S NAME	**PHONE NUMBER**
DATE OF LAST GYN EXAM	**NUMBER OF PREGNANCIES**
NUMBER OF LIVE BIRTHS	**ARE YOU CURRENTLY PREGNANT?** (IF YES, HOW MANY WEEKS)
	☐ No ☐ Yes:
HAVE YOU EVER EXPERIENCED A MISCARRIAGE? (IF YES, LIST DATES)	
☐ No ☐ Yes:	
HAVE YOU EVER HAD A TERMINATION/ ABORTION? (IF YES, LIST DATES)	
☐ No ☐ Yes:	

HAVE YOU EVER HAD A FETAL DEATH IN UTERO? (IF YES, LIST DATES)
☐ No ☐ Yes:
ARE YOU CURRENTLY OR HAVE YOU HAD DIFFICULTY CONCEIVING/INFERTILITY?
☐ No ☐ Yes
DO YOU SUFFER FROM PAINFUL OR HEAVY PERIODS?
☐ No ☐ Yes
DO YOU SUFFER FROM MODERATE TO SEVERE MOOD SWINGS RELATED TO YOUR MENSTRUAL CYCLE?
☐ No ☐ Yes
DO YOU HAVE CONCERNS ABOUT URINARY INCONTINENCE?
☐ No ☐ Yes
DO YOU HAVE CONCERNS ABOUT YOUR SEXUAL FUNCTIONING?
☐ No ☐ Yes

PERSONAL STATEMENT
PLEASE COMMENT ON ANY OTHER DETAILS THAT MAY BE IMPORTANT TO KNOW WHEN WORKING WITH YOU. THIS MAY INCLUDE SEXUAL ORIENTATION, RELIGIOUS CONVICTIONS OR SPIRITUALITY, ETHNICITY, CULTURAL BACKGROUND, SENSITIVITIES, DISABILITIES, OR ANYTHING ELSE IMPORTANT TO YOUR SENSE OF IDENTITY.

I have completed this form and believe the information that I have provided is truthful to the best of my knowledge.

PRINT NAME	**SIGNATURE**	**DATE**