VANGUARD
MENTAL HEALTH & WELLNESS CLINIC, LLC

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NEW PATIENT FORM

Today's Date: ________________

PATIENT INFORMATION

Name: ____
First Middle Last

Date of Birth: ________________________ Gender: Male Female Other: _________________

Social Security Number (REQUIRED): ____________________

Current Address: ____
Street City State Zip Code

Home Phone: (___)_____________ Cell Phone: (___)_____________ Other: (___)_____________

Email Address: ______________________________

Employer Name *(if applicable)*: _________________ Address: _____________________________

Relationship Status *(circle one)*: Single - Married - Partnered - Divorced - Widowed – Legally Separated

***** IMPORTANT: IF CLIENT IS A *MINOR* – PLEASE FILL OUT THE SECTION BELOW. INFORMATION ON PERSON RESPONSIBLE FOR THE FINANCIAL AGREEMENT *****

Last Name: ________________________ First Name ______________________________ MI ____

Address (*If different from client*): ____
Street City State Zip Code

Employer Name *(if applicable)*: _________________ Address: _____________________________

Home Phone: (___)_____________ Cell Phone: (___)_____________ Other: (___)_____________

INSURANCE INFORMATION

Name of Company: ________________________________ Coverage Began: _____________________
(If Preferred One, name the plan administrator e.g. DCA, CBSA, etc.): __________________________

Address: ____ Phone: ______________________
Street City State Zip Code

Member ID #: _______________________________ Group #:
____

Insured Person's Name: _______________________________ Date of Birth: _____________________

PRESENT CONCERNS

Please list your reasons for seeking services today: ____
____
____

HISTORY OF SERVICES

(Please check and list ANY mental health services you have received in the past)

	Provider/Agency:	Date of Services:
☐ Psychological assessment	_________________________/	______________________
☐ Individual or family counseling	_________________________/	______________________
☐ Psychiatric medication	_________________________/	______________________
☐ Residential treatment/foster care	_________________________/	______________________
☐ Chemical dependency treatment	_________________________/	______________________
☐ Psychiatric hospitalization	_________________________/	______________________

FAMILY HISTORY

Please list ALL individuals who are currently living in your home with you (*include their names, ages, and relationship to you*): ____
____
____

Please list any family history of mental health, on both sides of the family: _____________________

BEHAVIORAL, EMOTIONAL & SOCIAL HISTORY

(Please check ALL that apply and specify, if necessary)

- ☐ Problems with appetite or eating ____________________
- ☐ Sleep problems ____________________
- ☐ Appetite problems ____________________
- ☐ Low Energy ____________________
- ☐ Few interests or activities ____________________
- ☐ Irritable or easily upset ____________________
- ☐ Problems with anger or aggression ____________________
- ☐ Self-destructive behavior ____________________
- ☐ Nervous manners, movements, or sounds ____________________
- ☐ Repetitive habits or tics ____________________
- ☐ Sadness or depression ____________________
- ☐ Socially isolated ____________________
- ☐ Difficulty getting along with others ____________________
- ☐ Problems with anxiety ____________________
- ☐ Fears ____________________
- ☐ Harms self ____________________
- ☐ Unusual behavior ____________________
- ☐ Leaves home without permission ____________________
- ☐ Legal involvement ____________________
- ☐ Chemical use ____________________
- ☐ Physical or sexual abuse ____________________

MEDICAL HISTORY

(Please check ALL that apply and specify, if necessary)

- ☐ Current health problems ____________________
- ☐ Past health problems ____________________
- ☐ History of physical health hospitalizations ____________________
- ☐ Serious injuries ____________________
- ☐ Head injury or loss of consciousness ____________________

- ☐ Seizures ______________________________
- ☐ Current medication ______________________________

Primary Care Provider: ____

REFERRAL

How were you referred to see us?

- ☐ Self
- ☐ Family/Friend: ______________________________
- ☐ Doctor/Facility: ______________________________
- ☐ Online: ______________________________________
- ☐ Other: ______________________________________