Mental Health New Patient History Form

Personal Information

Full Name

Date of Birth

Gender

Phone Number

Email

Address

Emergency Contact

Name

Relationship

Phone Number

Referral

Referred By

Presenting Concerns

Main reason(s) for seeking help

Mental Health History

Previous diagnoses, hospitalizations, or mental health treatments

Current medications (psychiatric and others)

Family history of mental health concerns

Substance Use

Use of alcohol, tobacco, or other substances

Social History

Occupation / School

Living Situation

Relationship Status

Support System

Medical History

Medical conditions or major illnesses

Allergies