# DRS. GAULT, FISHBEIN, & ASSOCIATES

## NEW PATIENT INFORMATION SHEET

**PATIENT:**

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

**FOR PATIENTS UNDER AGE 18:**

MOTHER'S NAME: _____ AGE: _____ FATHER'S NAME: _____ AGE: _____

MOTHER'S OCCUPATION _____ FATHER'S OCCUPATION _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____

EMAIL: (M) _____ (D) _____

CELL: (M) _____ (D) _____

MARITAL STATUS OF PARENTS: (Circle One) Married Separated **Divorced*** Widowed

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***If Divorced:** Custody: _____

Visitation: _____

Child's Main Residence: _____

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**SIBLINGS:**

| NAME | DATE OF BIRTH | RELATIONSHIP TO PATIENT |
|---|---|---|
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| | | |
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**DOES THE PATIENT HAVE HISTORY OF…OR IS THERE ANY FAMILY HISTORY OF? (PLEASE NOTE RELATIONSHIP TO THE PATIENT IF THERE IS A FAMILY HISTORY):**

DEPRESSION: □ YES □NO _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: □ YES □NO _____

ANXIETY: □ YES □NO _____

ADHD: □ YES □NO _____

AUTISM: □ YES □NO _____

DEVELOPMENTAL DELAYS: □ YES □NO _____

SELF-INJURY: □ YES □NO _____

ATTEMPTED/COMPLETED SUICIDE: □ YES □NO _____

ALCOHOLISM/SUBSTANCE ABUSE: □ YES □NO _____

LEARNING DISABILITIES: □ YES □NO _____

PSYCHIATRIC HOSPITALIZATION: □ YES □NO _____

HEAD INJURY: □ YES □NO _____

CARDIAC ARRHYTHMIA: □ YES □NO _____

OTHER HEART PROBLEMS: □ YES □NO _____

DIABETES: □ YES □NO _____

SEIZURE: □ YES □NO _____

SUDDEN DEATH: □ YES □NO _____

HIGH BLOOD PRESSURE: □ YES □NO _____

OTHER SIGNIFICANT FAMILY HISTORY: _____

_____

_____

_____

_____

_____

_____

**MEDICAL:**

**1) OTHER THERAPIST OR OTHER MENTAL HEALTH PROVIDER OUTSIDE DRS. GF&A**
*May we contact this person for the purposes of care coordination?* □ YES □NO

NAME: _____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

**2) PRIMARY CARE PHYSICIAN/PEDIATRICIAN**
*May we contact this person for the purposes of care coordination?* □ YES □NO

NAME:_____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

**3) CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)**

| MEDICATION NAME | DOSAGE | SCHEDULE (e.g AM, PM) | REASON |
|---|---|---|---|
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**4) ALLERGIES:** _____

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_____

_____

_____

_____

**CURRENT SCHOOL:**

SCHOOL: _____ GRADE: _____ PHONE: _____

TEACHER'S NAME: _____ DEAN'S NAME: _____

IS THERE A 504 PLAN IN PLACE? YES NO IS THERE AN IEP IN PLACE? YES NO

HAS YOUR CHILD EVER HAD PSYCHOLOGICAL OR PSYCHOEDUCATIONAL TESTING? YES NO

**REFERRAL SOURCE/HOW DID YOU HEAR OF OUR PRACTICE?:**

REFERRAL SOURCE:_____ PHONE:_____