\*Please fill this out electronically and email back to us at [capsych@capsych.com](mailto:capsych@capsych.com) before your initial appointment if possible\*

Name of patient:

Date of birth of patient:

Name of informant and relationship to patient:

Who referred you:

Please describe what you are seeking treatment for:

PCP (please list contact information including fax number):

Current pharmacy (please list address with zip code and phone number):

Drug allergies:

History of past service providers:

Previous psychiatrists (please list names, dates, reason for discontinuing):

Previous medication trials (please include dates, doses and frequency):

Previous therapists (please list name, dates, reason for discontinuing):

Current therapist (please list name and dates of services):

History of previous levels of care (please include dates and placements) :   
 IOP:

Wrap around services (BHRS):

Family based services:

Partial hospital programs or Acute:

Previous inpatient hospitalizations:

Out of home placements:

Drug and alcohol treatment:

Caffeine use:

Medical history (current medication problems, hospitalizations, surgeries, etc):

Family history (please include anything psychiatric diagnosed or suspected and undiagnosed, also include substance use and medical history):

Maternal side:

Paternal side:

Patient strengths:  
Possible barriers to treatment or current life stressors:

Social history:

Who all lives at home (Include names, ages, occupations and relation to patient)

Legal custody:

Legal history for patient or parents:

CYF involvement either current or in the past:

Any history of abuse or domestic violence:

Educational history:

Current school:

All schools attended in the past:   
 Any grades that had to be repeated (please include when and why):

Does patient have an IEP or 504 plan? Have they in the past? If so please describe why IEP is in place and what

accommodations are being made:

Religion:

Developmental history:

How many weeks at delivery:  
 Did mother receive routine prenatal care:

Birth weight:

Any complications after birth:

Age for developmental milestones

Walking:

Talking:

Toilet trained:   
Any history of ongoing accidents after toilet training:

Please include any additional information that would be useful for us to know as your new mental health treatment provider: