Center for Anxiety & Behavioral Change

50 West Montgomery Ave, Suite 110 | Rockville, MD | 20850 | 301.610.7850

Jonathan Dalton, Ph.D., Dir. Renee DeBoard-Lucas, Ph.D. Lindsay Scharfstein, Ph.D. Rachel Singer, Ph.D.
Christina Brooks, Psy.D. Kristin Bianchi, Ph.D., Monique Reynolds, Ph.D.

New Patient Information Packet

Please fill out all relevant information to the best of your abilities**
**If you are a parent filling out this form for your child, please complete pages 8-10 at the end of the packet

Patient Information

Full Name: _____
First *Last* *M.I.*

Date of Birth: ___/___/___ **Current Age:** _____

_____
Gender *Grade (if applicable)* *School (if applicable)*

_____
Place of birth *Years in US*

Race:
- □ American Indian/Alaska Native
- □ Asian
- □ Black or African American
- □ Multi-Racial
- □ Native Hawaiian or Other Pacific Islander
- □ White/Caucasian
- □ Hispanic/Latino
- □ Other: _____

Ethnicity: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Cell Phone: _____ **Home Phone:** _____

Work Phone: _____ Additional: _____

Email: _____

Referred by:
- □ Self-Referral
- □ Previous Client
- □ Family Doctor
- □ Other (specify): _____
- ☐ Pediatrician
- ☐ Psychiatrist
- ☐ School personnel (counselor, teacher)
- □ Psychologist
- □ Internet

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Patient Mental Health Treatment History

PATIENT *PAST* THERAPY OR MEDICATION

Have you (or your child if applicable) *in the past* ever been evaluated or treated for any emotional or psychological concerns? (may include but are not limited to anxiety, depression, substance abuse, eating disorder, ADHD, and schizophrenia.)

□ **Yes** □ **No** **If yes, please answer the following:**

DATES (mo/yr)	CONCERN	TYPE OF TREATMENT and/or Medication	DOCTOR/AGENCY
Start ____ / ____			
End ____ / ____			
Start ____ / ____			
End ____ / ____			
Start ____ / ____			
End ____ / ____			

PATIENT *CURRENT* THERAPY

Are you (or your child if applicable) *currently being* evaluated or treated for any emotional or psychological problems? (Problems may include but are not limited to anxiety, depression, substance abuse, eating disorder, ADHD, and schizophrenia.)

□ **Yes** □ **No** **If yes, please answer the following:**

Name of Provider/Agency 1: _____

DATES (mo/yr)	CONCERN	TYPE OF TREATMENT and/or Medication
Start ____ / ____		
End ____ / ____		

Name of Provider/Agency 2: _____

DATES (mo/yr)
Start ____ / ____
End ____ / ____

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Name of Provider/Agency 3:

DATES (mo/yr)

Start ____ / ____

End ____ / ____

PATIENT CURRENT MEDICATION

Are you (or your child if applicable) *currently* on any medication □ Yes □ No

Name of Medication 1: Dosage:

Length of time taking medication

□ Less than 4 weeks
□ Less than 8 weeks
□ 8 weeks or more
□ Less than 12 weeks
□ 12 weeks or more

Has there been a change of dosage in the last 4 weeks? YES ____ NO ____

Have you (or child if applicable) stop taking the medication? YES ____ NO ____

If yes, please indicate when: _____(month) _____(year

Name of Medication 2: Dosage:

Length of time taking medication

□ Less than 4 weeks
□ Less than 8 weeks
□ 8 weeks or more
□ Less than 12 weeks
□ 12 weeks or more

Has there been a change of dosage in the last 4 weeks? YES ____ NO ____

Have you (or child if applicable) stop taking the medication? YES ____ NO ____

If yes, please indicate when: _____(month) _____(year

Name of Medication 3: Dosage:

Length of time taking medication

□ Less than 4 weeks
□ Less than 8 weeks
□ 8 weeks or more
□ Less than 12 weeks
□ 12 weeks or more

Has there been a change of dosage in the last 4 weeks? YES ____ NO ____

Have you (or child if applicable) stop taking the medication? YES ____ NO ____

If yes, please indicate when: _____(month) _____(year

Family Mental Health & Treatment History

Please indicate family members who have ever been treated or hospitalized for emotional or psychological concerns, such as anxiety or depression, or had such concerns but did not seek treatment.

	RELATION TO CHILD	DATES (mo/yr)	CONCERN	TYPE OF TREATMENT and/or Medication	DOCTOR/AGENCY
□	Biological Mother	Start ____ / ____ End ____ / ____			
□	Stepmother	Start ____ / ____ End ____ / ____			
□	Biological Father	Start ____ / ____ End ____ / ____			
□	Stepfather	Start ____ / ____ End ____ / ____			
□	Sister 1	Start ____ / ____ End ____ / ____			
□	Sister 2 (if applicable)	Start ____ / ____ End ____ / ____			

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	RELATION TO CHILD	DATES (mo/yr)	CONCERN	TYPE OF TREATMENT and/or Medication	DOCTOR/AGENCY
□	Sister 3 (if applicable)	Start ____ / ____ End ____ / ____			
□	Brother 1	Start ____ / ____ End ____ / ____			
□	Brother 2 (if applicable)	Start ____ / ____ End ____ / ____			
□	Brother 3 (if applicable)	Start ____ / ____ End ____ / ____			
□	Maternal Aunt	Start ____ / ____ End ____ / ____			
□	Maternal Aunt 2 (if applicable)	Start ____ / ____ End ____ / ____			
□	Maternal Uncle	Start ____ / ____ End ____ / ____			
□	Maternal Uncle 2 (if applicable)	Start ____ / ____ End ____ / ____			

RELATION TO CHILD	DATES (mo/yr)	CONCERN	TYPE OF TREATMENT and/or Medication	DOCTOR/AGENCY
□ Paternal Aunt	Start ____ / ____ End ____ / ____			
□ Paternal Aunt 2 (if applicable)	Start ____ / ____ End ____ / ____			
□ Paternal Uncle	Start ____ / ____ End ____ / ____			
□ Paternal Uncle 2 (if applicable)	Start ____ / ____ End ____ / ____			
□ Maternal Grandmother	Start ____ / ____ End ____ / ____			
□ Maternal Grandfather	Start ____ / ____ End ____ / ____			
□ Paternal Grandmother	Start ____ / ____ End ____ / ____			
□ Paternal Grandfather	Start ____ / ____ End ____ / ____			
□ Cousin	Start ____ / ____ End ____ / ____			
□ Other: _____	Start ____ / ____ End ____ / ____			

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Living Arrangements

Please indicate relatives or other individuals currently living with you – or your child- (ex. siblings, grandparents, aunts, uncles, family friends).

Name	Sex	Age	Relationship to Child

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Parent Information

To be completed by guardian(s) - please disregard this section if you are an adult

PARENT/CUSTODIAN 1

Full Name: _____
First *Last* *M.I.*

Background: _____
Country of Birth *Years in the US*

Race:
- □ American Indian/Alaska Native
- □ Asian
- □ Black or African American
- □ Multi-Racial
- □ Native Hawaiian or Other Pacific Islander
- □ White/Caucasian
- □ Hispanic/Latino
- □ Other: _____

Ethnicity: _____

Marital Status

□ Married □ Single □ Divorced from child's father/mother □ Widowed □ Remarried
□ Separated from child's father/mother □ Unmarried but living with partner □ Other _____

Date of current marriage (or date began living with current partner): ____ / __ / ____

If you are divorced, separated, or widowed, please answer the following questions about your child's father/mother.

How long were you married to your child's father/mother? _____

Date of divorce or separation or of death of child's father/mother: ___ / _____ / _____

Education (Check highest level attained):

□ Some Grade School □ Grade School □ Some High School □ High School □ GED
□ Some College □ College □ Bachelor's □ Master's □ Ph.D.
□ Technical Degree (specify): _____
□ Advanced Degree (specify): _____

Currently working? □ Yes □ No
□ Part-time □ Full-time Occupation _____

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Address: _____
(If different from child's) *Street Address* *Apartment/Unit #*

_____
City *State* *ZIP Code*

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Additional: _____

Email _____

PARENT/CUSTODIAN 2

Full Name: _____
First *Last* *M.I.*

Background: _____
Country of Birth *Years in the US*

Race:
- □ American Indian/Alaska Native
- □ Asian
- □ Black or African American
- □ Multi-Racial
- □ Native Hawaiian or Other Pacific Islander
- □ White/Caucasian
- □ Hispanic/Latino
- □ Other: _____

Ethnicity: _____

Marital Status

□ Married □ Single □ Divorced from child's father/mother □ Widowed □ Remarried
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Education (Check highest level attained):

□ Some Grade School □ Grade School □ Some High School □ High School □ GED

□ Some College □ College □ Bachelor's □ Master's □ Ph.D.

□ Technical Degree (specify): _____

□ Advanced Degree (specify): _____

Currently working? □ Yes □ No

□ Part-time □ Full-time Occupation _____

Address: _____
(If different from child's) *Street Address* *Apartment/Unit #*

_____
City *State* *ZIP Code*

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Additional: _____

Email _____