Center for Anxiety & Behavioral Change

50 West Montgomery Ave, Suite 110 | Rockville, MD | 20850 | 301.610.7850
1487 Chain Bridge Road, Suite 203 | McLean, VA | 22101 | 703.908.1020

Jonathan Dalton, Ph.D., Dir., Caitriona Hayes, Psy.D., Kristin Bianchi, Ph.D., Monique Reynolds, Ph.D., Krishtine Rosenthal, Ph.D., Taylor Wilmer, Ph.D., Kathleen Gifford, Ph.D., Jennifer Bienstock, Psy.D., Kelley Anderson, Ph.D., Christina Diaz, Psy.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 be sure to also complete pages 6-7 at the end of the packet

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

_____

Cell: _____ Home: _____ Other: _____

Email: _____

Gender: _____ School and Grade (if applicable): _____

Place of Birth: _____ Number of Years in US: _____

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

Ethnicity: _____

Referred By:
- ☐ Self-Referral
- ☐ Previous Client
- ☐ Family Doctor
- ☐ Pediatrician
- ☐ Psychiatrist
- ☐ School Personnel (Counselor, Teacher)
- ☐ Psychologist
- ☐ Internet
- ☐ Other (please specify): _____

Preferred Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Their ☐ Other: _____

Sexual Orientation (optional): _____

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, etc.)

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

Name of Provider: _____

Date Started: _____ Date Ended: _____

Treatment and Concern: _____

Name of Provider: _____

Date Started: _____ Date Ended: _____

Treatment and Concern: _____

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, etc)

☐ Yes ☐ No If yes, please answer the following:

Name of Provider: _____

Date Started: _____ Date Ended: _____

Treatment and Concern: _____

Name of Provider: _____

Date Started: _____ Date Ended: _____

Treatment and Concern: _____

PATIENT *CURRENT* MEDICATION

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

Name of Medication: ____ Dosage: _____________________

Length of Time Taking Medication:

☐ Less than 4 Weeks ☐ Less than 12 Weeks
☐ Less than 8 Weeks ☐ 12 Weeks or More
☐ 8 Weeks or More

Has the dose changed in the last 4 weeks? ☐ Yes ☐ No

Have you (or the child if applicable) stopped taking the medication? ☐ Yes ☐ No
If yes, please indication when: _______________________________

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

Name of Medication: ____ Dosage: _____________________

Length of Time Taking Medication:

☐ Less than 4 Weeks ☐ Less than 12 Weeks
☐ Less than 8 Weeks ☐ 12 Weeks or More
☐ 8 Weeks or More

Has the dose changed in the last 4 weeks? ☐ Yes ☐ No

Have you (or the child if applicable) stopped taking the medication? ☐ Yes ☐ No
If yes, please indication when: _______________________________

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

Name of Medication: ____ Dosage: _____________________

Length of Time Taking Medication:

☐ Less than 4 Weeks ☐ Less than 12 Weeks
☐ Less than 8 Weeks ☐ 12 Weeks or More
☐ 8 Weeks or More

Has the dose changed in the last 4 weeks? ☐ Yes ☐ No

Have you (or the child if applicable) stopped taking the medication? ☐ Yes ☐ No
If yes, please indication when: _______________________________

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.

Relationship	Dates	Concern	Treatment/Medication
Parent/Guardian 1			
Parent/Guardian 2 (if applicable)			
Step Parent 1 (if applicable)			
Step Parent 2 (if applicable)			
Sibling 1			
Sibling 2			
Sibling 3			
Aunt 1 (if applicable)			
Aunt 2 (if applicable)			
Uncle 1 (if applicable)			
Uncle 2 (if applicable)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other:			

Living Arrangements

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

Name	Gender	Age	Relationship

Parent /Guardian Information

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

PARENT/GUARDIAN 1

Name: _____

Country of Birth: _____ Years in US: _____

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

Ethnicity: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Remarried
- ☐ Separated from child's father/mother
- ☐ Unmarried but living with partner
- ☐ Other

Date of Current Marriage (or date you began living with current partner: _____

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

How long were you married? _____

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

Education: ☐ Some Grade School ☐ Grade School ☐ Some High School ☐ High School ☐ GED ☐ Some College ☐ Bachelor's ☐ Master's ☐ Ph.D./Psy.D.
- ☐ Technical Degree (please specify): _____
- ☐ Advanced Degree (please specify): _____

Currently Working: ☐ Yes ☐ No

☐ Part-time ☐ Full-time Occupation: _____

Address (if different from child's): _____

_____

Cell: _____ Home: _____ Other: _____

Email: _____

Preferred Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Their ☐ Other: _____

PARENT/GUARDIAN 2

Name: _____

Country of Birth: _____ Years in US: _____

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

Ethnicity: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Remarried
☐ Separated from child's father/mother
☐ Unmarried but living with partner
☐ Other

Date of Current Marriage (or date you began living with current partner: _____

If divorced, separated, or widowed, please answer the following questions about your child's father/mother:
How long were you married? _____
Date of divorce, separation, or death of child's father/mother: _____

Education: ☐ Some Grade School ☐ Grade School ☐ Some High School ☐ High School
☐ GED ☐ Some College ☐ Bachelor's ☐ Master's ☐ Ph.D./Psy.D.
☐ Technical Degree (please specify): _____
☐ Advanced Degree (please specify): _____

Currently Working: ☐ Yes ☐ No
☐ Part-time ☐ Full-time Occupation: _____

Address (if different from child's): _____

_____

Cell: _____ Home: _____ Other: _____

Email: _____

Preferred Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Their ☐ Other: _____