New Patient Form (TocDoc)

New patient intake form

* Required

1. **Email address** *

2. **Patient's name** *

3. **Patient's age (in years)** *

4. **Patient's date of birth** *

   Example: December 15, 2012

5. **Patient's sex** *

   Mark only one oval.

   - Female
   - Male
   - Prefer not to say

6. **Patient's phone number** *

7. **Patient's mailing address** *

8. **Patient's insurance (Payer name)** *

   Mark only one oval.

   - BlueCross BlueShield of Illinois
   - Other:

9. **Patient's insurance (Plan name and type)** *

   Mark only one oval.

   - Blue Choice PPO
   - Other:

10. **Patient's insurance (Primary Member Name & Address)** *

11. **Patient's insurance (Member ID)** *

12. **Patient's insurance (Group ID)** *

13. **Patient's insurance (Effective date)** *

14. **Patient's insurance (office Visit Copay)** *

15. **Patient's insurance (Relationship to Insured)** *

Mark only one oval.

- ◯ Self
- ◯ Spouse
- ◯ Child
- ◯ Other: _____

16. **Patient's emergency contact (name, phone number, relationship)** *

17. **Patient's marital status** *

Mark only one oval.

- ◯ Married
- ◯ Single
- ◯ Divorced
- ◯ Separated
- ◯ Significant other
- ◯ Other: _____

18. **Employment status** *
Mark only one oval.

- ◯ Full time
- ◯ Part time
- ◯ Unemployed
- ◯ Retired
- ◯ Disabled
- ◯ Other: _____

19. **Highest level of education** *

_____

20. **Have you served in the military** *
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Other: _____

21. **Primary care physician (name, phone number, email, fax)** *

_____

22. **Current therapist (name, phone number, email, fax)** *

_____

23. **What is the patient seeking our help for?** *

_____

24. **What are the patient's current medications? (names, dosage, reason it was prescribed)** *

_____

_____

_____

_____

_____

25. **What allergies does the patient have? (name the allergen and the reaction)** *

_____

26. **Current mental health diagnosis** *

_____

27. **Current mental health treatment** *

28. **Have you ever been in a psychiatric hospital? When and what led to the hospitalization (s)?** *

29. **Have you ever attempted suicide? What method did you use?** *

30. **How you ever harmed someone else? What was the consequence of your behavior?** *

31. **Current medical conditions** *

32. **Previous surgeries** *

33. **Smoking status** *

Mark only one oval.

- ◯ Never smoked
- ◯ Former smoker, not smoking anymore
- ◯ Active smoker
- ◯ Other

34. **How many caffeinated beverages do you drink per day?** *

Mark only one oval.

- ◯ 2 or less
- ◯ More than 2

35. **Are you currently using any of these?** *

Check all that apply.

- [ ] Alcohol
- [ ] Marijuana
- [ ] Hallucinogens (LSD)
- [ ] Heroin
- [ ] Methamphetamine
- [ ] Cocaine
- [ ] Stimulants
- [ ] Ecstasy
- [ ] Methadone
- [ ] Tranquilizers
- [ ] Pain killers
- [ ] Bath salts
- [ ] Incense/Potpourri
- [ ] None
- [ ] Other: _____

36. **Do you have any active legal issues?** *

Mark only one oval.

- ◯ No
- ◯ Yes
- ◯ Other: _____

37. **Are you adopted?** *

Mark only one oval.

- ◯ No
- ◯ Yes
- ◯ Other: _____

38. **Does anyone else in your family have mental illness? If so, who and what is there diagnosis?** *

_____

39. **Has anyone in your immediate family attempted suicide? Who and what was the consequence?** *

_____

40. **Is there anything else in particular that you want the doctor to know about you?** *

41. **Who filled this form?** *
Mark only one oval.

- ◯ Patient
- ◯ Someone else

42. **Date this form was filled** *

Example: December 15, 2012

☐ Send me a copy of my responses.