New Patient Information

Demographic Information:

Patient Name:	Date of Birth:
Age:	Gender:
Relationship status: □Married □Single □Partnered □Separated □Widowed □ Other	Employment status: □Employed □Seeking employment □Retired □Disabled □Student/trainee □Leave of absence
Home: □Renting apartment □Own home □Residing with family/friends □Assisted living □Nursing home □Independent living □Memory care	Education level: (check highest level achieved) □ HS Diploma □ Some college □ College degree □ Master's degree □ Doctorate / Advanced

Reason for Visit:

Briefly describe the reason(s) for seeking an appointment (you may attach additional pages if you prefer):
How did you hear about Dr. Keenmon / Keen Psychiatry?

Your Mental Health History:

List your current or prior mental health conditions: □ Check if none
List the names of any psychiatrists or counselors you have seen before: □ Check if none
If you have been hospitalized for a mental health or emotional condition in the past, list the dates and reasons for hospitalization: □ Check if none
Have you ever had a suicide attempt? □ YES □ NO

Medication History:

Are you allergic to any medicines? □ No □ Yes, _____

List your current medications below, or provide a written or typed medication list on a separate sheet.

Drug Name	Dose (strength and number of times per day)

Medical History:

Check off any medical conditions you currently have or had in the past:

□ Diabetes	□ Stomach ulcers	□ Seizures
□ High blood pressure	□ Liver disease / liver failure	□ Strokes
□ High cholesterol	□ Asthma	□ Multiple sclerosis
□ Thyroid disorder	□ Lung disease	□ Parkinson's disease
□ Heart problems or disease	□ Pulmonary embolism	□ Memory problems
□ Kidney stones	□ Blood clots / vein clots	□ Serious infections (like
□ Kidney disease / renal failure	□ Cataracts	tuberculosis, HIV/AIDS, syphilis)
□ Heartburn / reflux	□ Deafness	□ Lupus

List any other medical conditions you have that are not listed above:

List the dates of major surgeries or procedures you have had (for example: hysterectomy, appendectomy, heart stents):

List your current medical providers, including your Primary Care Physician (PCP) and specialists:

Women Only:
Are you pregnant or planning to become pregnant? □ YES □ NO. Date of last period? ___/____/____
Are you currently on hormones or birth control? □ YES □ NO
Are you undergoing infertility treatments? □ YES □ NO
Are you perimenopausal? □ YES □ NO
Are you postmenopausal? □ YES □ NO

Current bothersome symptoms:

Check off any of the following symptoms you are currently experiencing (with the past week):

□ Fever	□ Cough	□ Stomach pain	□ Leg swelling	□ Forgetfulness
□ Fatigue	□ Short of breath	□ Constipation	□ Easy bruising	□ Headaches
□ Weight loss	□ Cough	□ Diarrhea	□ Vision loss	□ Numbness
□ Weight gain	□ Nausea / Vomiting	□ Skin rash	□ Hearing loss	□ Weakness

Health Habits:

Check how often you use any of the following:

Substance	*Frequency of use*			
Caffeine	□ Current use	□ None in past month	□ None in past 12 months	□ Never used
Nicotine / tobacco	□ Current use	□ None in past month	□ None in past 12 months	□ Never used
Alcohol	□ Current use	□ None in past month	□ None in past 12 months	□ Never used
Marijuana / Cannabis/CBD	□ Current use	□ None in past month	□ None in past 12 months	□ Never used
Other drugs (cocaine, heroin, misuse of prescriptions)	□ Current use	□ None in past month	□ None in past 12 months	□ Never used

Family Medical History:

Please list any medical conditions that run in your family (parents, siblings or your children only):
Please list any emotional or mental health conditions that run in your family (parents, siblings, children only):
Has any one in your family attempted or completed suicide? □YES □NO

PERSONAL HISTORY:

Where were you born & raised (city, state):	Who raised you (parents or someone else)?
Briefly describe your childhood:	
Have you been through something so traumatic you feel it affects you now? □YES □NO □Decline to answer	
How many times have you been married?	If you have children, please list their names and ages:
If actively working, describe your current occupation:	
Are you a Military Veteran? □YES □NO If so, list branch and dates of service:	
Please list your religion or spiritual practices:	
Optional question: Are you struggling with any current legal issues? □YES □NO □Decline to answer	
Optional question: Do you currently have access to any guns or firearms? □YES □NO □Decline to answer	