POST TRAUMA INSTITUTE
of Louisiana

New Patient Information

Reason you are seeking treatment (select all that apply): __ Medication __ Therapy __ Testing

First Name:____________________________ Middle Initial:___ Last Name:_____________________________
Preferred Name:____

DOB: ____/____/____ Current age: ____

Address: __________________________________ City: ________________ State: ________ Zip:_________

Phone(Best Number): _______________________
Alternative Number We Can Use To Contact You: ________________________________

Email: ____

Preferred method of contact: Cell Phone___ House Phone___ Email___

Name of person (if any) it is ok for me to speak with about your care: __________________________________

Insurance Carrier: ______________ Policy Number: __________________ Member Number: _____________

Secondary Insurance: ___________ Policy Number: __________________ Member Number: _____________

Occupation: ___________________________________ How Long ___________________________________

Marital Status: ____

Children (ages): ____

Allergies: ____

Primary Care Physician: _________________________________ **Phone:** _____________________________

Other Physicians Currently Provide You Healthcare Services:

Physician/Physician Group: ______________________________ **Phone:** _____________________________

Physician/Physician Group: ______________________________ **Phone:** _____________________________

Physician/Physician Group: ______________________________ **Phone:** _____________________________

How did you hear about us? ____

Client Signature____ Date: ___/___/____

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Past Psychiatric History

Inpatient psychiatric admissions: YES ___ NO ___ If yes how many? ______________

Suicide attempts YES ___ NO ___ If yes please explain: ____

____

Previous outpatient treatment (with whom, how long and it did it help?):

____

____

Current Medications (please list all including Primary care meds, OTC meds and supplements):

____

____

Previous PSYCHIATRIC medications that helped (please list names and doses and how long you took them)

____

____

Previous PSYCHIATRIC medications that did not help (please list side effects, names, doses and how long you took them)

____

____

Medical History: any current or previous significant conditions, surgeries, seizures, head injuries
YES ___ NO ___ (If yes please elaborate.)

____

Do you drink alcohol YES ___ NO ___ If so how many drinks do you have in a typical week _______

Smoke? YES ___ NO ___ If so how much__________ Use recreational drugs? YES ___ NO ___
If so please elaborate: ____

Have you ever had any treatment for addiction or alcoholism (inpatient, outpatient, attended AA or NA meetings)? YES ___ NO ___ If yes please elaborate: ____

____

Family Psychiatric History (pertains to all blood relatives): ____

____

Any family suicides? YES ___ NO ___
Any family depression, anxiety, bipolar disorder, schizophrenia? YES ___ NO ___
Any family addiction/alcoholism? YES ___ NO ___

Significant family medical history: ____

____

Current stressors in your life: ____

____

Client Signature____ Date: ___/___/____