METRO NY DBT
CENTER

ADULT PATIENT INFORMATION

Date: _____

Name: _____

Date of Birth: _____ Age: _____

Mailing Address: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Who referred you? _____ Phone: _____

PRESENTING PROBLEM:

REASON FOR REFERRAL: Please describe why you are seeking services at this time.

When did these problems begin?

Does anything seem to make the problem better or worse?

Please describe: What do you consider your strengths/the best things in your life at this time?

TRAUMA HISTORY:

Has there been any history of trauma in your life? Trauma can include, but is not limited to: physical or sexual abuse, accidents, or serious injury. Y/N If yes, please explain:

BACKGROUND INFORMATION: Education level (check the highest level achieved):

☐ Some High School ☐ High School graduate ☐ Some College ☐ College graduate
☐ Graduate degree

Did you have any learning difficulties when you were a student (if so, please specify)? Y/N

Your Occupation: _____

Marital Status: (please check off)

☐ Single ☐ Dating ☐ Long-term relationship (not living together) ☐ Married/domestic partners
☐ Divorced ☐ Separated ☐ Other

Please list all individuals who currently live with you:

Name(s): Relationship to you: Age:

If you have children not living with you, please write down the following information:

Child's Name: _____ Child's age: _____ Where does child reside: _____

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Have there been any deaths/separations in your family? Are there are any significant interpersonal conflicts that are impacting your functioning? If so, please explain (include dates, relationship to you): Is there a family history of psychiatric illness Y/N If yes, please explain:

How do you identify in terms of race/ethnicity?

Please list any religious, cultural or social issues that may impact treatment:

Do you have any significant hobbies/interests? Y/N If yes, please describe:

Do you have a history of arrests/legal involvement? Y/N If yes, please explain:

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MEDICAL HISTORY

Please list/describe any medical issues you have: Hospitalizations/Surgeries: Dates Reason for Hospitalization/Surgery

Current Medications/Reasons for use:

PREVIOUS PSYCHOSOCIAL TREATMENT

Have you ever had psychological/psychiatric treatment of any kind? Y/N

If yes, please list the treatments you have had (i.e.: Individual therapy, Family therapy, Group therapy, Psychopharmacology, Residential Treatment Center, Therapeutic Boarding School). --Be sure to include: dates of treatment, previous provider's name and contact information, and reason for termination of treatment.

Was there anything you found particularly effective or ineffective in your past treatment? Psychiatric Hospitalizations (Please include dates, length of stay, and reason for hospitalization): Psychiatric Medications (Please indicate what medication and, if discontinued, reasons for change or stoppage of medication):

ADDITIONAL INFORMATION

Please use this space to describe any other issues, questions or concerns. Feel free to write on the back of this paper if you need more space.

NEW YORK OFFICE: 16 W. 86th Street, Suite #1A | New York, NY 10024
NEW JERSEY OFFICE: 205 Ridgedale Avenue | Florham Park, NJ 07932
212-560-2437 | info@MetroNYDBT.com