



## New Patient Information

Please Complete in Full for yourself or your child, if applicable

### Personal Information

Full Name: \_\_\_\_\_  
*Last* *First* *M.I.*

Address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_ *City* *State* *ZIP Code*

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Sec. #: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse's or Parents' Names: \_\_\_\_\_

Spouse's/Parent Employer: \_\_\_\_\_ Spouse's/Parents' Work Phone: \_\_\_\_\_

### Other Information

School Name (If Applicable) : \_\_\_\_\_ Contact Person: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Tel. Number: \_\_\_\_\_

Primary Care Dr.: \_\_\_\_\_ Tel. Number: \_\_\_\_\_

Current Psychiatrist: \_\_\_\_\_ Tel. Number: \_\_\_\_\_

Start Date: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

## Emergency Contact Information

Full Name: \_\_\_\_\_  
*Last* *First* *M.I.*

Address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_  
*City* *State* *ZIP Code*

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_



**GreenwichPsychPC**



<b>SYMPTOM</b>	<b>YES</b>	<b>NO</b>
Persistent nausea		
Lack of appetite		
Sudden/unexpected weight loss		
Diarrhea		
Constipation		
Difficulty controlling bowel movement		
Pain during urination		
Blood in urine		
Incontinence/bed wetting		
Bone/joint pain		
Bone fractures		
Joint swelling/redness		
Scoliosis		
<b>FEMALES ONLY</b>		
First period (if applicable)		
Irregular menstrual periods		
Using birth control		
Surgeries		
Hospitalizations		



<b>SYMPTOM</b>	<b>YES</b>	<b>NO</b>
Seizures/Epilepsy		
Eye sight problems		
Hearing difficulties/hearing loss		
Speech difficulties		
Motor coordination		
Tremor		
Skin rashes?Acne		
Eczema		
Allergies		
Hair loss		
Chronic sinus infections		
Chronic ear infections		
Inner ear Tube Placement		
Asthma/coughing/wheezing		
Difficulty breathing/shortness of breath		
Smoking		
Chest pains		
Palpitations		
Irregular heart beats		
Heart birth deffects		
High blood pressure		