Family Therapy Clinic of Louisiana, LLC
8480 Bluebonnet Blvd, Suite A,
Baton Rouge, LA 70810-2879

New Patient Background

Personal Details

First Name *

Last Name *

Date of Birth * / / (MM/DD/YYYY)

Gender * ☐ Male ☐ Female

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone

Work Phone

Extn

Primary Phone ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 *

Address Line2

City *

Country *

State *

Zip code *

Postbox No

Emergency Contact Name

Emergency Contact Number

Extn

Primary Insurance Details

Insurance Type * ☐ MEDICARE ☐ MEDICAID ☐ TRICARE CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER _____

Insurance Plan Name or Program Name *

ID *

Insurance Company Name (Payer Name) *

Payer Id *

Payer Address

Payer City

Payer Country

Payer State

Payer ZipCode

Valid From / / (MM/DD/YYYY)

Valid Until / / (MM/DD/YYYY)

Payer ZipCode

Copay _____

Deductible _____

Employer/School Name _____

Comments _____

_____

_____

_____

Insured Person Details

Patient Relationship * ☐ Self ☐ Spouse ☐ Child ☐ Other

First Name * _____

Last Name * _____

Date of Birth * / / (MM/DD/YYYY)

Gender * ☐ Male ☐ Female

Address Line 1 _____

Address Line 2 _____

City _____

Country _____

State _____

Zip Code _____

Home Phone _____

Mobile Phone _____

HEALTH AND WELLNESS

Primary Care Physician: * _____

Medical and Mental Health Conditions (N/A or list each condition, with medications/dosages): * _____

_____

_____

Supplements (N/A or list the name and dosages of _____

each): *

Allergic or adverse reactions to any type of medication (N/A or list): *

Previous mental health treatment (N/A or list previous providers): *

Recent significant life changes or stressful events (N/A or describe): *

Check any symptoms you have experienced in the last TWO WEEKS:

- ☐ Fatigue
- ☐ Crying Spells/Tearfulness
- ☐ Sadness
- ☐ Irritability
- ☐ Anger
- ☐ Easily Frustrated
- ☐ Feeling Overwhelmed
- ☐ Depressed Mood
- ☐ Grief
- ☐ Difficulty Concentrating
- ☐ Apathy/Loss of Interest in Activities
- ☐ Feeling Hopeless
- ☐ Isolating/Avoiding people
- ☐ Suicidal Thoughts
- ☐ Worry/Anxiety
- ☐ Panic Attacks
- ☐ Habitual/Compulsive Behavior
- ☐ Fears/Phobias
- ☐ Social Anxiety
- ☐ Traumatic Event (Within Last Year)
- ☐ Eating Disorder (past or present)
- ☐ Sleep Disturbance
- ☐ Trouble Falling Asleep
- ☐ Trouble Staying Asleep
- ☐ Appetite - Eating More
- ☐ Appetite - Eating Less
- ☐ Others _____

Recent changes in weight (N/A or list how much): *

SLEEP (estimated average): *

- ☐ 3 hrs or less/night
- ☐ 4-6 hrs/night
- ☐ 7-8 hrs/night
- ☐ 9-10 hrs/night
- ☐ greater than 10 hrs/night

EXERCISE (N/A or describe): * _____

CAFFEINE USE (N/A or describe): * _____

ALCOHOL USE: *
- ☐ Never
- ☐ Rarely
- ☐ 1-2 days/wk
- ☐ 3-4 days/wk
- ☐ 5 or more days/wk

SMOKING: *
- ☐ Never
- ☐ Former
- ☐ 1/2 pack/day or less
- ☐ About a pack a day
- ☐ More than a pack a day

SUBSTANCE USE: *
- ☐ Never
- ☐ Former
- ☐ Current (describe below)

Current Substance Use (N/A or list): * _____

Current Employment (describe): * _____

_____

_____

_____

Primary concerns and goals for therapy. * _____

_____

_____

_____

FAMILY MEDICAL HISTORY

Mother's Name: * _____

Is your mother living? *
- ☐ Yes
- ☐ No

Current age, or age of passing & cause: _____

Mother's Conditions:
- ☐ Diabetic
- ☐ COPD/Asthma
- ☐ Cancer
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Thyroid
- ☐ Vision Problems
- ☐ Liver Disease
- ☐ Depression/Mental Illness
- ☐ Drug Alcohol Dependence
- ☐ Others _____

Father's Name: * _____

Is your father living? *
- ☐ Yes
- ☐ No

Current age, or age of passing & cause: _____

Father's Conditions:

- ☐ Diabetic
- ☐ COPD/Asthma
- ☐ Cancer
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Thyroid
- ☐ Vision Problems
- ☐ Liver Disease
- ☐ Depression/Mental Illness
- ☐ Drug Alcohol Dependence
- ☐ Others _____

Do you have any siblings? * ☐ Yes ☐ No

If yes, list age and relationship of each: _____

_____

_____

_____

Sibling Conditions:

- ☐ Diabetic
- ☐ COPD/Asthma
- ☐ Cancer
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Thyroid
- ☐ Vision Problems
- ☐ Liver Disease
- ☐ Depression/Mental Illness
- ☐ Drug Alcohol Dependence
- ☐ Others _____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided. You can indicate any additional family mental health history in the space provided next to "Other".

Alcohol/Substance abuse _____

Anxiety _____

Depression _____

Domestic Violence _____

Eating-Disorders _____

Obesity _____

Obsessive Compulsive Disorder _____

Schizophrenia _____

Suicide Attempts _____

Learning Disorders _____

ADHD/ADD _____

Other _____

_____

_____

_____