Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

Name: ______________________________ **DOB:** ______________

Gender: MALE FEMALE **Social Security #:** ______________________

Address: ______________________ **City:** ____________ **Zip:** __________

Phone Numbers:

Home: ( ) ____________________ Can we call you at Home? Yes No

Cell: ( ) ____________________

Work: ( ) ____________________ Can we call you at Work? Yes No

Email:____

Marital Status (circle one): Single Married Divorced Separated

Race (circle one):

American Indian or Alaska	Native Black/African American	Chinese
Filipino	Guamanian or Chamorro	Korean
Hispanic White	Japanese	Other Asian
Native Hawaiian	Other Pacific Islander	Samoan
White/Caucasian	Other Race	

Ethnicity (circle one):

Cuban	Mexican/Mexican American	Not Hispanic or Latino
Other Hispanic or Latino	Puerto Rican	

Preferred Language (circle one):

English Spanish Chinese Italian Polish Russian French Turkish
Other

Known Allergies: ____

Employer: ______________________________ **Occupation:** ______________

Are you a Student? Yes No **If yes, Name of School:** ______________________

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

Primary Care Physician: ______________________________ **Phone #:** ____________________
Address: ____

Therapist Name: ____________________________________ **Phone #:** ______________________
Discipline: ____

Preferred Pharmacy Name: ___________________________ **Phone #:** ______________________
Pharmacy Address: ____

EMERGENCY CONTACT:

Name: ____**Relationship:** __________________
Address: ___________________________________ **City:** ___________________ **Zip:** __________
Phone Number: (H)______________________________**(C)**_________________________________

Name: ____**Relationship:** __________________
Address: ___________________________________ **City:** ___________________ **Zip:** __________
Phone Number: (H)______________________________**(C)**_________________________________

PRIMARY INSURANCE:

Insurance Plan: _________________________________ **Policy #:** _________________________
Policy Holder: ___________________________________ **Relation to Patient:** _________________
Policy Holder DOB: _____________________________ **Policy Holder SS#:** __________________

SECONDARY INSURANCE:

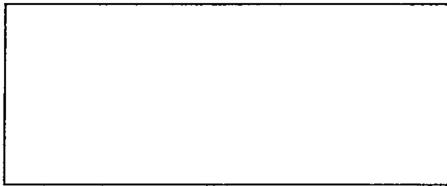
Insurance Plan: _________________________________ **Policy #:** _________________________
Policy Holder: ___________________________________ **Relation to Patient:** _________________
Policy Holder DOB: _____________________________ **Policy Holder SS#:** __________________

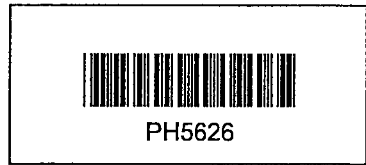
For Partial Hospitalization Clients Only

Will you be driving to the program? ______________
Make/Model/Plate #: ____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

John T. Mather Memorial Hospital • Partial Hospitalization Program • 100 Highlands Blvd. Suite 201, Port Jefferson, N.Y. 11777





ALLERGIES:____________________ **SPECIAL DIET:**________________

1. CURRENT PROVIDER OF MEDICAL CARE: (Include name and address of regular health care providers).

Physician/Program Name | Address | Phone Number

2. GENERAL HEALTH HABITS

Have the following changed in the last year?	**NO**	**Yes, in what way has it changed?**
Appetite		
Weight		
Sleeping Habits		
Energy Level		
Amount of water you drink daily		
Urination frequency		
Bowel movement frequency		
Do you...	**NO**	**Yes, how often?**
Exercise		
Smoke		
Drink alcoholic beverages		
Recreational drug use (Legal, controlled, illegal)		
Drink coffee or tea		
Have you ever had...	**NO**	**If you answer "Yes" explain in the spaces below**
Blurred vision or glaucoma		
Ringing in your ears; loss of hearing		
Head injuries		
Weakness, light headedness, dizziness		
Rapid heart beat		
Pains, discomfort or tightening in chest		
Discomfort or shortness of breath		
Breathing problems when asleep		
Cuts, bruises or scars from previous injuries or self-harm		
Pain or discomfort in arm, joint, leg		
Swollen legs, ankles, or feet		
Frequent nausea or vomiting, blood in vomit		

2. GENERAL HEALTH HABITS (CON'T)	NO	If you answer "Yes" explain in the spaces below
Discomfort after eating		
Burning sensation after eating food		
Discomfort when swallowing		
Frequent Diarrhea or constipation		
Painful or bloody bowel movements		
Painful urination or blood/dark urine		
Loss of urine when laugh, sneeze, cough		
Tendency to bleed or bruise easily		
Other (Specify)		
If female... Amenorrhea or Irregular Menses		
Pregnant		
Menopause		
Vaginal itching, burning, discharge		
Tender breasts, discharge from nipples, lumps		
Date of last period		
Date of last PAP smear		
Date of last mammography		
If male...		
Testicular masses, enlargement		
Difficulty staring urine stream		
Sore on penis, discharge		

3. ILLNESS AND SYMPTOMS (Indicate if you or a blood relative has ever had any of the following).

	No, I have not	Yes	Specify Relative or Significant Other	If you answer "Yes" give dates and type of treatment in space below
Kidney				
Diabetes				
Cancer or Tumor				
Heart Trouble				
Epilepsy, seizure, convulsion				
Thyroid problems or goiter				
Stroke				
Ulcers - stomach or duodenal				
Allergies, asthma, hay fever				
High blood pressure				
High cholesterol				

3. ILLNESS AND SYMPTOMS (CON'T)	No, I have not	Yes	Specify Relative or Significant Other	If you answer "Yes" give dates and type of treatment in space below
Sickle cell anemia				
Tuberculosis Date of last PPD ____________				
HIV/AIDS				
Hepatitis				
Sexually Transmitted Disease				
Anemia				
Eating Disorder				
Lupus				
Malaria				
Chicken Pox				
Measles - Rubeola				
German Measles - Rubella				
Rheumatic Fever				
Mumps				
Scarlet Fever				
Other (Specify)				
4. Dental History	Comments or additional information on Dental Treatment			
Date of Last Exam				
Tooth Enamel Erosion				
Cavities				
Dentist Name & Phone #				
Above Information Complete By				

5. EVALUATION (To be completed by a Nurse Practitioner, Physician, Physician's Assistant or Registered Nurse).

T__________ P__________ R__________ B/P__________ Ht.__________ Wt.__________

Do you have current pain? ❑ Yes ❑ No

Do you have chronic or re-occurring pain? ❑ Yes ❑ No

*****If YES for either question, completed a Pain Assessment Form*****

Date of last physical within 1 year? ❑ Yes ❑ No

If No, Parent/Patient agrees to obtain history and physical by primary care physician? ❑ Yes

Does Patient require nutritional referral? ❑ Yes ❑ No

Patient is able to self administer medication while at Partial Hospital as per prescription? ❑ Yes ❑ No

____

____

Staff Signature ______________________ **Title** __________ **Date**_______ **Time**_______

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Patient Label

Patient Name: ____ Date of Birth: ________________

Please list below any medications that you are currently taking for medical and psychiatric illnesses, and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

Medication	Dose	Route	Directions	Prescriber

Form Completed By: ____ Date: _________________

PATIENT/FAMILY SELF-REPORTED HOME MEDICATION LIST