# Candida Fink MD

4 Stanton Circle
New Rochelle NY 10804
Phone 877-534-1090  Fax 914-560-2106

## NEW PATIENT HISTORY

**Please enter requested information as completely as possible and fax your New Patient History Form to our office or bring it with you to your appointment. Entries marked with an asterisk (*) are required.**

*** Today's Date (MM/DD/YYYY): _____ / _____ / _____**

*** Patient Name: _____**

*** Patient Date of Birth (MM/DD/YYYY): _____ / _____ / _____**

*** Parents/Legal Guardians if patient under 22 or parent responsible for payment:**

_____

_____

**Currently living with — please list names, ages and relationships of all household members:**

| Name | Age |
|---|---|
| | |
| | |
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**Who can we thank for referring you to us?:**

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**If the patient is in school please tell me where/what grade. If patient is working please tell me where/what position.**

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*** Please list the patient's current medications and doses, including over-the-counter medications, vitamins/supplements, and alternative remedies.**

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_____

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_____

*** Please tell me why you are seeking evaluation at this time? What are your concerns?**

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**What do you see as the patient's (you or your child's) strengths? Successes? If the patient has been evaluated or treated by other psychiatrists, psychologists, therapists, neurologists, or developmental specialists please list names and dates:**

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**Please list any previous psychiatric hospitalizations (inpatient or partial) or residential programs. Also please list any intensive outpatient programs.**

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*** Please tell me about previous medications taken by the patient; please list the medicines, how long they were taken, and if known, why they were stopped.**

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**The Next Set of Questions Is Only for Patients Under 22 Years of Age**

*** Were there any health concerns during the pregnancy regarding mother or child? Did mother take any medications, drink alcohol, smoke cigarettes, or use any drugs during pregnancy?**

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**Was delivery on time, early, or late? Vaginal or C-section? Did the baby require medical care at or right after birth?**

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**How much did the baby weigh at birth?** _____

**Temperament as a baby/small child? Easy going? Difficult?**

_____

_____

**Age walked? Were there concerns about motor skill development?**

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_____

**Age talked? Were there concerns about language development?**

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_____

**Any challenges with toilet training? Is the child fully trained? Any ongoing concerns about daytime or night time accidents?**

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_____

**Remainder of Questions for Patients of All Ages**

**Any concerns about difficulties with sensory input such as touch, sound, or light? Please describe.**

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**Any concerns about sleep currently? Have there been problems with sleep in the past? Please describe**

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_____

**Any concerns about eating and appetite either currently or in the past? Any concerns about growth? Loss of or increased appetite? Weight loss or weight gain? Concerns about food restriction, bingeing, or purging?**

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**Has the patient (you or your child) experienced any known traumatic events or losses? Major illnesses in themselves or loved ones? Victim of or witness to violent verbal or physical behaviors? Victim of bullying? Major events such as flood or fire? Other?**

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**Tell me about you/your child's medical history: Are there any current significant medical problems? Past medical problems? Any allergies to medications? Any other significant allergies such as nuts or wheat? Any surgeries and/or hospitalizations?**

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_____

**Any history of seizures, head injuries, headaches, fainting, or motor or vocal tics?**

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_____

**Any history of heart murmur, structural heart problems, or rhythm abnormalities? Any family history of sudden death in someone under 50 years of age? Any family history of cardiac arrhythmias or other heart problems in people under 50?**

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_____

**Any problems with fatigue? Joint pain? Skin problems such as eczema? Gastrointestinal problems such as frequent belly pain, diarrhea, or constipation? Any breathing problems?**

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**For female patients — have periods started? Any problems with menstrual cycles? Pain? Irregularity? Any pregnancies? Have you started/completed menopause? Any other GYN health concerns?**

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**Please tell me about use of alcohol. Does the patient use alcohol? If so, how much and how often? Any problems related to alcohol at school, work, or home? Any legal problems such as DWI/DUI?**

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**Does the patient use marijuana recreationally or for medical purposes? How often? Any other drugs such as cocaine, Ecstasy/Molly, misuse of prescription medications such as narcotics or tranquilizers? Any school, work, home or legal problems related to drug use?**

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**Is there any family history of depression? Bipolar disorder? Suicide? Anxiety or OCD? Schizophrenia? Autism? Intellectual disability? Genetic disorders? ADHD? Language or learning problems? School problems?**

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**Tell about any concerns at school or work. What problems, if any, are occurring there?**

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**Are there any support services in place at school or work? If so please describe. Does the patient receive disability services?**

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**Please describe patients hobbies/leisure/extracurricular activities**

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_____

**Tell me about social connections and supports. Any worries about making/keeping friends? Any concerns about bullying as either a bully or a victim?**

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**Is there anything else you think it is important for me to know about you/your child or your current concerns?**