Gelareh Solomon, Ph.D.

Licensed Psychologist PSY26255
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Confidential New Patient Information Form

Personal

Name: ________________________________ Referred by: ________________________________

Home Address: ____ Birth Date: _______________________

Home Phone: ____ Cell Phone: __________________

On what phone number may I leave messages or confidential information?__________________________

Employer

Employer:___________________________________Phone:___________________________________

Address:____

Emergency

In Case of Emergency Notify: _______________________Phone:_________________________________

Relationship: _____________________________________

Primary Care Physician:_____________________________Phone:________________________________

Psychiatrist:_______________________________________Phone:_______________________________

Medical Problems

Do you have any medical conditions? (If yes, please describe)

____

List any prescription medications you are currently taking____

Name of prescribing physician___________________________Phone:_____________________________

Please check the symptoms you are currently experiencing:

Symptoms & Severity (check if applicable)	Mild	Moderate	Severe	For how long?
Depressed Mood, Hopelessness				
Social Isolation, Loneliness				
Suicidal Thoughts				
Bereavement or Feelings of Loss				
Anxiety, Frequent Worry or Tension				
Panic Attacks				
Anger, Hostility				
Violent Acts				
Obsessive Thoughts				
Strange, Unusual Thoughts				
Memory Problems				
Problems Concentrating				
Compulsive Behaviors				
Gender Dysphoria				
Sexual Problems				
Sleep Problems				
Weight Fluctuations				
Eating Problems				
Communication Problems				
Financial Problems				
Employment Difficulties				
Physical Disability				

Substance Use	No	Yes	How Often?	Substance Use	No	Yes	How Often?
Alcohol				Sedatives			
Marijuana				Opiates			
Cocaine				Hallucinogens			
Methamphetamines				Stimulants			

- Have you been in therapy before? If yes, when?____
- Have you ever been hospitalized for a psychiatric illness? If yes, please explain____
____
- Does anyone in your family have a mental illness?_______________________________________
- Has anyone in your family ever attempted suicide?_______________________________________
- Have you ever been arrested?____
- Has your substance use ever felt like a problem to you____________________________________