InnerView
Behavioral
Care

MBHC, Inc.
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Perrysburg, OH 43551
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New Patient History

Name: _____

Reason for visit: _____

When did the problem begin? _____

Have you been in therapy before or received any professional assistance for you problem? _____

If so, by whom? _____

Where? _____

Have you ever been hospitalized for psychological/psychiatric problems? _____

If so when: (Dates) _____

Where? _____

Education: _____

Employment (Past and present): _____

List any medical illness(es) you now have: _____

Present Medication: _____

Do you have any allergies? _____ What? _____

Have you or are you now considering harming yourself? _____

Have you or are you now considering harming someone else? _____

Do you have any relative(s) who suffer from medical/emotional problems? _____

If so, please explain: _____

What would you like to achieve from therapy? _____

Date: _____ Signature: _____