AKV PSYCHOLOGICAL & CONSULTING SERVICES

Woodbury Location:
2155 Woodlane Dr, Ste 200
Woodbury, MN 55125

Office:(651) 283-3794
Fax: (651) 738-1881
akvpsychservices.com

St. Paul Location:
1885 University Ave W, Ste 320
St. Paul, MN 55104

NEW PATIENT FORM

Today's Date: _____

PATIENT INFORMATION

Name: _____
First Middle Last

Date of Birth: _____ Gender: Male Female Other: _____

Social Security Number (REQUIRED): _____

Current Address: _____
Street City State Zip Code

Home Phone: (___)_____ Cell Phone: (___)_____ Other: (___)_____

Employer Name *(if applicable)*: _____ Address: _____

Relationship Status *(circle one)*: Single - Married - Partnered - Divorced - Widowed - Legally Separated

***** IMPORTANT: IF CLIENT IS A *MINOR* – PLEASE FILL OUT THE SECTION BELOW. INFORMATION ON PERSON RESPONSIBLE FOR THE FINANCIAL AGREEMENT *****

Last Name: _____ First Name _____ MI _____

Address (*If different from client)*: _____
Street City State Zip Code

Employer Name *(if applicable)*: _____ Address: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Other: (___)_____

INSURANCE INFORMATION

Name of Company: _____ Coverage Began: _____
(If Preferred One, name the plan administrator e.g. DCA, CBSA, etc.): _____

Address: _____ Phone: _____
Street City State Zip Code

Member ID #: _____ Group #: _____

Insured Person's Name: _____ Date of Birth: _____

PRESENT CONCERNS

Please list your reasons for seeking services today: _____
_____
_____

HISTORY OF SERVICES

(Please check and list ANY mental health services you have received in the past)

	Provider/Agency:	Date of Services:
☐ Psychological assessment	_____	_____
☐ Individual or family counseling	_____	_____
☐ Psychiatric medication	_____	_____
☐ Residential treatment/foster care	_____	_____
☐ Chemical dependency treatment	_____	_____
☐ Psychiatric hospitalization	_____	_____

FAMILY HISTORY

Please list ALL individuals who are currently living in your home with you (*include their names, ages, and relationship to you*): _____
_____
_____

Please list any family history of mental health, on both sides of the family: _____
_____

BEHAVIORAL, EMOTIONAL & SOCIAL HISTORY

(Please check ALL that apply and specify, if necessary)

- ☐ Problems with appetite or eating _____
- ☐ Sleep problems _____
- ☐ Appetite problems _____
- ☐ Low Energy _____

- ☐ Few interests or activities _____
- ☐ Irritable or easily upset _____
- ☐ Problems with anger or aggression _____
- ☐ Self-destructive behavior _____
- ☐ Nervous manners, movements, or sounds _____
- ☐ Repetitive habits or tics _____
- ☐ Sadness or depression _____
- ☐ Socially isolated _____
- ☐ Difficulty getting along with others _____
- ☐ Problems with anxiety _____
- ☐ Fears _____
- ☐ Harms self _____
- ☐ Unusual behavior _____
- ☐ Leaves home without permission _____
- ☐ Legal involvement _____
- ☐ Chemical use _____
- ☐ Physical or sexual abuse _____

MEDICAL HISTORY

(Please check ALL that apply and specify, if necessary)

- ☐ Current health problems _____
- ☐ Past health problems _____
- ☐ History of physical health hospitalizations _____
- ☐ Serious injuries _____
- ☐ Head injury or loss of consciousness _____
- ☐ Seizures _____
- ☐ Current medication _____

Primary Care Provider: _____

REFERRAL

How were you referred to see Dr. Vang?

- ☐ Self
- ☐ Family/Friend: _____
- ☐ Doctor/Facility: _____
- ☐ Online: _____
- ☐ Other: _____