

Dr Allen Kuo

Selah Healthcare Professionals
1000 Hart Rd, Ste 130
Barrington, IL 60010

New Patient Information Form

Patient Information

Please fill out all required fields.

Full Name: _____

Date of Birth: _____

Age: _____

Gender: Male Female Other Prefer not to answer

Social Security Number: _____

Marital Status: Single Married Divorced Widowed

Phone Number (Cell): _____

Phone Number (Home): _____

Email Address: _____

Preferred Method of Contact: Phone Email Text

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone: _____

Insurance Information:

Primary Insurance Provider: _____

Insurance Plan Number: _____

Group Number (if applicable): _____

Policy Holder Name: _____

Policy Holder's Date of Birth: _____

Secondary Insurance (if applicable): _____

Secondary Insurance Plan Number: _____

Referral Information:

How did you hear about us? Physician Friend/Family Online Search

Other: _____

Referring Physician (if applicable): _____

Phone Number of Referring Physician: _____

Medical History

Primary Care Physician Name: _____

Primary Care Physician Phone Number: _____

Current Medications (include dosage): _____

Do you have any allergies? Yes No (If yes, please list):

Past Psychiatric History (please check if applicable):

- Depression
- Anxiety
- Bipolar Disorder
- PTSD
- Schizophrenia
- ADHD
- Eating Disorder
- Substance Abuse
- Other: _____

Psychiatric Hospitalizations (if any):

Dates: _____ Reason: _____

Family History

Do any of your family members have a history of mental illness? Yes No (If yes, please specify):

Mental Health Questionnaire

Current Symptoms (check all that apply):

- Sadness
- Excessive Worry
- Panic Attacks
- Difficulty Concentrating
- Mood Swings
- Sleep Disturbances
- Low Energy
- Appetite Changes
- Self-Harm Thoughts
- Suicidal Thoughts
- Other: _____

Have you ever had thoughts of harming yourself or others? Yes No

If yes, please describe: _____

Have you ever attempted suicide? Yes No

Are you currently in therapy or counseling? Yes No

If yes, Therapist's Name: _____

Have you ever been prescribed psychiatric medication? Yes No

If yes, please list medications and dosages:

Consent & Acknowledgment

I hereby consent to psychiatric evaluation and treatment. Yes No

I consent to the use of my medical information for treatment purposes and for billing purposes, in accordance with HIPAA regulations. Yes No

I have received the Notice of Privacy Practices. Yes No

Signature: _____

Date: _____

Please bring your completed form to your first appointment, along with a valid ID and insurance information. Thank you for choosing our practice!