Dr. Shannon L. Sniff, M.D., PLLC
4502 Riverstone Blvd. #1301
Missouri City, TX 77459
T: 281-499-9402 F: 281-499-9360
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Fort Bend Psychiatry

Adult New Patient Information

Name:	**Birthdate**: / /		**Today's Date:** / /
Address: (street, city, zip)			
Preferred Phone Number:		Email:	
Career/ Job Title:		Employer:	
Are you adopted?		If so, at what age?	
Please list names/ relationships of all people with whom you live:			
Are you married?		If so, how long?	
Do you have children? YES NO	If so, #of children:	Ages:	
Emergency Contact Name:		Phone:	
What is/are your main goal(s)/concern(s) that led you to this appointment?			
Do you experience (circle any that apply):	Anxiety/fears	Depressed Mood	Irritability
	Compulsions	Flashbacks	Excessive Worry
	Sleep Trouble	Mood Swings	Post Partum Symptoms
	Suicidal Thoughts	Suicide Attempt	Cutting/ Self Harm
	Drug use	Low Appetite	Excessive Crying
How much alcohol do you drink per week?			
Do you use any illicit drugs or inappropriately use prescription pills? (If so, please explain)			
MEDICAL INFO			
Primary Care Physician Name:		Phone:	
Medical Problems (such as asthma, heart problems, murmur, head injury, seizure, diabetes, cancer, thyroid disease):			
Have you had any surgeries? Please list (including dates):			
CURRENT MEDICATIONS:		Dose/Timing:	
MEDICATION ALLERGIES (med name and reaction):			
PREFERRED PHARMACY (name/number/location):			

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PAST PSYCHIATRIC HISTORY:

Have you seen a psychiatrist before? If so, why and when?:

Have you been admitted to a psychiatric hospital? If so, why and when?:

Please list *all past psychiatric medications* (name, dose and timing):

Name of patient's outpatient therapist/counselor/psychologist:

FAMILY HISTORY: Please circle if you have a family history (applies only to biological relatives) of any of the following:

Depression Bipolar disorder (Manic Depression) Anxiety Obsessive Compulsive Disorder Suicide

Schizophrenia Drug dependence Alcohol Dependence ADHD/ADD Autism

DEVELOPMENTAL:

Are you aware of any developmental delays or disabilities you have been diagnosed with? YES NO

If yes, please explain:

Were you ever abused? YES NO If so, what type (physical, sexual, emotional)?

What is the highest level of education you completed?

OTHER

Have you ever abused/tried any type of illegal drug or pills that were not prescribed to you? YES NO

If so, please explain: Is this a current concern? YES NO

Have you ever been incarcerated? YES NO If so, for what reason?

ADDITIONAL CONCERNS

Please list any additional concerns you would like to have addressed. Your comments are confidential and used for the purpose of providing treatment:

Signature: Date: