|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***NEW PATIENT REGISTRATION FORM*** | | | | | | | | |
| **LAST NAME** |  |  |  |  | **FIRST NAME** | |  |  |
| **DOB** |  |  |  |  | **SSN** |  |  |  |
| **ADDRESS** |  |  |  |  |  |  |  |  |
| **ADDRESS** |  |  |  |  |  |  |  |  |
| **CITY** |  |  |  | **STATE** |  | **ZIP** |  |  |
| **PHONE (HOME)** | |  |  | **PHONE (CELL)** | |  |  |  |
| **E-MAIL ADDRESS** | |  |  |  |  |  |  |  |
| **MARRIED** | | **DIVORCED** |  | **SINGLE** | | **WIDOW OTHER** | | |
| **HOW DID YOU HEAR ABOUT US** | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **EMERGENCY CONTACT INFORMATION** | | | | |  |  |  |  |
| **LAST NAME** | |  |  |  | **FIRST NAME** | |  |  |
| **RELATIONSHIP** | |  |  |  |  |  |  |  |
| **PHONE (HOME)** | |  |  | **PHONE (CELL)** | |  |  |  |
| **PHONE (WORK)** | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **PATIENT INSURANCE INFO** | | | |  |  |  |  |  |
| **NAME OF PRIMARY INSURANCE** | | |  |  |  |  |  |  |
| **POLICY#** |  |  |  |  | **GROUP** | **#** |  |  |
| **CO-PAY AMOUNT** | |  |  |  |  |  |  |  |
| **INSURANCE COMPANY PHONE NUMBER** | | | |  |  |  |  |  |
|  | | |  |  |  |  |  |  |
| **SUBSCRIBER SSN** | |  |  |  |  |  |  |  |
| **RELATIONSHIP TO PATIENT** | | |  |  |  |  |  |  |
| **SUBSCRIBER ADDRESS (LEAVE IT BALNK IF IDENTICAL TO ABOBE MENTIONNED ADDRESS)** | | | | | | | | |
| **ADDRESS** |  |  |  |  |  |  |  |  |
| **CITY** |  |  |  | **STATE** |  | **ZIP** |  |  |
| **PHONE (HOME)** | |  |  | **PHONE (CELL)** | |  |  |  |
| **PAST MEDICAL HISTORY** | | | |  |  |  |  |  |
| **CURRENT WEIGHT** | |  |  |  |  | **HEIGHT** |  |  |
| **ALLERGIES** | |  |  |  |  |  |  |  |
| **CURRENT MEDICAL PROBLEMS** | | |  |  |  |  |  |  |
| **PAST SURGERIES** | |  |  |  |  |  |  |  |
| **LIST ALL CURRENT PRESCRIPTION MEDICATIONS/OVER-THE COUNTER MEDICATIONS** | | | | | | | | |
| 1 |  |  |  | 6 |  |  |  |  |
| 2 |  |  |  | 7 |  |  |  |  |
| 3 |  |  |  | 8 |  |  |  |  |
| 4 |  |  |  | 9 |  |  |  |  |
| 5 |  |  |  | 10 |  |  |  |  |
| **LIST ALL CURRENT SUPPLEMENTS** | | | |  |  |  |  |  |
| 1 |  |  |  | 6 |  |  |  |  |
| 2 |  |  |  | 7 |  |  |  |  |
| 3 |  |  |  | 8 |  |  |  |  |
| 4 |  |  |  | 9 |  |  |  |  |
| 5 |  |  |  | 10 |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **PAST PSYCHIATRIC HOSPITALIZATIONS** | | | |  |  |  |  |  |
| **OUPATIENT TREATEMENT** | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **INPATIENT TREATEMENT** | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **DATE OF YOUR LAST PHYSICAL EXAM** | | | |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **SUBSTANCE ABUSE:** | |  |  |  |  |  |  |  |
| **HAVE YOU EVER BEEN TRETAED FOR ALCOHOL OR DRUG USE OR ABUSE?** | | | | | | | **( ) YES** | **( ) NO** |
| **IF YES FOR WHICH SUBSTANCES?** | | | |  |  |  |  |  |
| **IF YES, WHERE WERE YOU TREATED AND WHEN?** | | | | |  |  |  |  |
| **HOW MANY DRINKS WOULD YOU HAVE PER WEEK?** | | | | |  |  |  |  |
| **HAVE YOU USED STREET DRUGS IN THE PAST 3 MONTHS?** | | | | | |  |  |  |
| **IF YES, WHICH ONES?** | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **HAVE YOU ABUSED PRESCRIPTION MEDICATIONS IN THE PAST 3 MONTHS?** | | | | | | | |  |
| **IF YES, WHICH ONES?** | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **TOBACCO HISTORY** | |  |  |  |  |  |  |  |
| **HAVE YOU EVER SMOKED CIGARETTES?** | | | |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **FAMILY PSYCHIATRIC HISTORY** | | | |  |  |  |  |  |
| **HAS ANYONE IN THE FAMILY BEEN DIAGNOSED WITH OR TREATED FOR:** | | | | | | |  |  |
|  |  | **Mother** | **Father** |  |  |  | **Mother** | **Father** |
| **BIPOLAR DISORDER** | |  |  |  | **SCHIZOPHRENIA** | |  |  |
| **DEPRESSION** |  |  |  |  | **PTSD** |  |  |  |
| **ANXIETY** |  |  |  |  | **ALCOHOL ABUSE** | |  |  |
| **ANGER** |  |  |  |  | **SUBSTANCE ABUSE** | |  |  |
| **SUICIDE** |  |  |  |  | **OTHER** |  |  |  |
|  |  |  |  |  |  |  |  |  |
| IF YES, PLEASE EXPLAIN: | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **TRAUMA HISTORY** | | |  |  |  |  |  |  |
|  |  |  |  |  |  | **YES** | **NO** |  |
| **WERE YOU ADOPTED** | | |  |  |  |  |  |  |
| **DID YOUR PARENTS DIVORCE** | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **DO YOU HAVE A HISTORY OF ABUSE?** | | | |  |  | **YES** | **NO** |  |
|  |  |  |  | **EMOTIONAL** | |  |  |  |
|  |  |  |  | **SEXUAL** |  |  |  |  |
|  |  |  |  | **NEGLECT** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **IF YOU RESPONDED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN** | | | | | | |  |  |
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| **IS THERE ANYTHING ELSE THAT YOU WOULD LIKE US TO KNOW** | | | | | | |  |  |
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| **SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | **DATE \_\_\_\_\_\_/\_\_\_\_\_\_/ 2018** | | |
| **PARENT/GUARDIAN SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | **DATE \_\_\_\_\_\_/\_\_\_\_\_\_/ 2018** | | |
| **EMERGENCY CONTACT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | **PHONE#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
|  |  |  |  |  |  |  |  |  |