PATIENT REGISTRATION

_____
DATE

PATIENT NAME:_____ SSN_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE (____)_____BUSINESS PHONE (____)_____

DOB_____ AGE_____ SEX_____ MARITAL STATUS_____

EMPLOYER:_____

ADDRESS_____

CITY_____STATE_____ZIP_____

SPOUSE NAME:_____SSN_____

EMPLOYER:_____BUSINESS PHONE_____DOB_____

IF THE ABOVE NAMED PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

RESPONSIBLE PARTY_____

ADDRESS_____

HOME PHONE(____)_____ BUSINESS PHONE(_____)_____

CONTACT PERSON IN CASE OF EMERGENCY:

NAME_____ RELATIONSHIP_____

PHONE NUMBER_____

REFERRAL SOURCE: _____

PERSONAL QUESTIONNAIRE:

FAMILY HISTORY: NAME	AGE	IF LIVING HEALTH	AGE AT DEATH	CAUSE
FATHER:				
MOTHER:				
SIBLING:				
1.				
2.				
3.				
4.				
5.				
CHILDREN:				
1.				
2.				
3.				
4.				
5.				

MEDICAL CONDITIONS:

	YOU	FAMILY MEMBER
CANCER		
TUBERCULOSIS		
DIABETES		
HEART TROUBLE		
STROKE		
HIGH BLOOD PRESSURE		
SEIZURES		
MENTAL ILLNESS		
AIDS TEST +/- DATE_____		

EDUCATION:

HIGHEST GRADE COMPLETED _____
GRADUATION: HIGH SCHOOL/YEAR_____ COLLEGE/YEAR_____

MARITAL HISTORY:

AGE AT MARRIAGE	CONDITION OF MARRIAGE	AGE AT DIVORCE
1.		
2.		
3.		

REASON FOR SEEKING CONSULTATION:

_ MEDICAL HISTORY :

DO YOU USE TOBACCO?_____HOW MUCH? _____
DO YOU USE ALCOHOL?_____ HOW MUCH?_____
DO YOU USE STREET DRUGS?_____ HOW MUCH?_____

HAVE YOU HAD A CHANGE IN APPETITE? _____
EXPLAIN_____

HAVE YOU HAD A CHANGE IN SLEEP? _____
EXPLAIN_____

WEIGHT:_____ 1 YEAR AGO_____ MAXIMUM_____

PREVIOUS PSYCHIATRIC HISTORY:

HAVE YOU EVER UNDERGONE COUNSELING?_____

THERAPIST:_____ FREQUENCY_____
DATE OF THERAPY: BEGAN_____ ENDED_____

THERAPIST:_____ FREQUENCY_____
DATE OF THERAPY: BEGAN_____ ENDED_____

HAVE YOU EVER BEEN TREATED WITH PSYCHIATRIC MEDICATIONS?_____

RX NAME:_____ DOSE:_____
APPROXIMATE DATE:_____ RESULT:_____

RX NAME:_____ DOSE: _____
APPROXIMATE DATE:_____ RESULT: _____

HAVE EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS?_____
HOSPITAL:_____ YEAR:_____
REASON: _____
PHYSICIAN:_____

MEDICAL HISTORY CONTINUED:

IS THERE A HISTORY OF ANY CHRONIC OR SERIOUS CONDITION? OR, ANY SURGERY? PLEASE EXPLAIN. _____
_____

DATE OF LAST PHYSICAL EXAM _____
PHYSICIAN_____

BROKEN BONES? _____
HAVE YOU EXPERIENCED ANY TYPE OF HEAD TRAUMA? _____
IF SO, PLEASE EXPLAIN. _____

NUMBER OF PREGNANCIES _____
NORMAL DELIVERY? _____
CESAREAN SECTIONS? _____ # _____
PREMATURE BIRTHS? _____ # _____
ABORTIONS? _____ # _____
LAST PELVIC EXAM/PAP SMEAR DATE _____

PLEASE LIST ALL CURRENT MEDICATIONS:

PRESCRIBED:	OVER THE COUNTER:
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE LIST MEDICAL ALLERGIES:
_____ _____

I GIVE MY PERMISSION FOR THE DOCTOR'S OFFICE TO LEAVE A MESSAGE ON MY ANSWERING MACHINE OR VOICE MAIL:
YES _____ NO_____

THE FOLLOWING INFORMATION MAY BE LEFT:
APPOINTMENT TIME
YES _____ NO_____

INSURANCE OR BILLING QUESTIOINS:
YES_____ NO_____

GUARANTEE OF PAYMENT

I understand that the ultimate responsibility of this account is mine. Insurance is filed and collected on my behalf as a courtesy to me, the client, and to be of assistance in managing my account as efficiently as possible. However, the total balance owed is my ultimate responsibility whether or not the insurance company reimburses.

PLEASE NOTE: APPOINTMENTS NOT CANCELLED WITH 24-HOUR NOTICE WILL BE CHARGED

CLIENT'S NAME:_____ **DATE:**_____

RESPONSIBLE PARTY:_____

RESPONSIBLE PARTY'S SIGNATURE:_____