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New Patient History and Registration Form

I. Identifying Information

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Gender: ☐Female ☐Male

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed
☐Committed Relationship ☐Domestic Partnership/Civil Union
Spouses Name (if applicable):_____

Address:_____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____ Work #:_____

Email address:_____

Is it OK to leave a message at your: ☐Home # ☐Cell # ☐Work # ☐Other # _____

Currently Employed? ☐Yes ☐No Employer:_____

Emergency Contact Name:_____ Relationship:_____

Emergency Contact #(s):_____

Who referred you to my practice or how did you hear about my practice?_____

Is it OK to contact the above to say thank you for the referral? ☐Yes ☐No

Primary Care Doctor (PCP):_____ Phone#:_____

PCP Address: _____

Current Mental Health Provider (if any):_____ Phone: _____

I don't submit insurances since I am an out-of-network provider. No worker's comp. Will you need a detailed receipt for an Out-of-network health insurance that you will be submitting?

Person responsible for payment (if other than identified above):_____

Address_____

Phone_____

II. Presenting Problem and Psychiatric History

Please describe your main reasons for seeking help at this time:_____

_____

_____

How long has this been a significant problem for you (be as specific as possible):_____

_____

_____

Are symptoms or issues related to the above problem? Please check/circle all that apply for you **now**.

☐Anger / Irritable / Temper	☐Alcohol/Drug use	☐Anxiety/ Nervousness	
☐Appetite/ eating concerns/ restricting food/ overeating	☐Arguing / fighting	☐Chronic pain	☐Compulsive behaviors
☐Concentration problems	☐Depression	☐Difficulty making decisions	☐Difficulty with assertiveness
☐ Fatigue / lack of energy	☐ Fears / worries	☐ Feeling moody	☐ Financial problems
☐ Health problems/ adjustment to illness	☐ Impulsivity/ not acting before thinking	☐ Infertility	☐ Job loss
☐ Loneliness	☐ Loss of a loved one/ grief	☐ Low motivation / apathy	☐ Low self-esteem
☐ Marital problems	☐ Marital Infidelity	☐ Nightmares	☐ Obsessive thoughts
☐ Panic attacks	☐ Pregnancy loss/ miscarriage	☐ Premenstrual tension	☐ Rape/ sexual assault
☐ Relationship problems	☐ Restlessness	☐ Self-harm	☐ Sexual concerns
☐ Sleep difficulties	☐ Social withdrawal	☐ Stress	☐ Suicidal thoughts/ behavior
☐ Traumatic experience	☐ Weight concerns	☐ Work/ school	☐ homicidal ideas
☐ Other:	☐ Other:	☐ Other:	☐ Other:

Have you ever been given a mental health diagnosis in the past from a mental health or health professional? ☐ Yes ☐ No If yes, as you understand it, what is/was the diagnosis? Who told you of the diagnosis and when?

Have you ever had treatment by, or are you currently seeing, a mental health or substance abuse professional or program, including a psychiatrist, psychologist, therapist, or counselor?
☐ Yes ☐ No If yes, please list the year(s), provider name(s), and reasons for treatment:

Have you ever been hospitalized for a mental health or psychiatric issue?
☐Yes ☐ No If yes, please list the year(s), hospital name(s), and reasons for hospitalization:

Have you ever experienced any of the following?

Experienced unwanted sexual attention or activity?	Yes____	No____
Experienced a violent or otherwise traumatic event?	Yes____	No____
Been the victim of physical, sexual, verbal, or emotional abuse?	Yes____	No____
Experienced suicidal thoughts or made a suicide attempt?	Yes____	No____

If you answered "Yes" to any of the above, please describe briefly:_____

_____

_____

III. Medical History

Date of last physical exam:_____ By whom?_____

Do you have any medical or physical problems? ☐ Yes ☐ No If yes, please describe:_____

_____

_____

Medical Specialists (other than your PCP):

Name Specialty Phone #

_____

_____

_____

For Women

Gynecologist's Name_____Phone #: _____

Date of last gynecological exam: _____Number of pregnancies_____

Are you currently pregnant? ☐ Yes ☐ No Are you menopausal ? _____

Have you ever experienced a pregnancy loss (e.g. miscarriage)? ☐Yes ☐No Date(s):_____

Have you ever had a pregnancy termination/abortion? ☐ Yes ☐ No Date(s) _____

Do you have any particular difficulties associated with menstruation, ovulation or menopause ?

☐ Yes ☐ No

If yes, please describe (include mood swings, headaches, pelvic pain, hot flushes, sleeping issues,etc.):___

_____

_____

Please list your **CURRENT** medications and dosages (including prescription, non-prescription, and herbal/alternative/supplements): Use back of page if need more room.

Medication	Dosage	Purpose	Prescribed by	When started	Benefits/Problems

PAST medications, including prescription, non-prescription, and herbal/alternative/supplements:

Medication	Dosage	Purpose	Prescribed by	When started/ stopped	Benefits/Problems

Are you allergic to any medications? _____

Food or environmental allergies?_____ Gut issues?_____

1. How many hours of sleep do you average per night?_____
2. Do you exercise? ☐ Yes ☐ No If so, what type of exercise and how often?_____
3. Do you use products with caffeine (i.e., coffee, caffeine/energy drinks)? ☐ Yes ☐ No
   If yes, specify type and amount/frequency _____
4. Would you consider that you engage in "high risk" sexual behaviors? ☐ Yes ☐ No
   If yes, explain _____
5. Do you diet? ☐ Yes ☐ No How frequently? _____
6. Do you consider yourself to have a weight problem? ☐ Yes ☐ No
7. Have you experienced any of the following?
   - Childhood medical, developmental, or learning problems? ☐ Yes ☐ No
   - History of significant illnesses, injuries, surgeries, or hospitalizations? ☐ Yes ☐ No
   - A head injury? ☐ Yes ☐ No
   - History of seizures? ☐ Yes ☐ No
   - Significant current medical illnesses or conditions? ☐ Yes ☐ No

   If yes to any of the above, please describe:_____

8. Do you currently smoke cigarettes? ☐ Yes ☐ No If yes, how many/day? _____
9. Did you previously smoke cigarettes? ☐ Yes ☐ No When did you quit? _____
10. Do you currently smoke marijuana? ☐ Yes ☐ No If yes, how often? _____
11. Did you previously smoke marijuana? ☐ Yes ☐ No When did you quit? _____
12. Have you ever used cocaine? ☐ Yes ☐ No Last time used? _____
13. Have you ever used other drugs? ☐ Yes ☐ No Type and last time used? _____
14. Do you drink beer, wine, liquor, or other alcoholic beverages? ☐ Yes ☐ No

    How many days per week?_____

    On the days you drink, how much do you drink?_____
15. Have you ever wondered if you had a problem with drugs or alcohol? ☐ Yes ☐ No

    If yes, why? _____
16. Has anyone ever suggested that you may have a problem with drugs or alcohol? ☐Yes ☐No

IV. Family and Social History

Did you finish high school? ☐ Yes ☐ No

Did you attend college? ☐ Yes ☐ No If yes, please list all:_____

_____

Highest degree earned:_____

Have you ever been in any legal difficulty? ☐ Yes ☐ No When?_____

Circumstances:_____

Has anyone close to you ever died? ☐ Yes ☐ No If so, who and when? _____

_____

Has anyone close to you ever committed suicide? ☐ Yes ☐ No If so, who and when?_____

_____

Has a family member ever been treated for emotional difficulties, mental health or psychiatric issues?

☐ Yes ☐ No If yes, please explain:_____

Have you ever had concerns about the use of alcohol or drugs by someone close to you?

☐ Yes ☐ No If yes, please explain:_____

Who lives with you in your current household?

First name	Age	Relationship to you

Other family members (i.e., spouse, children) who do not currently live with you:

First name	Age	Relationship to you

Your family of origin (i.e., parents, step-parents, siblings)

First name	Age	Relationship to you

Please provide any other information you feel may be relevant to an understanding of you as a person. This may include past or current family or social situations, cultural background, language, ethnicity, sexual orientation, spirituality or religion, or anything else important to a sense of your identity and view of the world.

Print Name _____ Signature _____ Date _____