Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian | Date

Name: _____ Age: _____ Sex: _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

Date symptoms started _____

Have you lost any days from work or school? ☐ Yes ☐ No

Medications

Have you ever taken the following medicines?

- ☐ SSRI (*eg* Prozac/fluoxetine, Paxil/paroxetine, Celexa/citalopram, Lexapro/escitalopram)
- ☐ Effexor/venlafaxine or Cymbalta/duloxetine
- ☐ Tricyclics (*eg* Elavil/amitryptyline, Pamelor/nortryptyline, Tofranil/imipramine, Anafranil/clomipramine)
- ☐ Wellbutrin/ buproprion
- ☐ Desyrel/trazodone, Serzone/nefazodone
- ☐ Mood stabilizers (*eg* Lithium, Tegretol/carbamazepine, Topramax/toprimate, Depakote/valproate, Lamictal/lamotrogine)
- ☐ Antipsychotic mood stabilizers (*eg* Seroquel/quetipine, Geodon/ziprasidone, Abilify/aripiprazole, Zyprexa/olanzapine, Haldol/haloperidol, Clozaril/clozapine, Prolixin/fluphenazine)
- ☐ Sleeping pills (*eg* Ambien/zolpidem, Desyrel/trazodone, Sonata/zaleplon, Restoril/temazepam)
- ☐ Anti-anxiety medicines (*eg* Ativan/lorzepam, Klonipin/clonazepam, Xanax/alprazolam, Valium/diazepam, Buspar/buspirone)
- ☐ ADHD medicines (*eg* Ritalin/Concerta/methylphenidate, Adderall/amphetamine, Strattera/atomoxetine)

List other medicines you are taking:

_____

_____

Past Psychiatric History

Check all that apply:

- ☐ ADHD
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Eating Disorder
- ☐ Phobia(s)
- ☐ Obsessive Compulsive
- ☐ Pre-Menstrual Dysphoric Disorder/PMS
- ☐ Post Traumatic Stress
- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Substance Abuse
- ☐ Suicide Attempt

Have you seen a psychiatrist, psychologist or therapist/counselor in the past?

☐ Yes ☐ No When? _____

Allergies

Are you allergic to any of the following?

- ☐ ACE Inhibitors
- ☐ Adhesive Tape
- ☐ Anesthetics
- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine (including contrast dye)
- ☐ Latex
- ☐ Penicillin
- ☐ NSAIDs (Ibuprofen, Naprosyn, Advil)
- ☐ Seizure Medicines
- ☐ Sulfa

Details/Reactions: _____

_____

Lifestyle Factors

Has anyone in your home ever physically, emotionally or sexually abused you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs? (Including abuse of prescription drugs)

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Are you currently:

☐ Working ☐ Not Working by Choice ☐ Unemployed ☐ Disabled ☐ Retired ☐ Volunteering

Have you ever served in the military?

☐ Yes ☐ No

How would you identify your sexual orientation?

☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Asexual ☐ Transsexual ☐ Other ☐ Unsure/Questioning ☐ Prefer Not to Answer

Have you ever been arrested?

☐ Yes ☐ No

Do you have any pending legal problems?

☐ Yes ☐ No

Do you belong to a particular religion or spiritual group?

☐ Yes ☐ No Please list: _____

Highest Educational Level Attained:

☐ Grade School ☐ High School ☐ Junior College ☐ Undergraduate College/University ☐ Graduate School

Name: _____ Age: _____ Sex: _____ Date of Appointment: _____

Past Medical History

Have you ever had any of the following?

- ☐ Anemia
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Head Injury
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Other: _____

Hospitalizations & Surgeries

Reason: Date:

_____ _____

_____ _____

Have you ever had an EKG?

☐ Yes ☐ No If yes, when? _____

Was the EKG: ☐ Normal ☐ Abnormal ☐ Not Sure

Women Only

Are you currently pregnant or think you may be pregnant?

☐ Yes ☐ No

Are you planning to get pregnant in the near future?

☐ Yes ☐ No

Birth Control Method:

☐ Condoms ☐ Pill ☐ Shot ☐ Patch ☐ Ring ☐ Under Skin

☐ IUD ☐ Tubal Ligation ☐ Vasectomy in Partner ☐ Not Applicable

Date of Last Menstrual Cycle: _____

Family History

Has anyone in your family (mother, father, siblings, grandparents) had a history of the following:

- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anger
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Obsessive Compulsive Disorder
- ☐ Phobias
- ☐ Post Traumatic Stress
- ☐ Schizophrenia
- ☐ Suicide Attempts or Thoughts
- ☐ Thyroid Disease
- ☐ Violence

Details: _____

Review of Systems

Psychological

- ☐ Anxiety Attacks
- ☐ Avoidance/Avoidant Personality Disorder
- ☐ Change in Appetite
- ☐ Decreased Libido
- ☐ Decrease Need For Sleep
- ☐ Excessive Energy
- ☐ Excessive Guilt
- ☐ Excessive Worry
- ☐ Fatigue
- ☐ Forgetfulness
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Racing Thoughts
- ☐ Sleeping problems
- ☐ Increased Irritability
- ☐ Increased Libido
- ☐ Increase in Risky Behavior
- ☐ Loss of Interest in Most Things
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Thoughts of harming or killing someone
- ☐ Trouble concentrating
- ☐ Unable to enjoy activities

General

- ☐ Chills
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Gastrointestinal

- ☐ Abdominal Cramping/Pain
- ☐ Acid Taste
- ☐ Bloating
- ☐ Diarrhea
- ☐ Frequent Belching
- ☐ Indigestion
- ☐ Nausea

Neurology

- ☐ Burning Pain
- ☐ Headache
- ☐ Seizures
- ☐ Tingling
- ☐ Tremor
- ☐ Visual Changes

Ear, Nose & Throat

- ☐ Hearing Problem
- ☐ Hoarseness
- ☐ Ringing in Ears

Cardiovascular

- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Lightheadedness
- ☐ Palpitations

Musculoskeletal

- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Weakness

Respiratory

- ☐ Chest Tightness
- ☐ Coughing
- ☐ Shortness of Breath
- ☐ Wheezing

☐ Other: _____