WELCOME

PATIENT REGISTRATION INFORMATION

Date _____

Patient's Name _____ **Age** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Telephone: Home _____ **Work** _____ **Cell** _____

Date of Birth _____ **Birth Place** _____ **Sex: Male** ☐ **Female** ☐

Marital Status: Single ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐

Social Security Number _____

Employer _____ **Telephone #** _____

Spouses Name _____

Telephone Number: Home _____ **Work** _____ **Cell** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Social Security Number _____ **D.O.B.** _____

Employer _____ **Telephone #** _____

Emergency Contact (Someone not living with you) _____

Telephone Number _____

Referred By _____ **Reason** _____

IMPORTANT: List any known medication allergies _____

_____

INSURANCE INFORMATION:

Person responsible for Health Insurance Coverage

Policy Holder's
Name _____ D.O.B. _____

Your Relationship to
Policy Holder _____

Address _____
(If different from 1st page)

City, State, Zip Code _____

Telephone #'s _____
(If not listed on 1st Page)

ID # (On Card) _____ Policy # _____

Insurance Company Telephone #'s On Card _____

Referral # _____

Referred by _____ Reason _____

I authorize the release of "minimum necessary" information to my insurance carrier if that information is required for authorization for care and payment. I authorize the use of my signature on insurance claims.

_____

Signature of Cardholder Date

FAMILY HISTORY:

Father's name_____Age_____
Occupation_____
If living, present condition of health_____
If deceased, cause of death_____

Mother's name_____Age_____
Occupation_____
If living, present condition of health_____
If deceased, cause of death_____

Please list any stepparents_____

Brothers and /or Sisters (Please indicate half and step siblings)

Names and Ages_____

_____

EDUCATION:

Highest level completed_____Currently in School? Yes_____ No_____

If yes, where?_____

MARITAL HISTORY:

Date of present marriage_____Children? Yes_____ No_____

Child's name	Birthplace	Age	Natural, Adopted, Step, Foster Child?	Lives at Home? Yes	No

MEDICAL HISTORY:

Please list any past and/or current medical illness.

Illness	Age or Year	Physician

Any Surgeries? Yes No

Type	Age or Year	Physician

History of accidents or trauma? Yes No

If yes, please describe_____

History of seizures, head injuries, or periods of unconsciousness? Yes No

If yes, please describe_____

PSYCHIATRIC HISTORY:

Current or previous psychiatrist/therapist_____

Any psychiatric hospitalization? Yes No

If yes, please list dates and treatment_____

MEDICATION HISTORY:

List any medications you have taken in the **past.**

Medication	Dosage	Prescribed by:

List any medication you are **currently taking**:

Medication	Dosage	Prescribed by:

Medication allergies, if any_____

Do you smoke?_____How much?_____

Do you drink alcohol?_____How much and at what frequency_____

Do you use drugs (marijuana, cocaine, etc.)?_____How much and at what frequency_____

Have you ever had trouble with the law?_____ Explain_____

Family History of Medical and/or Psychiatric Illness: Please check appropriate blank beside each illness. If you answer "Yes" indicate relationship (Self, Mother, Father, Grandparents, etc.). If you are a **parent or guardian completing this form** for a child or adolescent , **please indicate relationship to child/adolescent.**

ILLNESS	YES	NO	RELATIONSHIP TO YOU
Depression	___	___	_____
Manic Depression (Bipolar)	___	___	_____
Eating Disorder	___	___	_____
Schizophrenia	___	___	_____
Alcoholism	___	___	_____
Drug Use/Abuse/Addiction	___	___	_____
Panic Attack	___	___	_____
Child Abuse	___	___	_____
Thyroid Disease	___	___	_____
Cancer	___	___	_____
Heart Trouble	___	___	_____
Strokes	___	___	_____
Epilepsy (Seizures)	___	___	_____
Mental Retardation	___	___	_____
Diabetes	___	___	_____
Speech Problems	___	___	_____
Hearing/Vision Problems	___	___	_____
Reading/Writing Problems	___	___	_____
Arithmetic Problems	___	___	_____
Difficulty Following Directions	___	___	_____
Other_____ (I.e. "Nervous Breakdown)			_____