**NEW PATIENT REGISTRATION**

**\*Note: If you have been a patient here before, please fill in only the information that has changed.**

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| **Legal Name:** | **Preferred Name:**  | **Date: / /** |
| **Address:**  | **City:**  | **State:**  | **Zip Code:**  |
| **Home Phone:**  | May I Call This Number? [ ]  Yes [ ]  No Leave a Message? [ ]  Yes [ ]  No  | **Cell Phone:**  | May I Call This Number? [ ]  Yes [ ]  No Leave a Message? [ ]  Yes [ ]  No |
| **Social Security Number:**  | **Sex:**  | **Age:** | **DOB**:  **/ /** |
| **Sexual Orientation:** [ ] Straight [ ] Lesbian [ ] Gay [ ] Bisexual [ ]  Straight [ ] Queer [ ] Not sure [ ] Other, | **Gender Identity:** [ ] Male, [ ] Female, [ ] Trans ([ ] MTF [ ] FTM) [ ] Other, |
| **Email Address:**  | May I E-Mail Reminders? [ ]  Yes [ ]  No |
| Calls or e-mail will be discreet, but please indicate any restrictions: |  |
| **Responsible person for bill:**  | **Relationship:** | **Address**:  | **Phone:**  |
| **MEDICAL & REFERRAL INFORMATION** |
| Name of Physician/Primary Care Provider: | Phone:  |
| Name of Therapist/Counselor: | Phone: |
| By Whom Were You Referred? | Relationship:  |
| May I have your permission to thank this person for the referral? [ ]  Yes [ ]  No  |
| **HOUSEHOLD INFORMATION** |
| Relationship Status: [ ] Married [ ] Partnered [ ] Single [ ] Multiple Partners [ ] Separated/Divorced [ ] other |
| Living Environment: [ ]  Live Alone [ ]  Live with spouse/partner(s) [ ]  Live with roommate(s) [ ]  Live with parent(s)/guardian(s) or family [ ]  Live with children/dependents |
| Spouse / Partner(s) / Significant other(s) Others in Home: |
| **Emergency Contact** |
| Name(s):  | **Relationship:**  | Phone:  |
| If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call? |
| **Contact:** | **Relationship:**  | **Address:** |
| **Home Phone:**  | **Cell Phone:**  | **Work Phone:**  |
| **Legal Next of Kin:**  | **Relationship:**  | **Address:** |
| **Home Phone:**  | **Cell Phone:**  | **Work Phone:**  |
| **MEDICAL HISTORY** |
| Any changes in your general physical health in the past 3-6 months? No [ ]  Yes [ ]  please explain, |
| Do you experience chronic pain? No [ ]  Yes [ ]  If YES, how managed (PT, Rx, etc.)? |
| Have you ever been diagnosed with a mental illness, had a psychiatric hospitalization or suicide attempt, or struggled with drugs or alcohol? No [ ]  Yes [ ]  If Yes, please indicate condition, treatments, & medications. |
|   |
| Primary Care Provider (PCP):  | Clinic: | Phone: | Fax: |
| Please check all that apply: [ ]  Anemia [ ]  Arthritis/Joint Pain [ ]  Asthma [ ]  Abnormal blood clotting [ ]  Bronchitis [ ]  Cancer[ ]  Chemotherapy History [ ]  Cataracts [ ]  Diabetes [ ]  Elevated Cholesterol [ ]  Emphysema [ ]  Fainting or blackout spells [ ]  Frequent bladder infections [ ]  Gallbladder Disease [ ]  Glaucoma [ ]  Head Injury/trauma [ ]  Heart Disease [ ]  Heart valve problems [ ]  High Blood Pressure [ ]  HIV/ AIDS [ ]  Irritable Bowel Syndrome/Colitis [ ]  Cirrhosis [ ]  Hepatitis (A, B, C) [ ]  Loss of consciousness [ ]  Migraines/other headaches [ ]  MRSA (staph) [ ]  Obesity [ ]  Periods of lost memory [ ]  PMS syndrome [ ]  Prostate Trouble [ ]  Seizures[ ]  Sexually Transmitted Infection [ ]  Stroke [ ]  Thyroid Trouble [ ]  Tuberculosis [ ]  Ulcers (stomach/intestine)[ ]  Other, please list below:  |
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| **MENTAL HEALTH HISTORY**  |
| **have you had any mental health diagnoses from another doctor?** No [ ]  Yes [ ]  | **Date: / /** |
| Doctor Name:  | Phone:  |
| **PHARMACY INFORMATION** |
| Pharmacy Address:  | Pharmacy Phone:  |
| **FAMILY MEDICAL HISTORY** |
| If yes, who? ([ ]  Parent, [ ]  sibling, [ ]  children, [ ]  aunt/uncle, [ ]  grandparent) |
| Please check all that apply: [ ]  Anemia [ ]  Arthritis/Joint Pain [ ]  Asthma [ ]  Abnormal blood clotting [ ]  Bronchitis [ ]  Cancer[ ]  Chemotherapy History [ ]  Cataracts [ ]  Diabetes [ ]  Elevated Cholesterol [ ]  Emphysema [ ]  Fainting or blackout spells [ ]  Frequent bladder infections [ ]  Gallbladder Disease [ ]  Glaucoma [ ]  Head Injury/trauma [ ]  Heart Disease [ ]  Heart valve problems [ ]  High Blood Pressure [ ]  HIV/ AIDS [ ]  Irritable Bowel Syndrome/Colitis [ ]  Cirrhosis [ ]  Hepatitis (A, B, C) [ ]  Loss of consciousness [ ]  Migraines/other headaches [ ]  MRSA (staph) [ ]  Obesity [ ]  Periods of lost memory [ ]  PMS syndrome [ ]  Prostate Trouble [ ]  Seizures[ ]  Sexually Transmitted Infection [ ]  Stroke [ ]  Thyroid Trouble [ ]  Tuberculosis [ ]  Ulcers (stomach/intestine)[ ]  Other, please list below:  |
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| **FAMILY MENTAL HEALTH HISTORY**  |
| Has anyone in your family ever been diagnosed with a mental illness, had a psychiatric hospitalization or suicide attempt, or struggled with drugs or alcohol? No [ ]  Yes [ ]  If Yes, please indicate relation, condition, treatments, & medications. |
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| **CURRENT MEDICATIONS** **Please list your current medications, vitamins, & herbal supplements (or supply printed list).** |
| **Medication** | **Dosage** | **Times a day** | **Reason of taking** | **Prescriber** |
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| **Medication allergies/reaction:** [ ] No known drug allergies [ ] Yes, please list below.  |
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|  |  |  |  |  |
| **OTHER ALLERGIES** (Food/Environment): [ ]  No [ ]  Yes, please list below. |
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|  |  |  |  |  |
| **PREVENTION** |
| **Wears seatbelt? No** [ ]  **Yes** [ ]  | **Wears biking helmet?** No [ ]  Yes [ ]  | **Firearms kept in home?** No [ ]  Yes [ ]   |
| **Tobacco:** Current packs a day **\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** [ ]  Former Smoker [ ]  Non-smoker [ ]  Pipe [ ]  Cigars [ ]  Chew |  |
| **Alcohol**: Drinks a week **\_\_\_\_\_\_\_\_\_** [ ]  Drink occasionally [ ]  Do not drink | **Caffeine:** caffeinated beverages a day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No caffeine |
| **Sexual Partner(s) last 12 months:** [ ]  Men [ ]  Women [ ]  Transgender [ ] None/abstinent **, Number of partners:**  |
| **ACTIVITY (check one)** |
| [ ]  Sedentary life with little exercise [ ]  Occasional vigorous activity with work or [ ]  Mild Exercise with job, house, or recreation (climb stairs, walk over 3 blocks, etc) [ ]  Regular vigorous exercise program or hard work [ ]  Other, please explain:  |
| Does someone have power of attorney, or guardianship giving them the power to make decisions about your care in life-Recreation threatening situations, or a psychiatric advance directive? No [ ]  Yes [ ]  , **Name & relationship**:  |
| [ ]  **I verify that the above information is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my provider of any changes in my medical status.** |
| **Patient/Parent/Guardian Signature:** | **Date:**  | * **\*Must be completed before your appointment.**
* **\*Must be Submitted 2 days prior to your appointment.**
* **\*This document will be retained in your medical record.**
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|  | **/ /** |