**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. | | | | | | | | | | | | | | | | | | | |
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| 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.** | | | | | | | | | |
|  | | | **/ /** | | | |