PATIENT REGISTRATION & MEDICAL HISTORY

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

Today's Date: _____
Legal Name: _____ Preferred Name: _____ Age: _____ Sex: _____

Gender Identity: Male Female Trans (MTF FTM) _____ Preferred pronouns: _____

Sexual Orientation: Lesbian Gay Bisexual Straight Queer Not sure _____

Race / Ethnicity: African American/Black Asian Caucasian/White Multi Native American/Alaskan

Native/Inuit Pacific Islander Other _____ /Hispanic/Latino/Latina Not Hispanic/Latino/Latina

Address: _____ Social Security #: _____ City,
State, Zip: _____ Date of Birth: _____

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

E-mail: _____ May I E-Mail Reminders? Yes No
Calls or e-mail will be discreet, but please indicate any restrictions: _____

Party Responsible for Payment: _____ Relationship: _____
Address: _____ Phone: _____

EMPLOYER INFORMATION
Employer: _____ Occupation: _____
Address: _____

Work Phone: _____ May I Call This Number? Yes No Leave a Message? Yes No

INSURANCE INFORMATION
If we do not accept your specific insurance plan for services you may still be able to receive reimbursement for your care by submitting your own claims to your insurance company on your own. We may attempt to assist in the process, but we do not submit claims for patients.
Primary Insurance Company: _____ Effective date: _____
Name of Insured: _____ Policy/Member #: _____ Copay: $_____
Subscriber Name/ID #: _____ Relationship: _____ Group/Plan #: _____
Claims Address: _____ Phone: _____
Secondary Insurance Company: _____ Effective date: _____
Name of Insured: _____ Policy/Member #: _____ Copay: $_____
Subscriber Name/ID #: _____ Relationship: _____ Group/Plan #: _____
Claims 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 ☐ _____

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): _____ Phone: _____Relationship: _____

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: _____

FAMILY MEDICAL HISTORY - If yes, who? (Parent, sibling, children, aunt/uncle, grandparent)

❑ 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

❑ Prostate Trouble ❑ Seizures ❑ Sexually Transmitted Infection ❑ Stroke ❑ Thyroid Trouble

❑ Tuberculosis ❑ Ulcers (stomach/intestine) ❑ PMS syndrome

Any ongoing health problems not listed above? No ❑ Yes ❑

If yes, please list: _____

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.

Mother: _____
Father: _____
Sibling(s):_____
Maternal Grandmother:_____
Paternal Grandmother:_____
Maternal Grandfather:_____
Paternal Grandfather:_____
Unknown/Adopted:_____

YOUR MEDICAL HISTORY 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

❑Prostate Trouble ❑PMS syndrome ❑Seizures ❑Sexually Transmitted Infection ❑Stroke ❑Thyroid Trouble

❑Tuberculosis ❑Ulcers (stomach/intestine)

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, pain management clinic, yoga, acupuncture etc)?

Operations and/or Hospitalizations for MEDICAL REASONS: (Please list surgeries and/or hospitalization reasons and dates)

_____

_____

Who is your Primary Care Provider (PCP) _____ Clinic _____

When was your last complete physical exam including basic blood/lab work?_____

Telephone _____ Fax _____

YOUR MENTAL HEALTH HISTORY

Below are a listing of common mental health symptoms. Please **check all that apply** to you currently or in your past.

DEPRESSION: Have you ever experienced any of the following?

☐ Fatigue or loss of energy almost every day ☐ Feelings of worthlessness or guilt almost every day

☐ Impaired concentration, indecisiveness ☐ Insomnia most every day ☐ Loss of interest in things you once enjoyed ☐ Restlessness or feeling slowed down ☐ Recurring thoughts of death or suicide ☐ Weight loss or gain

ANXIETY: Have you ever experienced any of the following?

☐ Persistent worrying concerns that's out of proportion to the impact of the event ☐ Inability to set aside or let go of a worry

☐ Inability to relax, restlessness, and feeling keyed up or on edge

☐ Difficulty concentrating, or the feeling that your mind "goes blank"

Physical: ☐ Fatigue ☐ Irritability ☐ Muscle tension or muscle aches ☐ Trembling, feeling twitchy ☐ Being easily startled

PTSD/TRAUMA: Have you ever experienced any of the following?

☐ Hypervigilance: feeling “on edge” constantly for no known reason, having a heightened or exaggerated startle response. ☐ Avoidance: intentionally avoiding people or activities to limit triggering events

☐ Flashbacks/Nightmares of past painful experiences or reoccurring dreams with themes of being attacked, chased, falling, etc

BIPOLAR/MOOD DISREGULATION: Have you ever experienced any of the following?

☐ Inflated self-esteem or grandiosity ☐ Decreased need for sleep (e.g., feels rested after 3 hours of sleep.) ☐ More talkative than usual or pressure to keep talking. ☐ Flights of ideas or subjective experience that thoughts are racing. ☐ Increase in goal directed activity, or psychomotor agitation. ☐ Distractibility (too easily drawn to unimportant or irrelevant external stimuli). ☐ Excessive involvement in activities that have a high degree for painful consequences (e.g., extravagant shopping, sexual adventures or improbable commercial schemes)

SLEEP: Have you ever experienced any of the following?
☐ Difficulty Falling Asleep ☐ Difficulty Staying Asleep ☐ Early Waking ☐ Waking without feeling rested

APPETITE: low/increased/normal

ENERGY: low/increased/normal

PSYCHOSIS: Have you ever experienced any of the following?
☐ Hallucinations: hearing, seeing, or feeling (touch) things others said where not real ☐ Delusion: beliefs that others told you were "wrong" or "not true" even though it felt true to you. (ex. Believing that you could fly or that someone was out to hurt you or that you were being watched) ☐ Ideas of Reference: have you ever believed that seemingly normal or common occurrences had a special secret meaning meant only for you? (ex. Songs playing on the radio, commercials on TV, finding a particular object in a certain place)

INATTENTION: Have you ever experienced any of the following? ☐ Often fail to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities ☐ Often have trouble holding attention on tasks or play activities. ☐ Often do not seem to listen when spoken to directly. ☐ Often do not follow through on instructions and fail to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked) ☐ Often has trouble organizing tasks and activities. ☐ Often avoid, dislike, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).☐ Often lose things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones) ☐ Are often easily distracted ☐ Are often forgetful in daily activities.

HYPERACTIVITY/IMPULSIVITY: Have you ever experienced any of the following? Check all that apply ☐ Often fidget with or tap hands or feet, or squirms in seat ☐ Often leave seat in situations when remaining seated is expected ☐ Often run about or climb in situations where it is not appropriate (adolescents or adults may be limited to feeling restless) ☐ Often unable to play or take part in leisure activities quietly ☐ Often "on the go" acting as if "driven by a motor" ☐ Often talk excessively ☐ Often blurt out an answer before a question has been completed ☐ Often has trouble waiting your turn ☐ Often interrupt or intrude on others (e.g., butts into conversations or games)

SUICIDAL IDEATION HISTORY:
☐ Have you ever made an attempt to intentionally hurt (including but not limited to cutting self, burning self, self-harming behaviors, self-mutilation, etc) or kill yourself (including but not limited to intentional overdosing on pills/alcohol, cutting self with the hope to die, asphyxiation) Please circle all that apply.
Other: _____
☐ Did you seek help by contacting EMS, Going to the emergency room or calling poison control? Yes or No
☐ Did you receive treatment in the hospital/admitted to the hospital due to the severity of your attempt?

HOMICIDIAL IDEATION/VIOLENCE:
☐ Have you ever intentionally physically harmed another person or animal?
☐ Have you ever been charged with or convicted of a violent crime against a person or animal (including but not limited to assault, battery, domestic violence, child or elder abuse/neglect, murder, manslaughter, animal abuse or neglect) Please circle all that apply.
Other: _____
COPING SKILLS: How would you rate your ability to cope with daily life stressors?
☐ Good – I do not get easily distressed by minor life stresses
☐ Fair – I have some ability to cope with stress most of the time, but occasionally I feel I react more negatively than someone else would in my situation. During these times I may try to cope by using with negative and destructive life skills such as self-medicating with drugs or alcohol or self-harm.
☐ Poor – I get overwhelmed easily and make poor like choices when I am stressed such as using drugs or alcohol, spending money I do not have to feel good, promiscuous or dangerous sexual behaviors, or self-mutilation or harm

PSYCHIATRIC HISTORY:

CURRENT PROVIDERS: Are you currently under the care of a health care professional for your mental health needs?
If so please list their name, office location, and phone number in the space below and add an additional sheet if needed.

PAST PROVIDERS: Have you previously been under the care of a health care professional for your mental health needs?
If so please list their name, office location, and phone number in the space below and add an additional sheet if needed.

PSYCHIATRIC HOSPITALIZATION: Have you ever been treated in an inpatient psychiatric facility (voluntary or involuntary), residential treatment program for mental health or substance abuse issues, or participated in an intensive outpatient program or partial hospitalization program?
If so please list their facility name, office location, and phone number in the space below and add an additional sheet if needed.

PAST PSYCHIATRIC MEDICATION:
☐ Please list all the past psychiatric medications you have tried. Include all medications for anxiety, depression, sleep, chronic pain management, and seizure disorder meds as many of these medications can have multiple uses. Please also include the last dosages you were prescribed, and side effects you experienced, and the length of time you took the medication.
☐ Please attach another sheet if needed.

HISTORY OF ABUSE/TRAUMA:
☐ Childhood emotional, physical, or sexual abuse. If yes, what ages did the abuse take place? _____
☐ Do you still have contact with your abuser? Y/N
☐ Adult emotional, physical, or sexual abuse. If yes, what ages did the abuse take place? _____
☐ Do you still have contact with your abuser? Y/N
☐ Have you been involved in a serious situation, accident, or natural/manmade disaster that has caused you significant distress?
☐ Are you actively enlisted or formerly enlisted in the military and have experienced combat
☐ Does your employment or career involve you being in situations where your life may be compromised or you have been exposed to traumatic events (including but not limited to police/fire/ems worker/emergency department health care worker, security personnel)

DRUG AND ALCOHOL USE AND ABUSE HISTORY:
Have you EVER used any of the following. Check all that apply.
☐Tobacco products (cigarettes, chewing tobacco, cigars, etc.) ☐Alcoholic beverages (beer, wine, spirits, etc.)
☐Cannabis (marijuana, pot, grass, hash, etc.) ☐Cocaine (coke, crack, etc.) ☐ Amphetamine type stimulants (speed, diet pills, ecstasy, etc.) ☐Inhalants (nitrous, glue, petrol, paint thinner, etc.) ☐Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
☐Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
☐Opioids (heroin, morphine, methadone, codeine, etc.) ☐Other - specify:

In the *past three months*, how often have you used the substances you mentioned?
☐Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Alcoholic beverages (beer, wine, spirits, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Cannabis (marijuana, pot, grass, hash, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Cocaine (coke, crack, etc.)

☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐ Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Inhalants (nitrous, glue, petrol, paint thinner, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Opioids (heroin, morphine, methadone, codeine, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Other - specify:

During the past three months, how often have you had a *strong desire* or urge to use?
☐Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Alcoholic beverages (beer, wine, spirits, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Cannabis (marijuana, pot, grass, hash, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Cocaine (coke, crack, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐ Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Inhalants (nitrous, glue, petrol, paint thinner, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Opioids (heroin, morphine, methadone, codeine, etc.)
☐Never ☐Once or twice in three months ☐ Once a Month ☐Weekly ☐Daily
☐Other - specify:

ADDITIONAL SOCIAL HISTORY:
Relationships: How many times have you been:
☐Married:_____
☐Widowed:_____
☐Divorced:_____
☐In a Domestic Partnership:_____
☐Separated but living together:_____
☐Separated and living apart:_____
☐Engaged to be married:_____
☐In a committed long term relationship with no plan to legally marry do to current laws or personal preference/Common Law Marriage: _____

Children: How many children do you have?
☐Biological living: _____
☐Biological deceased (including any miscarriages, chemical pregnancies, or still-births):_____
☐Adopted children:_____
☐Foster Children:_____
☐Stepchildren or Children from blended family: _____
☐Nieces, nephews, grandchildren or others that reside with you where you are the primary caregiver or guardian: _____

Education: How far did you go in school?
☐ Some High School ☐ High School Diploma ☐GED ☐Some College Classes ☐Associates Degree in:_____ ☐Bachelor's Degree in:_____ ☐ Master's Degree in:_____ ☐Doctorate in:_____

Work: Please describe your work history
☐First job: _____ Age: _____
☐Most Recent Previous Job: _____
☐ Current Job:_____

Legal: If not already stated above
☐Have you even been arrested, charged with or convicted of a felony or misdemeanor?
☐Are you currently on probation or parole?
☐ Are legally required to attend mental health treatment as a condition of an early release or controlled release program or in leu of jail time?

CURRENT MEDICATIONS Please list **ALL** your current medications, vitamins, & herbal supplements (or supply printed list).
Please include Medication Name, Dosage & Time of Day Taken, Reason for Taking and Past Prescriber Name
_____
_____

MEDICATION ALLERGIES/REACTIONS ❑No known drug allergies ❑Yes, please list below.

OTHER ALLERGIES (Food/Environment) ❑No ❑Yes, please list below.

PREVENTION & SAFTEY

Do you wear your seatbelt? ❑Yes ❑No

Wear biking helmet? ❑Yes ❑No

Are Firearms kept in home? ❑Yes ❑No
Are other weapons kept in the home? [Including but not limited to hunting equipment, cross-bows, knives (outside of kitchen cutlery), swords] ❑Yes ❑No

Vaccinations: Have you received all standard vaccinations for someone your age ❑Yes ❑No

Sexual Partner(s) last 12 months: ☐Men ☐Women ☐Transgender ☐None/abstinent ❑Number of partners: _____
☐Prefer not to answer

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

Do you have an advanced health directive, such as a "do not resuscitate" or Medical/financial Power of Attorney? No ❑ Yes ❑
Location: _____

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/Guardian signature _____ Date _____

_____-THE REMAINDER OF THIS PAGE IS FOR INTERNAL USE ONLY-_____

New Patient Paperwork Chain of Custody
Paperwork Received on:
Reviewed by Intake on:
Referred to Provider for acceptance on:

Accepting Provider:
Provider Signature:

Received back to Intake on:_____
Patient contacted regarding acceptance on:_____ Contact Made / Voicemail Left
Initial Appointment Offered: Patient Declined/ Patient Accepted
Policies and Procedures Reviewed with Patient:

Initial Appointment Date Scheduled for:
All paperwork must be uploader to HER prior to patient's first appointment
Initial Appointment: Completed/Rescheduled/Patient No Showed