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Child & Adolescent Psychiatry

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New Patient Registration
For Adult Patient

Date: _____

Name: _____ Date of birth: _____ □ Female □ Male

Address: _____ City, State, Zip: _____

SS#: _____ Email: _____

Home Phone: (____)_____ Cell: (____)_____ Work: (____)_____

Current employer: _____ Position: _____

May we leave messages on: □ Home phone □ Cell phone □ Work phone

May we send mail to you at the address above? □ Yes □ No

Person responsible for bill: _____

Address: _____

Please list all other persons living in your household:

Name	Age	Relationship	Employment	Welfare
_____	_____	_____	□ yes □ no	□ yes □ no
_____	_____	_____	□ yes □ no	□ yes □ no
_____	_____	_____	□ yes □ no	□ yes □ no

List any hobbies: _____

Highest level of education attained: _____ Name of school: _____

Primary Care Physician: _____

Address: _____ Phone: (_____)_____

May we exchange information with your treating physicians to coordinate your care? □Yes □No

By whom were you referred? _____

Insurance provider: _____ Policy Number: _____

Please describe your reason(s) for seeking treatment at this time (Include when the problem started):

_____

_____

_____

_____

Please list other health care professionals currently treating you:

_____

_____

_____

Please list current allergies (be as specific as possible) or other health problems for you:

_____

_____

Please indicate past problems with a "P" and current problems with a "C"

__Depression
__Anxiety
__Stress
__Grief/Loss
__LD/ADHD
__Anger
__Obsessions/Compulsions
__Trauma

__Chronic Illness
__Chronic Pain
__Loneliness
__Eating or Weight Problem
__Abuse/victimization
__Domestic Violence
__Manic Episodes
__Legal Matters

__Relationship Issues
__Sexuality/Sexual Issues
__Family Conflict
__Behavioral Problems
__Schizophrenia/Psychosis
__Phobias/fears
__Eliminating a Drug/Alcohol Habit
__Eliminating Another Habit (eg, over-spending, gambling, etc.)

Other:_____(Please explain)

Please indicate how the problems are affecting the following areas of you and your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Relationships with peers	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A

Total: _____

Have you ever received mental health or substance abuse treatment before? If yes, please describe:

Type of treatment	Provider Name	Phone Number	First Seen	Last Seen

Prior Psychiatric History:

Prior hospitalization: □ No □ Yes

If yes, please explain reason for admission: _____

Prior psychotherapy: □ No □ Yes

Prior medication: □ No □ Yes

If yes, please list: _____

Family history of psychiatric disorders:

_____

_____

Family history of medical disorders:

_____

_____

Medical history:

Major illnesses: _____

Hospitalization: _____

Labs: _____

EKG: _____

Please list your current medication:

_____

_____

_____