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New Patient Registration

This form requests information about your child which will help us design a treatment plan geared specifically to your child's needs. Please take a few moments to complete the form carefully. We appreciate your time and effort in completing these documents. If you have any questions, please feel free to discuss them with us. Thank you.

Date: _____

Patient Name: _____ Date of birth: _____ Age: ____ □ Female □ Male

Address: _____ City, State, Zip: _____

SS#: _____ Phone: (_____)_____ Cell: (_____)_____

Mother: _____

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

Father: _____

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

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

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

Father's address, if different from above _____
Relationship Status of Parents: □Never Married □Married/Partnership □Separated □Divorced □Widowed

Person responsible for bill: _____
Address:_____

Please list all other persons living in your household, as well as children not living in your home.

Name	Age	Relationship	Employment	Welfare
_____ At home / Not at home (Circle one)	_____	_____	□ yes □ no	□ yes □ no
_____ At home / Not at home (Circle one)	_____	_____	□ yes □ no	□ yes □ no
_____ At home / Not at home (Circle one)	_____	_____	□ yes □ no	□ yes □ no

Household income ($):
□ 0 – 20,000
□ 20,000 – 50,000
□ > 50,000
□ Unknown

Education level (father):
□ Kindergarten
□ Elementary (grade level:____)
□ Middle Sch (grade level:____)
□ High Sch (grade level:____)
□ Graduate

Education level (mother)
□ Kindergarten
□ Elementary (grade level:____)
□ Middle Sch (grade level:____)
□ High Sch (grade level:____)
□ Graduate

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 Type: □ Private □ Public
Please describe your reason(s) for seeking treatment at this time (Include when the problem started):
_____
_____

Please list other health care professionals currently treating your child:
_____
_____
_____

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

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 child's 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

_____

_____

_____