CONFIDENTIAL HISTORY / PRE-REGISTRATION

Date: _____

Patient Information

Last_____ First _____MI_____DOB_____

Sex: M F Marital Status_____ SSN_____ TDL_____

Address_____Zip_____

Email _____

Home Phone #_____ Work #_____

Employer_____ Referred by_____

*Emergency Contact _____Phone #_____Relationship:_____

IF THE PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING:

Mother's Last _____ First _____MI_____DOB_____

Father's Last_____ First _____MI_____DOB_____

Who Does Child Live With? _____Are parents: Living together _____ Not living together _____

Legal Guardian: _____ please provide copy of court order.

Patient History

Have you had previous psychiatric treatment? _____ Yes _____ No

Name and Phone # of previous practitioner: _____

Date last Seen: _____ May we contact your last practitioner _____Yes _____No

*(If yes please complete a **Authorization for Release of Medical Records** so we may obtain records)

Are you currently under the care of a Primary Care Physician? _____Yes _____No

Name and phone # of Physician: _____

Hospitalizations: (Women do not need to add normal pregnancies or child birth)

If you have had any hospitalization: Please list them here:

_____

Reason for your visit here today: _____

_____

_____