

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: _____
