Patient Registration Form

DATE: ______________________________

Patient Demographic Information

Patient Name:	Social Security #:
Street Address:	Date of Birth:
City, State, Zip Code:	Home Phone:
Gender:	Work Phone:
Email Address:	Mobile Phone:
Primary Physician:	Psychiatrist:
Emergency Contact Person:	Emergency Contact Phone:
How did you hear about us?	Marital Status:

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Mobile Phone:
Relationship to Patient:	Responsible Party SSN:

Do you have access to a computer? Yes / No
May we contact you at the above phone numbers and email address? Yes No
May we leave a voice mail message at the above phone numbers? Yes No
May we leave a message with anyone besides you at the above numbers? Yes No
If yes, please list the name(s) of the individuals we may leave a message with: ______________________

Emergency Contact: Please list who we may contact in case of emergency

Name: ____ **Phone**: ______________________________

Relationship: _________________ **Address:** ____

If under 18, legal guardian(s): ____

Have you participated in therapy before? ______ Yes ______No When? __________________

Are you currently experiencing any legal issues? _____ Yes _____ No
Explain: ____

____

Are you on any psychiatric medications? _____Yes _____No

Medication	Reason	How Long?

Are you currently experiencing suicidal thoughts, feelings or actions? _____ Yes _____ No

Have you ever attempted suicide? _____ Yes _____ No
When? ____

Are you currently experiencing homicidal or violent thoughts, feelings or urges? _____ Yes _____ No

Any psychiatric hospitalizations? _____ Yes _____ No

Please explain any "yes" answers: ____

____

Are you currently experiencing any significant health issues? _____ Yes _____ No
____

____

Are you a veteran? _____ Yes _____ No

Are you a first responder? _____ Yes _____ No