PETER B. VAN DYCK, M.D. & ASSOCIATES, PA

PATIENT REGISTRATION

Name: ______________________ DOB: __________ Date: __________

Sex: ______________________ Marital Status: __________

Primary Phone: ______________________

Cell Phone: ______________________ Home Phone: ______________________

Work Phone: ______________________ Fax No: ______________________

Email Address: ____

Mailing Address: ____

City: ______________________ State: __________ Zip: __________

Employer: ______________________ Address: ______________________

School: ______________________ Address: ______________________

Emergency Contact: ______________________ Phone: ______________________

Address: ____

Nearest Relative: ______________________ Phone: ______________________

Address: ____

Referred By: ______________________ Phone: ______________________

Address: ____

I will be paying by: Cash Check Credit Card

Person Responsible For Bill: ______________________ Phone: ______________________

Address: ____

(Rev 06/24/2018)

Name: DOB: Date:

HOW DID YOU FIND OUT ABOUT US?

Referral Source: Agency:

Telephone:

Address:

WHAT PROMPTED YOU TO CONTACT US FOR HELP?

CURRENT PROBLEMS (Check any problems you have ever experienced. Circle problems you've experienced in the past 3 months.)

Depression	Unhappy with your situation	Short attention span	Hallucinations
Grief/loss	Pessimism about the future	Memory problems	Paranoid thoughts
Anxiety	Traumatic memories	Compulsive behaviors	Other unusual thoughts
Panic attacks	Nightmares	Compulsive overeating	Self-destructive behavior
Fears/phobias	Sleep disturbance	Anorexia	Suicidal urges
Obsessive worry	Appetite changes	Bulimia	Aggressive urges
Feeling helpless or trapped	Fatigue/energy problems	Alcohol abuse or dependence	Other:
Unhappy with your self	Inability concentrating	Drug abuse or dependence	

HABITS & SUBSTANCE USE

SUBSTANCE	AMOUNT USED
Tobacco products:	
Alcohol:	
Street drugs:	
Other:	

PSYCHIATRIC TREATMENT HISTORY

PSYCHIATRIST/THERAPIST/HOSPITAL	DATES
1.	
2.	
3.	
4.	
5.	

Name: DOB: Date:

ALLERGIES

1.	4.
2.	5.
3.	6.

CURRENT MEDICATION

1.	5.
2.	6.
3.	7.
4.	8.

MEDICAL PROBLEMS & SURGERY

1.	5.
2.	6.
3.	7.
4.	8.

MEDICAL CARE

Doctor	Specialty	Office/Address
1.		
2.		
3.		

REVIEW OF SYSTEMS (Check any problems you have ever experienced. Circle problems you've experienced in the past 3 months.)

High blood pressure	Numbness or tingling	Angina or chest pain	Esophagitis/Reflux
Weakness	Headache	Heart rhythm disturbances	Gastrits/Ulcer
Fatigue	Seizure	Heart attack	Hepatitis
Dizziness	Head injury	Heart valve problems	Irritable bowel
Chronic pain	Loss of consciousness	Shortness of breath	Other intestinal problems
Fibromyalgia	Glaucoma	Asthma	Diabetes
Bone or joint problems	Blurred or double vision	Tuberculosis	Thyroid problems
Coordination problems	Hearing loss	HIV/AIDS	Menstrual problems
Balance problems		Kidney disease	Other hormonal problems
		Other urinary tract problems	

Signature: **Date:**