## New Patient Registration Form - SPOUSE/KELLY RYAN, LPCC

AHeARTT

Date ____/____/____

| Section I: | Patient Information |
|---|---|

| | | |
|---|---|---|
| Name: | | Age: |
| Address: | | DOB: |
| City, State, Zip: | | Sex: M ____ F ____ |
| e-mail: | | |
| Telephone: ( ) | | Marital Status: |
| Work Phone: ( ) | | Date of Wedding: |
| Cellular Ph. / Pager: ( ) | | |
| | | Previous Marriage/Relationship: |
| Employment Status: | | Yes ____ No ____ |
| Occupation: | | Length of Commitment: |
| Employer: | | Reason for ending relationship: |
| | | |
| **Spouse / Significant Other Information:** | | |
| Name: | | Age: |
| Address: | | DOB: |
| Occupation: | | Previous Marriage/Relationship: |
| Employer: | | Yes ____ No ____ # of yrs _____ |
| | | |

How did you hear about AHeARTT?

| Section II: | Communication |
|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Can therapist/office leave a message: | ❑ | yes | ❑ | no | Phone: |
| | ❑ | yes | ❑ | no | E-mail: |
| | ❑ | yes | ❑ | no | Other: |
| Communication preference: | ❑ | E-mail | ❑ | | Phone: Home / Cell (circle one) |

Do you wish to receive occasional **e-newsletters** including tips and ideas for improved well-being? (You have the option to automatically add or remove yourself from the list and your information is always private.)

❑ Yes ❑ No

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## Section III: Family Information

| Who are the members in your family? | Age | Relationship | Notable health condition or concerns |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |

## Section IV: Reason for Visit/Goals for Assistance

Please describe the reason for your visit: _____

_____

_____

What is your primary concern or worry related to the current issue? _____

_____

_____

List five words that describe your thoughts and feelings related to your primary concern? _____

_____

_____

_____

_____

What are goals you hope to achieve from our visits?: _____

_____

_____

How have the following symptoms bothered you **recently**?

❑ - Significant/Major Problem ❍ - Slight/Moderate Problem

| | | |
|---|---|---|
| ❑ ❍ Depressed, sad, or crying | ❑ ❍ Inability to concentrate | ❑ ❍ Anger or temper problems |
| ❑ ❍ Suicidal thoughts, plans, or attempts | ❑ ❍ Anxious, nervous, or panicky feelings | ❑ ❍ Repetitive thoughts, behaviors |
| ❑ ❍ Guilty feelings | ❑ ❍ Insecurity or inferiority | ❑ ❍ Memory problems |
| ❑ ❍ Loss of interest or energy | ❑ ❍ Change in spending habits | ❑ ❍ Sexual worries / problems |
| ❑ ❍ Physical problems, pain, or illness | ❑ ❍ Periods of euphoria, boundless energy or unstoppable activity | ❑ ❍ Confused or disorganized thoughts |