

# New Patient Registration Form –

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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:
<b>Spouse / Significant Other Information:</b>	
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:	<input type="checkbox"/> yes	<input type="checkbox"/> no	Phone:
	<input type="checkbox"/> yes	<input type="checkbox"/> no	E-mail:
	<input type="checkbox"/> yes	<input type="checkbox"/> no	Other:
Communication preference:	<input type="checkbox"/> E-mail	<input type="checkbox"/> Phone: Home / Cell	(circle one)
Do you wish to receive occasional <b>e-newsletters</b> 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.)			
<input type="checkbox"/> Yes <input type="checkbox"/> No			



**Section III: Family Information**

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

**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

<input type="checkbox"/> <input type="radio"/> Depressed, sad, or crying	<input type="checkbox"/> <input type="radio"/> Inability to concentrate	<input type="checkbox"/> <input type="radio"/> Anger or temper problems
<input type="checkbox"/> <input type="radio"/> Suicidal thoughts, plans, or attempts	<input type="checkbox"/> <input type="radio"/> Anxious, nervous, or panicky feelings	<input type="checkbox"/> <input type="radio"/> Repetitive thoughts, behaviors
<input type="checkbox"/> <input type="radio"/> Guilty feelings	<input type="checkbox"/> <input type="radio"/> Insecurity or inferiority	<input type="checkbox"/> <input type="radio"/> Memory problems
<input type="checkbox"/> <input type="radio"/> Loss of interest or energy	<input type="checkbox"/> <input type="radio"/> Change in spending habits	<input type="checkbox"/> <input type="radio"/> Sexual worries / problems
<input type="checkbox"/> <input type="radio"/> Physical problems, pain, or illness	<input type="checkbox"/> <input type="radio"/> Periods of euphoria, boundless energy or unstoppable activity	<input type="checkbox"/> <input type="radio"/> Confused or disorganized thoughts