New Patient Registration

INTRODUCTION

Date Completed: ____________________

The following necessary information will help make your first session most productive. If your first appointment with us is for psychiatric evaluation for medication management, **please bring all of your medication bottles to your first appointment.** If you have a **family law, criminal, or civil case** active or forthcoming and it is relevant to you obtaining services, or if you are court-mandated to receive services, please bring all related court and historical documents to your first appointment. Please fill out this form **COMPLETELY**.

PATIENT DEMOGRAPHICS

Last Name | First | Middle | Date of Birth | Age

Street Address | City | State | Zip Code

Phone Number (Cell) | Home | Email | Social Security Number

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other: ____________________

CARE COORDINATION AND EMERGENCY CONTACT

Primary Care Physician: ____________________ ☐ Do not have PCP
Name | City | Phone Number

Preferred Pharmacy: ____________________
Name | City | Phone Number

Emergency Contact: ____________________
Name | Relationship | Phone Number

PRESENTING PROBLEM

Why are you seeking treatment at this time? *(include symptoms, onset, duration, frequency, etc.)*

____

____

____

Check all problematic experience areas or events within the past six (6) months?

☐ Abuse/Domestic Violence	☐ Depression	☐ Hospitalization	☐ Sleep Problems
☐ Academic Problems	☐ Developmental Delay	☐ Hyperactivity/Impulsivity	☐ PTSD/Trauma
☐ Addiction/Dependency	☐ Employment Problems	☐ Intrusive Thoughts	☐ Relationship Stress
☐ Anger Management	☐ Extramarital Affair	☐ Legal Problems	☐ Self-injury
☐ Anxiety/Panic Attack	☐ Family/Parenting	☐ Mood Swings	☐ Suicidal Thoughts
☐ Behavior/Poor Decisions	☐ Fire Setting	☐ Obsessive Thoughts	☐ Suicide Attempts
☐ Concentration/Focus	☐ Grief	☐ Paranoia/Delusions	☐ Thoughts of Harming Others
☐ Cruelty to Animals	☐ Hallucinations	☐ Physical/Medical Problems	☐ Weight Gain/Loss

PSYCHIATRIC HISTORY

At your comfort, briefly describe (Yes) answers:

Question	Yes	No	Description
Have you ever received counseling before?	☐ Yes	☐ No	______
Do you have any previous psychiatric diagnoses?	☐ Yes	☐ No	______
Do you have history of emotional trauma?	☐ Yes	☐ No	______
Have you ever experienced suicidal or homicidal thoughts?	☐ Yes	☐ No	______
Have you ever intentionally harmed yourself?	☐ Yes	☐ No	______
Have you ever been hospitalized for mental health reasons?	☐ Yes	☐ No	______
Does anyone in your **family history** have mental health problems?	☐ Yes	☐ No	______

MEDICAL HISTORY

Check **BOX** ☒ for all conditions that applies to your **personal medical history**.

Bubble **CIRCLE** ● for all conditions that applies to your **family medical history** *(mother, father, siblings, grandparents)*.

☐ ○ ADHD	☐ ○ COPD	☐ ○ High Blood Pressure	☐ ○ Sensory Loss
☐ ○ Alcohol/Substance Abuse	☐ ○ Depression	☐ ○ HIV/AIDS	☐ ○ Seizures
☐ ○ Alzheimer's	☐ ○ Diabetes	☐ ○ IBS	☐ ○ Sleep Apnea
☐ ○ Anemia	☐ ○ Fibromyalgia	☐ ○ Kidney Disease	☐ ○ Speech/Language Impaired
☐ ○ Anxiety	☐ ○ GERD	☐ ○ Migraine	☐ ○ Stroke
☐ ○ Asthma	☐ ○ Head injury	☐ ○ Muscular Disease	☐ ○ Other: ______
☐ ○ Bleeding Abnormality	☐ ○ Heart Disease	☐ ○ Parkinson's	☐ ○ Other: ______
☐ ○ Cancer	☐ ○ Hepatitis	☐ ○ Pituitary Disease	☐ ○ Other: ______
☐ ○ Chronic Pain	☐ ○ High Cholesterol	☐ ○ PCOS	☐ ○ Other: ______

Surgical history: ______________________________

MEDICATIONS

List ALL medications that you **currently** take, including any vitamins and/or herbal supplements. ☐ I am not taking any medications.

CURRENT Medications Prescribed *Example: (Zoloft)*	**Dosage** *(50mg)*	**Time of day taken** *(Every morning)*	**Provider** *(Dr. Nick Riviera)*

List ALL psychiatric medications that you have **previously** tried. ☐ I have never taken psychiatric medications.

PAST Psychiatric Medication *Example: (Lexapro)*	**Length of time taken** *(Three months)*	**Why you stopped taking the medication** *(It made me too drowsy)*

ALLERGIES ☐ I have no known allergies.

Clinical Notes

SUBSTANCE USE HISTORY

Describe any substance use history, including casual or recreational: *(include alcohol and tobacco usage)*

FAMILY HISTORY

Describe who you were **raised by** and the family relationship:

Describe the relationship with your **siblings**: *(with names and ages)*

☐ not applicable

Describe the relationship with your **spouse or partner**: *(with name and age)*

☐ not applicable

Describe the relationship with your **children**: *(with names and ages)*

☐ not applicable

SOCIAL HISTORY

Who is your support system? ______

Describe activities/relationships you have recently started or stopped:

Describe your leisure/recreational activities:

DEVELOPMENTAL HISTORY

Were there any known problems during mother's pregnancy or your birth? ☐ Yes ☐ No

Did you experience any developmental delays as an infant or young child? ☐ Yes ☐ No

(eating, talking, sleeping, walking, potty train): ______

EDUCATIONAL / OCCUPATIONAL HISTORY

What is your highest level of education? ______ ☐ Student

Where are you presently employed? ______ ☐ Unemployed

Military or First Responder employment history: ______ ☐ No history

LEGAL HISTORY

Have you ever been arrested for any reason? ☐ Yes ☐ No

Are you currently on probation or community supervision/control? ☐ Yes ☐ No

Are you under court order or other requirement to obtain services? ☐ Yes ☐ No

Will you require progress notes for probation or other supervision? ☐ Yes ☐ No

Are you involved in an active or forthcoming family law and/or child custody case? ☐ Yes ☐ No

Are you and your family involved in a Department of Children and Families investigation? ☐ Yes ☐ No

Please describe details of any (yes) answers: ______

STRENTHGS / LIMITATIONS

What strengths or limitations should we be aware of that may help us with your treatment plan?