



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to you obtaining services, or if you are court-mandated to receive services, please bring all related court and historical documents to your first appointment.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
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Preferred Pharmacy: _____

Name	City	Phone Number
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Emergency Contact: _____

Name	Relationship	Phone Number
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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?

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

Santa Rosa Counseling Center

5642 Jones Street, Milton, Florida 32570 (Main Office)
 5441 Berryhill Road, Milton, Florida 32570 (Psychiatric Services)
 Office (850) 626-7779 Fax (850) 626-7171
 santarosacounselingcenter.com

PSYCHIATRIC HISTORY

- 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 _____

At your comfort, briefly describe (Yes) answers:

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*).

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> <input type="radio"/> ADHD | <input type="checkbox"/> <input type="radio"/> COPD | <input type="checkbox"/> <input type="radio"/> High Blood Pressure | <input type="checkbox"/> <input type="radio"/> Sensory Loss |
| <input type="checkbox"/> <input type="radio"/> Alcohol/Substance Abuse | <input type="checkbox"/> <input type="radio"/> Depression | <input type="checkbox"/> <input type="radio"/> HIV/AIDS | <input type="checkbox"/> <input type="radio"/> Seizures |
| <input type="checkbox"/> <input type="radio"/> Alzheimer's | <input type="checkbox"/> <input type="radio"/> Diabetes | <input type="checkbox"/> <input type="radio"/> IBS | <input type="checkbox"/> <input type="radio"/> Sleep Apnea |
| <input type="checkbox"/> <input type="radio"/> Anemia | <input type="checkbox"/> <input type="radio"/> Fibromyalgia | <input type="checkbox"/> <input type="radio"/> Kidney Disease | <input type="checkbox"/> <input type="radio"/> Speech/Language Impaired |
| <input type="checkbox"/> <input type="radio"/> Anxiety | <input type="checkbox"/> <input type="radio"/> GERD | <input type="checkbox"/> <input type="radio"/> Migraine | <input type="checkbox"/> <input type="radio"/> Stroke |
| <input type="checkbox"/> <input type="radio"/> Asthma | <input type="checkbox"/> <input type="radio"/> Head injury | <input type="checkbox"/> <input type="radio"/> Muscular Disease | <input type="checkbox"/> <input type="radio"/> Other: _____ |
| <input type="checkbox"/> <input type="radio"/> Bleeding Abnormality | <input type="checkbox"/> <input type="radio"/> Heart Disease | <input type="checkbox"/> <input type="radio"/> Parkinson's | <input type="checkbox"/> <input type="radio"/> Other: _____ |
| <input type="checkbox"/> <input type="radio"/> Cancer | <input type="checkbox"/> <input type="radio"/> Hepatitis | <input type="checkbox"/> <input type="radio"/> Pituitary Disease | <input type="checkbox"/> <input type="radio"/> Other: _____ |
| <input type="checkbox"/> <input type="radio"/> Chronic Pain | <input type="checkbox"/> <input type="radio"/> High Cholesterol | <input type="checkbox"/> <input type="radio"/> PCOS | <input type="checkbox"/> <input type="radio"/> 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 <i>Example: (Zoloft)</i>	Dosage <i>(50mg)</i>	Time of day taken <i>(Every morning)</i>	Provider <i>(Dr. Nick Riviera)</i>

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

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

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?
(eating, talking, sleeping, walking, potty train): _____ Yes No

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: _____

STRENGTHS / LIMITATIONS

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