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| PATIENT Tx REGISTRATION AND HISTORY |
| Date: Provider: |
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| Patient Name: | M  F  DOB: Age: |
| Address: | Marital Status:  |
| City: State: Zip: | Occupation: |
| Home Phone: ( ) | Employer: |
| Cell Phone: ( ) | Address: |
| Email: | Work Phone: |
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| Billing: If patient is a minor or person responsible for billing is other than the above patient, please complete the following: |
| Name: | Relationship to patient: |
| Address:  | Home Phone: ( ) |
| City: State: Zip: | Cell Phone: ( ) |
| Email: | Work Phone: |
| Employer: | Occupation: |
| **Insurance Information** |
| Primary Insurance: | Secondary Insurance: |
| Subscriber: | Subscriber: |
| Subscriber's DOB: | Subscriber's DOB: |
| Ins. ID#: | Ins. ID#: |
| Ins. Group #: | Ins. Group #: |
| Deductible $\_\_\_\_\_\_\_\_\_ Co-Pay $\_\_\_\_\_\_\_\_\_\_ | Deductible $\_\_\_\_\_\_\_\_\_ Co-Pay $\_\_\_\_\_\_\_\_\_\_ |

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| Emergency Contact: Person to contact in case of emergency, not living at above address |
| Name: | Relationship to patient: |
| Address: | Phone: |
| City: State: Zip: | Email: |
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| Primary Physician: | Phone: |
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| If patient is in school |
| Name of School:**OFFICE USE ONLY**AXIS I: Primary\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Secondary\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Other\_\_\_\_\_\_\_\_\_\_\_\_AXI II: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AXIS III: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AXIS IV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AXIS V: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Address: |
| Area of Study: |  |
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 **Medical History:**

1. Do you or have you had any chronic health problems (e.g. asthma, diabetes, heart disease)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you have any **Allergies** (food, environmental, etc.)?

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1. Are you taking any type of medication currently?

Name of medication Dosage Reason Date begun

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

1. Have you taken any psychiatric medications in the past? If so what and when?
2. Have you received any previous diagnosis from a medical health care provider or psychologist? If so, what are they and when?

5. Please list any health professionals you are working with at this time?

 Name Phone Number Reason for Seeing Them

**Life History:**

 Yourself Spouse/Partner (if any)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion/Spirituality \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you receive any special services or accommodations while in school?

If you have any children, please provide their name(s) and date(s) of birth:

 Mother Father

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion/Spirituality \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply, past or present:

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|  | You | Mother | Father | Siblings | Spouse OrPartner | Children |
| Social Awkwardness |  |  |  |  |  |  |
| Learning problems |  |  |  |  |  |  |
| Attention problems |  |  |  |  |  |  |
| Autism Spectrum |  |  |  |  |  |  |
| Problems w/ Anger |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |
| Drug/Alcohol Abuse |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |
| Suicide Attempt |  |  |  |  |  |  |
| Problems w/ Anxiety  |  |  |  |  |  |  |
| Bipolar Disorder |  |  |  |  |  |  |
| Psychosis |  |  |  |  |  |  |
| Criminal History |  |  |  |  |  |  |

**Our Work Together:**

What are your goals for our work together?

What do you have in your life currently that provides you with a sense of support and well being? (e.g. family, friends, spirituality/religion, time alone, exercise, pets, being in nature, hobby, etc.)

Is there anything else you feel it would be helpful for me to know about you?