Briar Rose Center: The Home Of Hope & Healing, P.L.L.C.
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Office Use Only

Dx Code: __________

NEW PATIENT REGISTRATION

Today's Date: __________________

PERSONAL INFORMATION

Name: ____ **Age:** __________ **Gender:** ___________

Address: ____ **Social Security #:** ____________________

City, State, Zip: ____ **Date of Birth:** ________________

Home Phone: ________________________ **May I call this number? Y N** **May I leave a message? Y N**

Cell Phone: __________________________ **May I call this number? Y N** **May I leave a message? Y N**

Status: □ Single □ Married □ Significant Other □ Domestic Partner □ Separated □ Divorced □ Widowed

Person responsible for bill: ___________________________________ **Relationship:** __________________

Address: ____ **Phone:** ________________________

EMPLOYER INFORMATION

Employer/School: ____**Occupation:** _________________

Address: ____

Work Phone: _______________________ **May I call this number? Y N** **May I leave a message? Y N**

INSURANCE INFORMATION

<u>Primary Coverage:</u>

Name of Insured: __________________________________ **Social Security #:** _____________________

Date of Birth: _____________________________________

Insurance Company:____

Address: ____ **Phone:** _______________

Subscriber ID #: _________________________________ **Group #:** ___________________________________

Secondary Coverage:

Name of Insured: ______________________ **Social Security #:** ____________________

Insurance Company:____

Address: ______________________________________ **Phone:** ______________

Subscriber ID #: ______________________ **Group #:** ______________________

MEDICAL & REFERRAL INFORMATION

Physician: ______________________________________ **Phone:** ______________

Therapist/Counselor: ______________________________**Phone:** ______________

Psychiatrist/ARNP: _______________________________**Phone:** ______________

HOUSEHOLD INFORMATION

Spouse/Significant Other Name: ____

Employer: _______________________________________**Phone:** ______________

Others in home (name):	Gender:	Age:	Relationship:

EMERGENCY CONTACT INFORMATION

Emergency Contact: ______________________ **Relationship:** ________________

Address: ____

Home Phone: ______________**Cell Phone:** ______________**Work Phone:** ______________

Legal Next of Kin: ______________________ **Relationship:** ________________

Address: ____

Home Phone: ______________**Cell Phone:** ______________**Work Phone:** ______________

FAMILY MEDICAL HISTORY

	Living?	Age?	Illness/Cause of Death
Father:	Y N		
Mother:	Y N		
Brother / Sister	Y N		
Brother / Sister	Y N		
Son / Daughter	Y N		
Son / Daughter	Y N		
Partner (Male / Female):	Y N		

PERSONAL MEDICAL HISTORY

Have you ever had or do you currently have any of the following (check all that apply):

- ☐ **Fibromyalgia**
- ☐ **Head Injury with a Loss of Consciousness**
- ☐ **Memory Lapses**
- ☐ **Heart Attack or Heart Problems**
- ☐ **Toxic Reaction to Medications or Drugs**
- ☐ **Asthma**
- ☐ **Sexually Transmitted Diseases/HIV**
- ☐ **Difficulty Urinating**
- ☐ **Insomnia**
- ☐ **Seizure(s)**
- ☐ **Neuroleptic Malignant Syndrome (NMS)**
- ☐ **High Blood Pressure**
- ☐ **Diabetes**
- ☐ **Thyroid, Parathyroid, or Adrenal Problems**
- ☐ **Constipation/Bowel Obstruction**
- ☐ **Glaucoma**

☐ **Allergies to Medication(s):** ______________________________

☐ **Other medical problems (please explain):** ______________________________

____

____

____

Current Medications (If any)	Dosage	Reason For Taking

FAMILY PSYCHIATRIC HISTORY

Has any family member experienced or been diagnosed with any of the following (check all that apply):

☐ **Anxiety** **Who?** ____________ **Treatment received?** _________________________

☐ **Bipolar Disorder** **Who?** ____________ **Treatment received?** _________________________

☐ **Dementia / Alzheimer's** **Who?** ____________ **Treatment received?** _________________________

☐ **Depression** **Who?** ____________ **Treatment received?** _________________________

☐ **Eating Disorder** **Who?** ____________ **Treatment received?** _________________________

☐ **Learning Disability** **Who?** ____________ **Treatment received?** _________________________

☐ **Obsessive-Compulsive Disorder (OCD)Who?** ____________**Treatment received?** ____________________

☐ **Posttraumatic Stress Disorder (PTSD)Who?** ____________**Treatment received?** ____________________

☐ **Schizoaffective Disorder** **Who?** ____________**Treatment received?** _________________________

☐ **Schizophrenia** **Who?** __________________**Treatment received?** ____________________

☐ **Other:** _________________________ **Who?**_____________ **Treatment received?** ____________________

INTERPERSONAL VIOLENCE HISTORY

This next series of questions are/may be considered extremely personal. If you are not comfortable answering them now, please feel free to skip them.	
Do you have a support system?	☐ **Good** ☐ **Minimal** ☐ **None**
Have you ever been sexually abused as a child?	☐ **Yes** ☐ **No** ☐ **Don't Know**
Have you ever been physically abused as a child?	☐ **Yes** ☐ **No** ☐ **Don't Know**
Have you ever been emotionally/psychologically abused as a child?	☐ **Yes** ☐ **No** ☐ **Don't Know**
Have you ever been sexually assaulted as an adult?	☐ **Yes** ☐ **No**
Have you ever been physically abused as an adult?	☐ **Yes** ☐ **No**
Have you ever been emotionally/psychologically abused as an adult?	☐ **Yes** ☐ **No**
Are you currently in a Domestic Violence relationship?	☐ **Yes** ☐ **No**
Are you safe?	☐ **Yes** ☐ **No** ☐ **Don't Know**
Do you have a safety plan?	☐ **Yes** ☐ **No**

I HAVE READ, UNDERSTAND, AND ACCEPT THE OFFICE POLICY:

____ _________________________

Signature **Date**