

Client # \_\_\_\_\_

## REGISTRATION INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Age now \_\_\_\_\_ Gender  M  F SS# \_\_\_\_\_

Relationship Status  Single  Married  Partner  Divorced  Widowed  Separated  Minor

Employer/School \_\_\_\_\_ Job/Title/Occupation \_\_\_\_\_

Spouse/Partner Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse/Partner Employer \_\_\_\_\_ Workphone \_\_\_\_\_

### CONTACT PREFERENCES

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> OK to leave message<br><input type="checkbox"/> with details<br><input type="checkbox"/> with call back number only | <input type="checkbox"/> OK to leave message<br><input type="checkbox"/> with details<br><input type="checkbox"/> with call back number only | <input type="checkbox"/> OK to leave message<br><input type="checkbox"/> with details<br><input type="checkbox"/> with call back number only |
|--|--|--|

Written Communication/Mail

OK to mail to home address above  OK to fax to \_\_\_\_\_

OK to mail to work/office address \_\_\_\_\_

Email  OK to email to \_\_\_\_\_

Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### MEDICAL CARE PROVIDERS

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

### MENTAL HEALTH CARE PROVIDERS

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**EMERGENCY INFORMATION** In case of emergency, please notify:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Client # \_\_\_\_\_

**INSURANCE INFORMATION**

Person Responsible for Account \_\_\_\_\_  
 Relation to Client \_\_\_\_\_ Birthdate \_\_\_\_\_ SS # \_\_\_\_\_  
 Address (if different from client) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business phone ( ) \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
 Contact # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

**AUTHORIZATION AND RELEASE** I hereby authorize the clinician to release all information necessary to secure payment of benefits from my insurance company. I authorize the use of this signature on all my insurance submissions. I fully understand that I am financially responsible for all charges whether or not paid by my insurance company.

\_\_\_\_\_  
 Signature of Client/Parent/Personal Representative Date \_\_\_\_\_  
 \_\_\_\_\_  
 Print name of person above Relationship to client

**CURRENT PSYCHIATRIC MEDICATIONS**

Please include any medication (including herbs, natural products, etc) that you are taking for depression, anxiety or any other nervous condition or psychiatric symptoms.

Name	Dose	Frequency	Start Date	Reason	Response	Provider

**PAST PSYCHIATRIC MEDICATIONS**

Please list any medications you have taken in the past (including any herbs, natural products, etc) for depression, anxiety or any other nervous condition or psychiatric symptoms.

Name	Dose	Frequency	Start Date	Stop Date	Reason	Response	Provider

**CURRENT NON-PSYCHIATRIC MEDICATIONS**

Please include any medication (including herbs, natural products, etc) that you are taking for any medical condition (for example: pain, infection, high blood pressure, diabetes, etc)

Name	Dose	Frequency	Start Date	Condition	Provider

**PAST NON-PSYCHIATRIC MEDICATIONS**

Please include any medication (including herbs, natural products, etc) that you have taken in the past for any medical condition (for example: pain, high blood pressure, diabetes, etc)

Name	Dose	Frequency	Start Date	Stop Date	Condition	Provider

**SELF AND FAMILY MEDICAL AND PSYCHIATRIC HISTORY**

**Do you** or does any blood relative have a history of any of the following illnesses? If so, please check illness and list yourself or your relative’s relationship to you (self, parent, sibling, grandparent, child, uncle, etc)

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Anemia      | <input type="checkbox"/> Liver disease, hepatitis | <input type="checkbox"/> Drug Abuse/Dependency   |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Heart Disease/CHF/CAD    | <input type="checkbox"/> Anxiety   |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Lung Disease/COPD, etc   | <input type="checkbox"/> Headaches   |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Stroke      | <input type="checkbox"/> Thyroid Disease          | <input type="checkbox"/> Bipolar Illness   |
| <input type="checkbox"/> Seizures    | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Schizophrenia   |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Alcoholism               | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> HIV         | <input type="checkbox"/> Other Neurological _____ | <input type="checkbox"/> gambling, internet, hair-pulling, eating, sexual disorders/prob’s |

**HISTORY OF HOSPITALIZATION**

Please include hospitalization for any surgeries, medical, and psychiatric illness.

Hospital/Provider	Date	Reason for Hospitalization

**ALLERGIES**

Client # \_\_\_\_\_

Please list any medication, food, and environmental allergies


**DRUG AND ALCOHOL HISTORY**

Do you use caffeine?  Y  N Which products and how often? \_\_\_\_\_

Do you use tobacco?  Y  N Which products and how often? \_\_\_\_\_

Do you or did you use recreational drugs?  Y  N

Name	Amount	Start Date	Stop Date

**Place an X in one box that best describes your answer to each question.**

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

**Please circle any symptoms you are experiencing:**

Physical	Cognitive/Mental	Emotional	Behavioral
Fatigue	Poor attention	Anxiety	Change in activity
Muscle tremors	Change in alertness	Grief	Suspiciousness
Chest pain	Memory problems	Severe pain	Inability to rest
Elevated blood pressure	Poor problem solving	Fear	Sleep problems
Thirst	Poor decisions	Loss of emotional control	Pacing
Visual difficulties	Increased or decreased awareness of surroundings	Apprehension	Emotional outbursts
Grinding teeth	Difficulty identifying familiar objects or people	Agitation	Hyper-alert to environment
Dizziness	Intrusive images	Inappropriate emotional response	Erratic movements
Chills	Poor abstract thinking	Guilt	Somatic complaints
Fainting	Nightmares	Denial	Withdrawal
Nausea, vomiting	Confusion	Emotional shock	Alcohol consumption
Twitches	Poor concentration	Uncertainty	Antisocial acts
Difficulty breathing	Hyper-vigilance	Depression	Change in speech pattern
Rapid heart rate	Blaming someone	Feeling overwhelmed	Loss of or increased appetite
Headaches	Loss of orientation to time, place, or person	Irritability	Startle reflex intensified
Weakness	Hallucinations	Mood Swings	Change in sexual functioning
Profuse sweating	Paranoia		Change in communication
Shock symptoms			

**Is there anything else you think I should know?**

