

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) _____

- OK to leave message OK to leave message OK to leave message
- with details with details with details
- with call back number only with call back number only 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 _____

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 _____ | |

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

#1 How often did you have a drink containing alcohol in the past year?

- never
- monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week

#2 How many drinks did you have on a typical day when you were drinking in the past year?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

#3 How often did you have six or more drinks on one occasion in the past year?

- Never
- Less than monthly
- Monthly
- 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 from 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 you had been drinking?
- Never
 - Less than monthly
 - Monthly
 - Weekly
 - Daily or almost daily
- #9** Have you or someone else been injured as a result of your drinking?
- No
 - Yes, but not in the last year
 - Yes, during the last year
- #10** Has a relative or friend, or a doctor or other health care provider 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			Change in sexual functioning
Profuse sweating			Change in communication
Shock symptoms			

