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Child & Adolescent Psychiatry

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New Patient Registration
For Adult Patient

Date: ______________

Name: _________________________________ Date of birth: _______________ □ Female □ Male

Address: ____ City, State, Zip: _____________________

SS#: ____________________________ Email: ____

Home Phone: (____)_______________ Cell: (____)________________ Work: (____)_______________

Current employer: _________________________________ Position: _____________________________

May we leave messages on: □ Home phone □ Cell phone □ Work phone

May we send mail to you at the address above? □ Yes □ No

Person responsible for bill: ____

Address: ____

Please list all other persons living in your household:

Name	Age	Relationship	Employment	Welfare
______________	_____	___________	□ yes □ no	□ yes □ no
______________	_____	___________	□ yes □ no	□ yes □ no
______________	_____	___________	□ yes □ no	□ yes □ no

List any hobbies: ____

Highest level of education attained: __________________ Name of school: _______________________

Primary Care Physician: ___________________________________

Address: ____ Phone: (_____)_______________

May we exchange information with your treating physicians to coordinate your care? □Yes □No

By whom were you referred? ____

Insurance provider: ___________________________________ Policy Number: ___________________

Please describe your reason(s) for seeking treatment at this time (Include when the problem started):

____

____

____

____

Please list other health care professionals currently treating you:

____

____

____

Please list current allergies (be as specific as possible) or other health problems for you:

____

____

Please indicate past problems with a "P" and current problems with a "C"

__Depression
__Anxiety
__Stress
__Grief/Loss
__LD/ADHD
__Anger
__Obsessions/Compulsions
__Trauma

__Chronic Illness
__Chronic Pain
__Loneliness
__Eating or Weight Problem
__Abuse/victimization
__Domestic Violence
__Manic Episodes
__Legal Matters

__Relationship Issues
__Sexuality/Sexual Issues
__Family Conflict
__Behavioral Problems
__Schizophrenia/Psychosis
__Phobias/fears
__Eliminating a Drug/Alcohol Habit
__Eliminating Another Habit (eg, over-spending, gambling, etc.)

Other:____(Please explain)

Please indicate how the problems are affecting the following areas of you and your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Relationships with peers	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A

Total: ______

Have you ever received mental health or substance abuse treatment before? If yes, please describe:

Type of treatment | Provider Name | Phone Number | First Seen | Last Seen

____

____

____

Prior Psychiatric History:

Prior hospitalization: ◻ No ◻ Yes

If yes, please explain reason for admission: ____

Prior psychotherapy: ◻ No ◻ Yes

Prior medication: ◻ No ◻ Yes

If yes, please list: ____

Family history of psychiatric disorders:

____

____

Family history of medical disorders:

____

____

Medical history:

Major illnesses: ____

Hospitalization: ____

Labs: ____

EKG: ____

Please list your current medication:

____

____

____