

Registration Form

General Information

Name : _____ DOB : _____

Address : _____

City : _____ State : _____ Zip : _____

Phone 1 (home/work/cell ?) : _____ May I leave a message? YES__ NO __

Phone 2 (home/work/cell ?) : _____ May I leave a message? YES__ NO __

E-mail: _____ (please fill out the email consent form if you want to use email for communication)

Emergency Contact

Who should I contact in case of an emergency? _____

Relationship to you : _____ Phone (work/home/cell?) : _____

Insurance Information (Please also bring your insurance card to your appointment)

Primary Insurance : _____

Subscriber: _____ Relation to Subscriber : _____

Group # : _____ ID #: _____

Employer : _____

Secondary Insurance (If Any): _____

Subscriber: _____ Relation to Subscriber : _____

Group # : _____ ID #: _____

Employer : _____

Medical and Referral Information

Primary Care Provider: _____

Phone Number : _____

Preferred Pharmacy Name : _____

Referred to my practice by whom? Psychology Today Google Other _____

Another Provider (please write down the name) _____

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Health History

1. Any medical conditions including diabetes, high blood pressure, thyroid dysfunction, seizure and head injury?

2. Do you have any **allergies** to medications? NO ___ If **YES**, list _____

3. **Current Medications** (including prescription drugs, over-the-counter medications, and herbs/vitamins/ minerals, etc.):

Drug Name	Dosage	Drug Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. **For women:** Are you currently pregnant or nursing? _____ Do you use birth control? If so, what kind? _____

5. **Height** _____ **Weight:** _____

6. **Review of Systems:** Please circle any of these symptoms that you are currently experiencing.

General: fatigue fever weight gain >10 Lb weight loss > 10 Lb

Skin: rash color change any other lesions

Eyes, Ears, Mouth: double vision decreased vision decreased hearing dry mouth dental issues

Respiratory: coughing difficulty breathing wheezing snoring

Cardiovascular: chest pain leg swelling heart beating fast

Gastrointestinal: abdominal pain nausea vomiting constipation diarrhea

Genitourinary: pain on urination frequent urination vaginal or penile discharge menstrual irregularities
sexual difficulties

Musculoskeletal: joint pain muscle pain joint swelling

Neurological: Headaches dizziness numbness tingling passing out seizures tremor

Endocrine: cold intolerance heat intolerance increased thirst hair changes

Hematology: easy bruising enlarged lymph nodes

Breast: breast pain breast mass nipple discharge

7. Substance Use History

How many times a week do you drink alcohol? _____ How much do you drink at one setting? _____

Do you use cannabis or MJ? _____ Any other drugs you use currently or in the past? _____

7. **Family Psychiatric History:** Are there any mental health issues in your family members?