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: ______________ May I leave a message (for scheduling)? Yes ___ NO ___

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)______________________________

Seong-Hun Kim, MD, PhD
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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; coughing up blood; 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

Hemotology: 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?

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