

NEW PATIENT REGISTRATION AND INFORMATION (CONFIDENTIAL)

Date: _____

DMB DS SG _____

Part I. Personal Information

Last Name: _____ First Name: _____

Home Address: _____

E-Mail Address: _____

Phone Numbers: Home _____ O.K to call: yes no

Cell _____ O.K to call: yes no

Work _____ O.K to call: yes no

Date of Birth: _____ Age: _____

Marital Status:

Married/Living in a Committed Relationship

Name of Spouse/Partner _____

Single

Divorced

Widowed

Do you have children? If yes, how many and their ages:

Number of Children

Names and Ages

Schools children attend: _____

Referred by (if any): _____

Emerg. contact: _____ Relationship: _____ Phone: _____

Medical Insurance _____ ID# _____

Insured's Name (if different) _____

Insured's DOB: _____ Patient's Social Security #: _____

Employment Information

Are you currently employed? Yes No

Company Name: _____

Occupation: _____

Do you enjoy your work? Is there anything stressful about your current work?

If you are a student, please indicate your school and year _____

Part III. Medical/Mental Health Information

Current Medications	Dose and frequency	Began (Month and Year)
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_____	_____	_____
_____	_____	_____
_____	_____	_____

List your primary care physician, psychiatrist, or any other clinicians involved in your care:

Name	Address	Phone
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been in psychotherapy before? Yes No

If yes, when?

May I contact your previous therapist (s)? Yes No

Therapist:

Address:

Phone:

current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

Are you currently experiencing any chronic pain? Yes No
If yes, please describe.

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

Please list any difficulties you experience with your appetite or eating patterns.

Are you currently experiencing sadness, grief or depression? Yes No
If yes, when did you begin experiencing this? Please describe your symptoms:

Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to it.

Have you ever been hospitalized for psychiatric reasons? Yes No
 If yes, when was the last date of hospitalization and reason for hospitalization?

Are you currently experiencing anxiety, panic attacks or have any phobias? Yes No
 If yes, when did you begin experiencing this? Please describe your symptoms:

Have you ever experienced hearing voices that appear to be "in your head"? Yes No

If yes, please describe? _____

Do you drink alcohol more than once a week? Yes No

Do you use drugs? Yes No

Part IV: Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle	List Family Member
Alcohol/Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	
Domestic Violence <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	
Obesity <input type="checkbox"/> Yes <input type="checkbox"/> No	
Obsessive Compulsive Behavior <input type="checkbox"/> Yes <input type="checkbox"/> No	
Schizophrenia <input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicide Attempts <input type="checkbox"/> Yes <input type="checkbox"/> No	

Part V: Additional Information

1) Do you consider yourself to be spiritual or religious? Yes No
If yes, describe your faith or belief:

2) What do you consider to be some of your strengths?

3) What do you consider to be some of your weakness?

4) Do you have supportive people in your life at this time with whom you can confide your problems?

5) When you are faced with difficulties, what is your usual manner of coping?

6) Please describe your primary reason for seeking treatment at this time. How long has this problem existed?

7) What are your goals for your therapeutic process?
