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: ________________

Emergency Contact

Who should I contact in case of an emergency? ______________________________

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

Insurance Information (you don't need to enter this unless you want me to pre-authorize medications)

Primary Insurance : ____

Subscriber: ________________________ Relation to Subscriber : ________

Group # : ____________________ ID #: ____________________

Employer : ____

Medical and Referral Information

Primary Care Provider______________________________ Phone Number:_____________________________

Other medical providers ____

____

Other mental health providers/therapists____

____

Preferred Pharmacy
Name:____ Phone number:______________________

Demographics and social history

Employment status: Employed___ Retired____ Disabled______ Student_____ Not employed______
Occupation (if employed)____ Full time?____ Part time?_______
Name of school (if student) ____ Full time?____ Part time?_______

Gender_______________________ Preferred pronouns:______ Assessed female at birth?____ Assessed male at birth?_____

Current marital status: married____ how long?______ Times married?_____ OR domestic partner______ how long?_________
single___ widowed___ separated___ divorced___

Current or past abusive relationships (including childhood)?____

Family mental health history:____

Medical history

1, Conditions you have or are seen for (when did it start, currently being treated, severity, etc):___________________________________

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2. Do you have any allergies to medications?______ If yes, please list them:____

3. Current Medications I tc.)

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 Do you smoke?______Packs per day? _____Vape?_____ Other nicotine?_______ Past use?_______

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

Do you use cannabis?________ Flower?________Concentrates?_________ Time per week?_____________ Total amt pr month?_________

Stimulants (coke, crack, speed, meth)?___________Frequency?________________________________Past Use?________________

Opiates (heroin, oxycodone, fentanyl, etc.)?__________ Frequency?_______________________________Past Use?________________

Psychedelics/Club drugs (acid, mushrooms, ecstasy/molly)?_____________________________________Past Use?____________

Other drugs?_______ Type?________________ Frequency?_________________________ Past Use?___________________________

_____ Argued about use?______ Felt guilty about using? _________ Used first thing in morning?_________

Inpatient drug/alcohol treatment?________________________ Outpatient?_______________________ Self-help?________________________

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