**NEW PATIENT REGISTRATION**

Note: If you have been a patient here before, please fill in only the information that has changed.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Sex: \_\_\_\_\_\_

Gender Identity: 􏰀Male 􏰀Female 􏰀Trans (􏰀MTF 􏰀FTM) 􏰀 \_\_\_\_\_\_\_\_\_\_\_\_ Preferred pronouns: \_\_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation: 􏰀Lesbian 􏰀Gay 􏰀Bisexual 􏰀 Straight 􏰀Queer 􏰀Not sure 􏰀\_\_\_\_\_\_\_\_\_\_\_\_

Race / Ethnicity: 􏰀African American/Black 􏰀Asian 􏰀Caucasian/White 􏰀Multi 􏰀Native American/Alaskan Native/Inuit􏰀Pacific Islander􏰀Other\_\_\_\_\_\_\_\_\_\_\_\_ /􏰀Hispanic/Latino/Latina􏰀Not Hispanic/Latino/Latina

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I Call This Number? 􏰀 Yes 􏰀 No

Leave a Message? 􏰀 Yes 􏰀 No

**Cell Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I Call This Number? 􏰀 Yes 􏰀 No

Leave a Message? 􏰀 Yes 􏰀 No

**E-mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **May I E-Mail Reminders?** 􏰀 Yes 􏰀 No

Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Responsible for Bill: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYER INFORMATION**

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I Call This Number? 􏰀 Yes 􏰀 No

Leave a Message? 􏰀 Yes 􏰀 No

**INSURANCE INFORMATION**

**Primary** Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date: \_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/Member #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay: $\_\_\_\_\_\_\_\_\_\_ Subscriber Name/ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Group/Plan #: \_\_\_\_\_\_\_\_\_\_\_\_ Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary** Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date: \_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/Member #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay: $\_\_\_\_\_\_\_\_\_\_ Subscriber Name/ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Group/Plan #: \_\_\_\_\_\_\_\_\_\_\_\_ Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL & REFERRAL INFORMATION**

Name of Physician/Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Therapist/Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By Whom Were You Referred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I have your permission to thank this person for the referral? 􏰀 Yes 􏰀 No

**HOUSEHOLD INFORMATION**

Relationship Status: 􏰀Married 􏰀Partnered 􏰀Single 􏰀Multiple Partners 􏰀Separated/Divorced 􏰀\_\_\_\_\_\_\_\_\_\_\_\_

Living Environment**:** 􏰀 Live Alone 􏰀 Live with spouse/partner(s) 􏰀 Live with roommate(s) 􏰀 Live with parent(s)/guardian(s) or family 􏰀 Live with children/dependents

Spouse / Partner(s) / Significant other(s) Others in Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Next of Kin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Any changes in your general physical health in the past 3-6 months? No ❑ Yes ❑, please explain.

Do you experience chronic pain? No ❑ Yes ❑ If YES, how managed (PT, Rx, etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Operations and/or Hospitalizations: (Please list surgeries and/or hospitalization reasons and dates)

Primary Care Provider (PCP) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

❑ Anemia ❑ Arthritis/Joint Pain ❑ Asthma ❑ Abnormal blood clotting

❑ Bronchitis ❑ Cancer ❑ Chemotherapy History ❑ Cataracts ❑ Diabetes

❑ Elevated Cholesterol ❑ Emphysema ❑ Fainting or blackout spells ❑ Frequent bladder infections

❑ Gallbladder Disease ❑ Glaucoma ❑ Head Injury/trauma ❑ Heart Disease

❑ Heart valve problems ❑ High Blood Pressure ❑ HIV/ AIDS ❑ Irritable Bowel Syndrome/Colitis

❑ Cirrhosis ❑ Hepatitis (A, B, C) ❑ Loss of consciousness ❑ Migraines/other headaches

❑ MRSA (staph) ❑ Obesity ❑ Periods of lost memory ❑ PMS syndrome ❑ Prostate Trouble ❑ Seizures

❑ Sexually Transmitted Infection ❑ Stroke ❑ Thyroid Trouble ❑ Tuberculosis

❑ Ulcers (stomach/intestine)

❑ Other, please list below:

|  |
| --- |
|  |

**FAMILY MEDICAL HISTORY** - If yes, who? (Parent, sibling, children, aunt/uncle, grandparent)

Please check all that apply:

❑ Anemia ❑ Arthritis/Joint Pain ❑ Asthma ❑ Abnormal blood clotting

❑ Bronchitis ❑ Cancer ❑ Chemotherapy History ❑ Cataracts ❑ Diabetes

❑ Elevated Cholesterol ❑ Emphysema ❑ Fainting or blackout spells ❑ Frequent bladder infections

❑ Gallbladder Disease ❑ Glaucoma ❑ Head Injury/trauma ❑ Heart Disease

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❑ Sexually Transmitted Infection ❑ Stroke ❑ Thyroid Trouble ❑ Tuberculosis

❑ Ulcers (stomach/intestine)

❑ Other, please list below:

|  |
| --- |
|  |

**FAMILY MENTAL HEALTH HISTORY**

Has anyone in your family ever been diagnosed with a mental illness, had a psychiatric hospitalization or suicide attempt, or struggled with drugs or alcohol? No ❑ Yes ❑ If Yes, please indicate relation, condition, treatments, & medications.

|  |
| --- |
|  |

**CURRENT MEDICATIONS** Please list your current medications, vitamins, & herbal supplements (or supply printed list).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **Times a day** | **Reason for taking** | **Prescriber** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**MEDICATION ALLERGIES/REACTIONS**

❑No known drug allergies ❑Yes, please list below.

**OTHER ALLERGIES** (Food/Environment) ❑ No ❑Yes, please list below.

**PREVENTION**

**Wears seatbelt?** No ❑ Yes ❑ **Wears biking helmet?** No ❑ Yes ❑ **Firearms kept in home?** No ❑ Yes ❑

**Tobacco:** Current packs a day \_\_\_\_\_\_\_\_\_ ❑ Former Smoker ❑ Non-smoker ❑ Pipe ❑ Cigars ❑ Chew

**Alcohol:** Drinks a week \_\_\_\_\_\_\_ ❑ Drink occasionally ❑ Do not drink

**Caffeine:** caffeinated beverages a day \_\_\_\_\_\_\_\_\_ ❑ No caffeine

Sexual Partner(s) last 12 months: 􏰀Men 􏰀Women 􏰀Transgender 􏰀None/abstinent Number of partners: \_\_\_\_\_\_\_\_\_\_\_\_

**ACTIVITY** (check one)

❑ Sedentary life with little exercise ❑ Occasional vigorous activity with work or

❑ Mild Exercise with job, house, or recreation (climb stairs, walk over 3 blocks, etc)

❑ Regular vigorous exercise program or hard work

Do you have an advanced health directive, such as a “do not resuscitate”? No ❑ Yes ❑ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does someone have power of attorney, or guardianship giving them the power to make decisions about your care in life-

Recreation threatening situations, or a psychiatric advance directive? No ❑ Yes ❑

Name & relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I verify that the above information is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my provider of any changes in my medical status.

Patient/Parent/Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescriber signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed with Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_