CONFIDENTIAL HISTORY / PRE-REGISTRATION

Date: _____

Patient Information

Last_____ First_____MI_____DOB_____

Sex: M F Marital Status_____ SSN_____TDL_____

Address_____Zip_____

Home Phone #_____ Work #_____

Employer_____ Referred by_____

IF THE PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING:

Mother's Last _____ First_____MI_____DOB_____

Father's Last_____ First_____MI_____DOB_____

Who Does Child Live With?_____Are parents: Living together _____ Not living together _____

Legal Guardian:_____ Please provide copy of court order.

Patient History

Have you had previous psychiatric treatment? _____ Yes _____ No

Name and Phone # of previous practitioner: _____

Date last Seen: _____ May we contact your last practitioner _____Yes _____No
*(If yes please complete a **Authorization for Release of Medical Records** so we may obtain records)

Are you currently under the care of a Primary Care Physician? _____Yes _____No

Name and phone # of Physician:_____

Hospitalizations: (Women do not need to add normal pregnancies or child birth)

If you have had any hospitalization: Please list them here:

_____
_____
_____

Reason for your visit here today: _____
_____
_____
_____