

Physician Name _____
Address _____

Phone # () _____ - _____
Fax # () _____ - _____

New Patient Registration

This form requests information about your child which will help us design a treatment plan geared specifically to your child's needs. Please take a few moments to complete the form carefully. We appreciate your time and effort in completing these documents. If you have any questions, please feel free to discuss them with us. Thank you.

Patient Name: _____ Birthdate: _____ Today's date: _____

Address: _____ Age: _____ Female Male

City, State, Zip: _____

Telephone (_____) _____ (_____) _____
Home Cell Phone

Mother: _____ Hm(_____) _____ Wk(_____) _____ C(_____) _____
Name Phone numbers

Father: _____ Hm(_____) _____ Wk(_____) _____ C(_____) _____
Name Phone numbers

Father's Address, if different from above _____

Relationship Status of Parents: Never Married Married/Partnership Separated Divorced Widowed

Person responsible for bill: _____

Address: _____

Please list all other persons living in your household, as well as children not living in your home.

Name	Age	Relationship	Employment	Welfare (Are you on welfare aid?)
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
At home / Not at home (Circle one)				
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
At home / Not at home (Circle one)				
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
At home / Not at home (Circle one)				
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
At home / Not at home (Circle one)				

Household income (\$):

- 0 – 20,000
- 20,000 – 50,000
- > 50,000
- Unknown

Education level (father)

- Kindergarten
- Elementary (grade level: _____)
- Middle Sch (grade level: _____)
- Higher Sch (grade level: _____)
- Graduate

Education level (mother)

- Kindergarten
- Elementary (grade level: _____)
- Middle Sch (grade level: _____)
- Higher Sch (grade level: _____)
- Graduate

Primary Care Physician _____ Address _____ Phone (_____) _____

May we exchange information with your treating physicians to coordinate your care? Yes No

By whom were you referred? _____

Insurance Type: Private Public

Please describe your reason(s) for seeking treatment at this time (Include when the problem started):

Please list other health care professionals currently treating your child: _____

Please list current allergies or other health problems for your child: _____

Please indicate past problems with a "P" and current problems with a "C"

- | | | |
|---|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Relationship Issues |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Sexuality/Sexual Issues |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Family Conflict |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Eating or Weight Problem | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> LD/ADHD | <input type="checkbox"/> Abuse/victimization | <input type="checkbox"/> Schizophrenia/Psychosis |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Obsessions/Compulsions | <input type="checkbox"/> Manic Episodes | <input type="checkbox"/> Eliminating a Drug/Alcohol Habit |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Legal Matters | <input type="checkbox"/> Eliminating Another Habit (eg, over-spending, gambling, etc.) |

Other: _____ (Please explain)

Please indicate how the problems are affecting the following areas of you and your child's life:

	No effect	Little effect	Some effect	Much effect	Significant effect	Not applicable
Relationships with peers	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A

Total: _____

Have you ever received mental health or substance abuse treatment before? If yes, please describe:

Type of treatment	Provider Name	Phone Number	First Seen	Last Seen
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Medications	Dose	Prescribing Physician
_____	_____	_____
_____	_____	_____

Thank you for your help.