541 Willamette Street, Suite 208B, Eugene, OR 97405 ■ (541) 636-0131 ■ www.amandalies.com

New Patient Registration Form

Identifying Information

Client's Name _____Today's Date_____

_____

Address City State Zip Code

_____T

elephone(s) Home Cell Work Partner's

May we leave a message for you at home? Yes or No____ May we leave a message for you at work? Yes or No___

Gender: M_____F_____ Age_____ Birthday_____ Marital Status:_____

Other's living in your home: (Name, Birthday, Relationship to Client)_____

_____

_____

Education?: Self:_____Partner:_____

Occupation?: Self:_____Partner:_____

Client's Employer?:_____

Social Security Number: Self:_____Partner:_____

Emergency Contact:_____Phone:_____

Referred by:_____

Insurance Information

Name of insured:_____ Insured date of birth:_____

Address of Insured Person:_____

Relationship of client to insured person:_____

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Employer of insured person:_____

Insurance Company:_____Phone:_____

Insurance Company Address_____

Insurance identification Number:_____ Group Number_____

Secondary Insurance:_____ Phone: _____

Name of secondary insured:_____ Date of Birth: _____

Secondary company address: _____

Secondary identification number: _____ Group Number: _____

PATIENT OR AUTORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____

Name Date

Presenting Problems

Describe the problem that brought you here today:

Check any of the symptoms that are having:

Depression _____ Feeling hopeless ____ Extreme sadness ____ Feeling tearful ____ Trouble concentrating ____

Change in sleeping habits ____ Memory problems ____ Lack of energy ____ Increase in appetite ____

Loss of appetite ____ Weight gains ____ Weight loss ____ Feeling of extreme happiness ____ Increased spending ____

Change in sexual interest or function ____ Trouble performing your job ____ Feeling stressed ____ Easily irritated ____

Problems getting along with friends or family ____ Lack of enjoyment of usual activities ____ Self-esteem problem ____

Perfectionism ____ Feeling nervous ____ Feeling guilty ____ Feeling nervous ____ Feeling fearful ____

Obsessive compulsive counting, hoarding, cleaning, washing hands ____ Pulling out hair ____ Muscle tension ____

Sudden feelings of panic ____ Physical complaints of pain ____ Acting violently physically or verbally ____

Problems with anger ____ Thoughts about hurting yourself or others ____ Thoughts about killing yourself or others ____

This space reserved for additional comments by clinician _____

_____

Current Medications

Please list all current medications - name, dose, how long you've been taking, the doctor who prescribes the medication.

Please list additional over the counter or supplements that you are taking.

Past Psychiatric History

Have you ever been in counseling before? _____

From what dates or how old were you when you were in counseling? _____

Who did you see?_____ In what city? _____

Was this a good experience or bad experience? _____

What were the issues you were working on in counseling at that time? _____

_____

Please describe other episodes of counseling you have had in the past if more than one: _____

_____

Have you ever been treated with medications for your mental health issues? If so, what were the medications you've been on in the past? _____

_____

Have you ever been admitted to the psychiatric hospital? _____ If so, when and what was the event that lead to the admission? _____ Have you ever attempted suicide? _____ How many suicide attempts have you completed? _____ How long ago was the last attempt? _____

Have you ever been treated in inpatient drug and alcohol treatment? ____ Outpatient drug and alcohol treatment? ____

Medical Information

Have you seen a doctor within the past year? _____ Why have you seen a doctor?_____

_____

Who is your primary doctor and how long have you been under their care? _____

Describe any problems you may have with allergies: _____

_____

Is there any chance that you may be pregnant or are planning to become pregnant? _____

Substance Use History

Do you / have you used tobacco? _____ Current ____ Past ____ No ____

Do you / have you used alcohol? _____ Current ____ Past ____ No ____

Do you use / have you used caffeine (tea, soda, energy drinks)? _____ Current _____ Past ____ No ____

Do you / have you used recreational drugs? _____ Current _____ Past _____ No _____