Physician Name__________________________ Phone # ( ) ____-________
Address________________________________ 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?)
_____________________________ At home / Not at home (Circle one)	_____	__________	□ yes □ no	□ yes □ no
_____________________________ At home / Not at home (Circle one)	_____	__________	□ yes □ no	□ yes □ no
_____________________________ At home / Not at home (Circle one)	_____	__________	□ yes □ no	□ yes □ no
_____________________________ At home / Not at home (Circle one)	_____	__________	□ yes □ no	□ yes □ no

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"

__Depression
__Anxiety
__Stress
__Grief/Loss
__LD/ADHD
__Anger
__Obsessions/Compulsions
__Trauma

__Chronic Illness
__Chronic Pain
__Loneliness
__Eating or Weight Problem
__Abuse/victimization
__Domestic Violence
__Manic Episodes
__Legal Matters

__Relationship Issues
__Sexuality/Sexual Issues
__Family Conflict
__Behavioral Problems
__Schizophrenia/Psychosis
__Phobias/fears
__Eliminating a Drug/Alcohol Habit
__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.