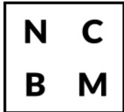

Newport Center For
Behavioral Medicine

PATIENT REGISTRATION FORM

(Please Print Legibly)

Date: ______________________

Patient Name: ______________________________________ **Date of Birth:** ______________

Home Address: ____

City: ____________________________ **State:** ________________ **Zip:** ________________

Home Phone: ( ) ______________________ **Cell Phone:** ( ) ______________________

Soc Sec: _______________ **Email:** ______________________ **CDL:** __________________

Sex: [ ] **Female** [ ] **Male** [ ] **Married** [ ] **Single** [ ] **Divorced** [ ] **Widowed**

*** Employer:** _____________________________ **Position:** _____________________________

* Parent/guardian, if patient is a minor

Work Address: ____________________________ **City:** __________ **State:** _____ **Zip:** _____

Work Phone: ___________________________ **Work Email:** ___________________________

Emergency Contact: __________________ **Relationship:** __________ **Phone:** ( ) _________

Primary Care Physician: ___________________ **Cell Phone:** ( ) ______________________

Who may we thank for referring you to our office? ____

Current Problems

Please provide a brief description of the major concerns that led you to seek treatment.

____

____

____

Previous Psychiatrist/Therapist

Name of the clinician: Phone Number/Address Treatment Dates

Name of the clinician:	Phone Number/Address	Treatment Dates
______________________	______________________	________________
______________________	______________________	________________
______________________	______________________	________________

Have you been hospitalized for psychiatric or substance abuse problems? No _____ Yes _____

Facility: ______________ Dates: __________ Reason: ________________

Facility: ______________ Dates: __________ Reason: ________________

Do you have any history of suicide attempts or assault? No _____ If yes, please describe:

____

____

____

Medications

Please list all current drugs/medications, including over-the-counter:

Name of medication:	Dose	Dates
______________________	__________	________
______________________	__________	________
______________________	__________	________
______________________	__________	________
______________________	__________	________

Please list any previous psychiatric drugs/medications:

Name of medication:	Dose	Dates
______________________	__________	________
______________________	__________	________
______________________	__________	________
______________________	__________	________

Physical Health Status
Do you have any diagnosed medical conditions?

____

____

Medications taken for medical conditions:

____

____

Do you smoke? No ____ Yes, (#) ______ per day

Do you drink alcohol? No ____ Yes, (# drinks) ______ per week

Do you engage in any substance/drug use? No ____ If yes, please explain:

____

Do you exercise? Regularly ____ Occasionally ____ Rarely ____ Never ____

How is your diet? Very healthy ____ Questionably healthy ____ Not very healthy ____ Changes ____

How is your general health? Excellent ____ Good ____ Fair ____ Poor ____

Family History of Psychiatric Disorders
Have any family members had any psychiatric conditions? How were they treated?
(Please include parents, brothers, sisters, grandparents, aunts, uncles, children, and cousins)

____

____

____

____

Social/Occupational/Family Functioning

What is your social network?
No close friends ____ One close friend ____ Few friends ____ Many friends ____

How often do you make contact with friends?
Regularly ____ Occasionally ____ Infrequently ____ Never ____

Are you currently in a romantic relationship?
No ____ Yes, it is.... Generally positive ____ Neutral ____ Problematic ____

What is your living situation?
Live alone ____ Live with others, with whom? ____

How do you feel about (select one) work/school?
Pleased ____ Mostly satisfied ____ Mixed ____ Mostly dissatisfied ____ Unhappy ____

Any major dissatisfaction with: Work ____ School ____ Other ______________________________

If so, please explain ____

____

Please describe any hobbies or recreational activities: _________________________________

____

____