HEALTH GROUP PSYCHOLOGICAL SERVICES INC.

NEW PATIENT REGISTRATION

ADULT FORM

Welcome to Health Group Psychological Services. We are here to help you reach your treatment goals. This form requests information from you about your needs as well as providing information to you concerning how your care will be addressed. Please take a few moments to complete this form.

Patient's Name____ Today's Date_________________

Home Phone________________________________(ok to call YES NO) Date of Birth_________________

Cell Phone__________________________________(ok to call YES NO) Age________________________

Address____ Gender ___Female ___ Male

Marital Status __ Single __ Married

City, State, Zip____ __Separated __Divorced __Widowed

Patient's SSN ______________________________ Full Time Student (YES NO) School?_____________________

Provider Being Seen________________________ Occupation____

Primary Care Physician________________________________ Phone_______________________________________

Emergency Contact________________________ Relationship to Patient______________ Phone_________________

Please list other Persons living in your household and their relationship to you:

Name	Age	Relationship to Patient

How were you referred to this office?_______________________________________ May we acknowledge contact with this office? YES NO

Primary Insurance Information

Medical Plan Name______________________________

Insured Name___________________________________

Insured SSN____________________________________

Insured Birth Date_______________________________

Employer_______________________________________

Payor/ Health Plan_______________________________

Patient's Relationship to the
Insured (check one) __self __spouse __dependent

Psychiatric/ Mental Health Plan______________________

Member # _____________________________________

Policy/ Group #_________________________________

Secondary Insurance Information

Medical Plan Name__________________________

Insured Name______________________________

Insured SSN_______________________________

Insured Birth Date___________________________

Employer__________________________________

Payor/ Health Plan___________________________

Patient's Relationship to the
Insured (check one) __self __spouse __dependent

Psychiatric/ Mental Health Plan ________________

Member #__________________________________

Policy/ Group #______________________________

Please describe your reason(s) for seeking treatment at this time (Include date or month/year the problem started):

____

____

Was there an event or circumstance which made these issues or problems surface? ___YES ___NO

If yes, please describe:

____

____

What goal(s) or changes do you expect to achieve from treatment?

____

____

Please indicate and rate the severity (1-4) of the following issues or problems you would like to work on in treatment.

NONE 1 | MILD 2 | MODERATE 3 | SEVERE 4

___ Depression
___ Anxiety
___ Controlling stress
___ Loss of loved one
___Problems at school
___Problems at work
___Lack of friends
___Loneliness
___Problem solving
___Abuse/victimization
___Financial problems
___Legal matters
___Marriage/Relationship issues
___Sexuality/Sexual issues
___Family conflict
___Behavioral Problems
___Eliminating a Drug/alcohol habit
___Eliminating another habit (i.e. overspending Overeating, gambling, ect.)

___ Other ____

Please indicate how the issue(s) for which you are seeking treatment are affection the following areas in your life:

Area	No effect	Little effect	Some effect	Much effect	Significant effect	N/A
Marriage/relationship	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
Anxiety level/ nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
Sleeping habits	1	2	3	4	5	N/A
Sexual functioning	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control temper	1	2	3	4	5	N/A

PERSONAL MEDICAL HISTORY

Do you have any allergies to medications or food? ____YES ____NO

If yes, please describe:

____

____

Please list any prescriptions you currently use:

NAME | DOSAGE/FREQUENCY | SIDE EFFECTS

____

____

____

Please list any over the counter medications you currently use:

NAME | DOSAGE/ FREQUENCY | SIDE EFFECTS

____

____

____

Please list hospitalization from past medical/surgical illnesses (include name of hospital, dates, illness/procedures):

HOSPITAL | DATES | ILLNESS/PROCEDURE

____

____

When was your last physical exam done? (include date, doctor name)____
Were there any significant findings?____
Are you currently being treated for any medical conditions: ____YES ____NO
If yes, please list:____
Do you experience any of the following:

___Double vision	___Unusual excessive thirst	___Difficulty hearing
___Indigestion, gas, heartburn	___Fainting	___Stomach pain
___Blackouts	___Diarrhea or constipation	___Convulsions
___Vomiting/vomiting blood	___Paralysis	___Blood in stool
___Dizziness	___Change in appetite or eating habits	___Headaches
___Thyroid problem	___Sexual problems	___Cough or wheezing
___Chest pains	___Problems with memory, thinking or concentration	___Shortness of breath
___Lumps any where on the body	___Joint Pain	___Palpitations or heart fluttering

Please specify location:____

___Weight Change: LOSS: ______ # lbs or GAIN______# lbs Time period:___________________________
For any of the above items, please describe briefly:____
____
Have you ever abused drugs or alcohol? ___YES ___NO
If yes, please describe:

Substance	Amount	Frequency	Last taken

Do you have a history of blackouts, seizures, or withdrawl symptoms? ____YES ____NO
If yes, please describe:____
Have you ever received mental health or substance abuse treatment before? ____YES ____NO
If yes, please describe:____

Type of treatment: (counseling, psychotherapy, psychiatric medications, substance abuse programs, pastoral therapy)

(inpatient, outpatient)	Providers Name	1st seen	Last seen	Medication and dose (if any)

LIFESTYLE/ HABITS

	Amount currently using	Most ever used
Coffee (cups/day)	________________________	______________
Caffeinated soft drinks	________________________	______________
Cigarettes (packs/day)	________________________	______________
Alcohol (drinks/day)	________________________	______________
Exercise	Type(s)	Frequency
	________________________	_________________
	________________________	_________________
Hobbies	________________________	________________

Hrs/week spent at work ________________________ Work stress level: ____High ____Low

FAMILY MEDICAL HISTORY

A. Has any one in your family had a serious medical illness? If so, please explain: ______________________________
____
B. Has anyone in your family had a psychiatric (nervous or mental) illness? ____YES ____NO
If yes, please explain:____
If yes, what type of treatment, if any, did they receive? ____
C. Has anyone in your family had a substance abuse problem? ____YES ____NO
If yes, please explain: ____