PATIENT REGISTRATION

PLEASE FILL OUT ALL INFORMATION AS COMPLETELY AS POSSIBLE

Patient Name:_____

Address:_____**City:**_____**State**_____**Zip**_____

Sex: M F Age:_____ **DOB:**_____

Marital Status: Single___ Married___ Divorced___ Widowed___ Other_____

Home Phone:_____ **Work Phone:**_____

Cellular Phone:_____ **Pager:**_____

e-mail:_____

Please answer the following questions.

Are you having thoughts of suicide? Yes No
Have you ever attempted suicide? Yes No
Have you ever harmed yourself? Yes No
Have you ever harmed anyone else? Yes No
Are you addicted to Alcohol or Drugs? Yes No
Are you using any illegal drugs? Yes No
Are you on any prescription drugs (antidepressants, etc.)? Yes No
Are you on any herbal medications? Yes No
Have you had a period of prolonged depression that was not responsive to a combination of medication and counseling? Yes No
Have you had a history of having frequent or acute emergencies requiring more than two counseling sessions per week, after hours help or weekend help? Yes No
Have you ever been convicted of any crimes, incarcerated or broken laws other than minor traffic violations? Yes No
Have you ever had a disorder that caused you to lose touch with reality (psychosis, schizophrenia, acute manic phase of bi-polar disorder, etc.)? Yes No
Have you sought psychotherapy/counseling in the past? Yes No
If so, how long were you in treatment?_____ **Was it helpful? Yes No ?**
Have you ever been hospitalized for psychiatric issues? Yes No
Is anyone else requiring or pressuring you to be in therapy? Yes No
Do you believe that it is possible for you to get better? Yes No ?