MENTAL BLISS
PSYCHOPHARMACOLOGY SERVICES
AND PSYCHOTHERAPY

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NEW PATIENT REGISTRATION

Note: If you have been a patient here before, please fill in only the information that has changed. Today's Date: _____

Legal Name: _____ Preferred Name: _____ Age: _____ Sex: _____

Gender Identity: ☐Male ☐Female ☐Trans (☐MTF ☐FTM) ☐ _____ Preferred pronouns: _____

Sexual Orientation: ☐Lesbian ☐Gay ☐Bisexual ☐ Straight ☐Queer ☐Not sure ☐_____

Race / Ethnicity: ☐African American/Black ☐Asian ☐Caucasian/White ☐Multi ☐Native American/Alaskan Native/Inuit ☐Pacific Islander ☐Other _____ / ☐Hispanic/Latino/Latina ☐Not Hispanic/Latino/Latina

Address: _____ Social Security #: _____

City, State, Zip: _____ Date of Birth: _____

Home Phone: _____ May I Call This Number? ☐ Yes ☐ No Leave a Message? ☐ Yes ☐ No

Cell Phone: _____ May I Call This Number? ☐ Yes ☐ No Leave a Message? ☐ Yes ☐ No

E-mail: _____ May I E-Mail Reminders? ☐ Yes ☐ No

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Person Responsible for Bill: _____ Relationship: _____

Address: _____Phone: _____

EMPLOYER INFORMATION

Employer: _____Occupation: _____

Address: _____

Work Phone: _____ May I Call This Number? ☐ Yes ☐ No Leave a Message? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance Company: _____ Effective date: _____

Name of Insured: _____ Policy/Member #: _____ Copay: $_____

Subscriber Name/ID #: _____ Relationship: _____ Group/Plan #: _____

Claims Address: _____ Phone: _____

Secondary Insurance Company: _____ Effective date: _____

Name of Insured: _____ Policy/Member #: _____ Copay: $_____

Subscriber Name/ID #: _____ Relationship: _____ Group/Plan #: _____

Claims Address: _____ Phone: _____

MEDICAL & REFERRAL INFORMATION

Name of Physician/Primary Care Provider: _____ Phone: _____

Name of Therapist/Counselor: _____ Phone: _____

By Whom Were You Referred? _____ Relationship: _____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

HOUSEHOLD INFORMATION

Relationship Status: ☐Married ☐Partnered ☐Single ☐Multiple Partners ☐Separated/Divorced ☐_____

Living Environment: ☐ Live Alone ☐ Live with spouse/partner(s) ☐ Live with roommate(s) ☐ Live with parent(s)/guardian(s) or family ☐ Live with children/dependents

Spouse / Partner(s) / Significant other(s) Name(s): _____ Phone: _____

Others in Home:	Gender:	Age:	Relationship:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMERGENCY CONTACT

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Contact: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Legal Next of Kin: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

This form will be retained in your medical record.

MEDICAL HISTORY Please check all that apply:

- ☐ Anemia
- ☐ Arthritis/Joint Pain
- ☐ Asthma
- ☐ Abnormal blood clotting
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chemotherapy History
- ☐ Cataracts
- ☐ Diabetes
- ☐ Elevated Cholesterol
- ☐ Emphysema
- ☐ Fainting or blackout spells
- ☐ Frequent bladder infections
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ Head Injury/trauma
- ☐ Heart Disease
- ☐ Heart valve problems
- ☐ High Blood Pressure
- ☐ HIV/ AIDS
- ☐ Irritable Bowel Syndrome/Colitis
- ☐ Cirrhosis
- ☐ Hepatitis (A, B, C)
- ☐ Loss of consciousness
- ☐ Migraines/other headaches
- ☐ MRSA (staph)
- ☐ Obesity
- ☐ Periods of lost memory
- ☐ PMS syndrome
- ☐ Prostate Trouble
- ☐ Seizures
- ☐ Sexually Transmitted Infection
- ☐ Stroke
- ☐ Thyroid Trouble
- ☐ Tuberculosis
- ☐ Ulcers (stomach/intestine)

Do you have any ongoing health problems not listed above? No ☐ Yes ☐ If yes, please list.

_____

Any changes in your general physical health in the past 3-6 months? No ☐ Yes ☐, please explain.

_____

_____

Do you experience chronic pain? No ☐ Yes ☐ If YES, how managed (PT, Rx, etc)? _____

Operations and/or Hospitalizations: (Please list surgeries and/or hospitalization reasons and dates)

_____

_____

_____

Primary Care Provider (PCP) _____ Clinic _____

Telephone _____ Fax _____

FAMILY MEDICAL HISTORY - If yes, who? (Parent, sibling, children, aunt/uncle, grandparent)

Alcoholism	No ☐ Yes ☐		Drug use	No ☐ Yes ☐	
Arthritis	No ☐ Yes ☐		Migraine Headaches	No ☐ Yes ☐	
Cancer/ Type(s)	No ☐ Yes ☐		Obesity	No ☐ Yes ☐	
Diabetes	No ☐ Yes ☐		Seizures	No ☐ Yes ☐	
Heart Disease	No ☐ Yes ☐		Stroke	No ☐ Yes ☐	
High Blood Pressure	No ☐ Yes ☐		Thyroid Disease	No ☐ Yes ☐	

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family ever been diagnosed with a mental illness, had a psychiatric hospitalization or suicide attempt, or struggled with drugs or alcohol? No ☐ Yes ☐ If Yes, please indicate relation, condition, treatments, & medications.

_____

_____

CURRENT MEDICATIONS Please list your current medications, vitamins, & herbal supplements (or supply printed list).

Medication	Reason for taking	Dosage & Times a day	Prescriber

MEDICATION ALLERGIES/REACTIONS ☐ No known drug allergies ☐ Yes, please list below.

_____

_____

OTHER ALLERGIES (Food/Environment) ☐ No ☐ Yes, please list below.

_____

PREVENTION

Wears seatbelt? No ☐ Yes ☐ Wears biking helmet? No ☐ Yes ☐ Firearms kept in home? No ☐ Yes ☐

Tobacco: Current packs a day _____ ☐ Former Smoker ☐ Non-smoker ☐ Pipe ☐ Cigars ☐ Chew

Alcohol: Drinks a week _____ ☐ Drink occasionally ☐ Do not drink

Caffeine: caffeinated beverages a day _____ ☐ No caffeine

Sexual Partner(s) last 12 months: ☐ Men ☐ Women ☐ Transgender ☐ None/abstinent Number of partners: _____

ACTIVITY (check one)

☐ Sedentary life with little exercise

☐ Mild Exercise with job, house, or recreation (climb stairs, walk over 3 blocks, etc)

☐ Occasional vigorous activity with work or recreation

☐ Regular vigorous exercise program or hard work

Does someone have power of attorney, or guardianship giving them the power to make decisions about your care in life-threatening situations, or a psychiatric advance directive? No ☐ Yes ☐ Name & relationship: _____

Do you have an advanced health directive, such as a "do not resuscitate"? No ☐ Yes ☐ Location: _____

I verify that the above information is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my provider of any changes in my medical status.

Patient/Parent/Guardian signature _____ Date _____

Prescriber signature _____ Date Reviewed with Patient _____

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