MENTAL BLISS
PSYCHOPHARMACOLOGY SERVICES
AND PSYCHOTHERAPY

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NEW CHILD & ADOLESCENT PATIENT REGISTRATION

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

Name of person completing form: _____ Relationship to patient: _____

Child/Adolescent Legal Name: _____ Preferred Name: _____ Age: _____ Sex: _____

Gender Identity: ☐Male ☐Female ☐Transgender (☐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: _____

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 Pediatrician/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

FAMILY INFORMATION

Parent Name: _____ Present Health: _____ Age: _____

Occupation/Employer: _____ Education Level: _____

Parent Name: _____ Present Health: _____ Age: _____

Occupation/Employer: _____ Education Level: _____

Parent(s)/Guardian(s) are: ☐ Partnered/Married ☐ Single ☐ Separated ☐ Divorced

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?

Emergency Contact: _____ Relationship: _____

Address: _____

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

Emergency Contact: _____ 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
- ❑ Diabetes
- ❑ Elevated Cholesterol
- ❑ Fainting or blackout spells
- ❑ Frequent Bladder/kidney infections
- ❑ Glaucoma
- ❑ Head Injury/trauma
- ❑ Heart Disease
- ❑ Heart valve problems
- ❑ High Blood Pressure
- ❑ HIV/ AIDS
- ❑ Irritable Bowel Syndrome/Colitis
- ❑ Liver problem
- ❑ Hepatitis (❑A, ❑B, ❑C)
- ❑ Loss of consciousness
- ❑ Migraines/other headaches
- ❑ MRSA (staph)
- ❑ Obesity
- ❑ Periods of lost memory
- ❑ Pneumonia
- ❑ Premenstrual syndrome
- ❑ Seizures
- ❑ Sexually Transmitted Infection
- ❑ Stroke
- ❑ Thyroid Trouble
- ❑ Tuberculosis
- ❑ Ulcers (stomach/intestinal)

Do you (your child) have any ongoing health problems not listed above? ❑ No ❑ If yes, please explain.

_____

_____

Have you noticed any changes in your (child's) physical health in the past 3-6 months? ❑ No ❑ If yes, please explain.

_____

_____

Do you (your child) 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, aunt/uncle, grandparent)

Alcoholism	No ❑ Yes ❑		High Blood Pressure	No ❑ Yes ❑	
Arthritis	No ❑ Yes ❑		Learning Problems	No ❑ Yes ❑	
Asthma	No ❑ Yes ❑		Migraine Headaches	No ❑ Yes ❑	
Birth/genetic defects	No ❑ Yes ❑		Obesity	No ❑ Yes ❑	
Cancer/ Type(s)	No ❑ Yes ❑		Stroke	No ❑ Yes ❑	
Diabetes	No ❑ Yes ❑		Thyroid Disease	No ❑ Yes ❑	
Drug use	No ❑ Yes ❑		Seizures	No ❑ Yes ❑	
Heart Disease	No ❑ Yes ❑		Sudden death before 40y	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 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 ❑ If Yes, please explain.

_____

_____

OTHER ALLERGIES (Food/Environment) ❑ No ❑ If Yes, please explain.

_____

PREVENTION

How often does your use a seatbelt/car seat? ❑ Never ❑ Rarely ❑ Sometimes ❑ Often ❑ Always

If riding bicycle, how often does he/she use helmet? ❑ Never ❑ Rarely ❑ Sometimes ❑ Often ❑ Always

Are there any firearms kept in your home? ❑ No ❑ If Yes, is it locked up? No ❑ Yes ❑

Does anyone in your household smoke? ❑ No ❑ Yes

LIVING ARRANGEMENTS

How many times have you moved in the last year? _____times. Do you feel that you live in a safe place? No ❑ Yes ❑

You (you child) live(s) with: ❑ Mother ❑ Mother/Father ❑ Mother/Partner ❑ Father/Partner ❑ Grandparent/Other

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

Do you (your child) 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.

Parent/Guardian signature _____ Date _____

Adolescent signature (if 13 years or older) _____ Date _____

Prescriber signature _____ Date Reviewed with Patient _____

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