VALLEY PSYCHIATRY & COUNSELING LLC
REGISTRATION FORM

Patient Name:_____

Home Phone #:_____ Cell Phone#:_____

Street Adress:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Soc. Security #:_____

Sex (M/F):_____Marital Status: (Single/Married/ Other)_____

Spouse/ Parent:_____

Employer:_____

Student: Yes/ No

Referred by:_____

INSURANCE INFORMATION

(Please remit insurance card to office staff for photo-copy)

Insurance Name:_____

Policy/ ID #:_____ Group #:_____

Ins. Address: _____

Is this Insurance through Employer: Yes/No

Insured Party Name (policy holder):_____Soc. Security #:_____

Date of Birth:_____Address:_____

Sex (M/F):_____ Relationship to patient:_____

Phone #:_____

Assignment of Benefits:

I authorize payment of insurance benefits to myself or to to the Physician/ Practice named in claims submitted and Authorize release of any medical information Necessary to process claims on my behalf.

X_____
Signed (Insured) Date

Primary Care Physician Authorization:

I authorize Release/ Disclose of any medical information to my Primary Care Physician in regards to my diagnosis, treatment and any tests that may be required by the performing Physician.

X_____
Signed Date

NOTE: **A CHARGE WILL BE MADE FOR ALL BROKEN APPOINTMENTS. PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.**

X_____
Signed Date

Intake Questionnaire

In order for us to provide accurate and essential care for you, please fill out the following questionnaire.

REQUIRED INFORMATION		
Pharmacy Name:	**Street:**	**City:**
Allergies:		
Smoking: please circle	Current - every day smoker Former smoker	Current - some days Never a smoker
E-mail		

PATIENT IDENTIFICATION

Name _____ First Appointment Date _____

Birth Date _____ Age _____ Sex _____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

_____

_____

_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

_____

MEDICAL HISTORY

Current medical problems/medications: _____

_____

Past medical problems/medications: _____

_____

Other doctors/clinics seen regularly: _____

Allergies/drug intolerances (describe): _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

_____

_____

SCHOOL HISTORY: Last grade completed _____ Last school attended _____

Any behavior problems in school? _____

EMPLOYMENT HISTORY: (summarize jobs you've had)

_____

_____

_____

Any work-related problems? _____

Any Legal Problems? _____

_____

ALCOHOL AND DRUG HISTORY: (Please list age started and types of substances used through the years and any current usage. These include alcohol, marijuana or hash, prescription tranquilizers or sleeping pills, inhalants, cocaine, amphetamines, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

_____

_____

_____

Ever experience withdrawal symptoms from alcohol or drugs? _____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever used drugs or alcohol first thing in the morning? _____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____
_____

FAMILY/SOCIAL HISTORY

Family Structure (who lives in your current household, please give relationship to each):

_____
_____
_____

Current Marital or Relational Satisfaction_____
_____
_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse etc.)_____
_____
_____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Mother's alcohol/drug use history _____
Have any of **mother's** blood relatives ever had any psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, and psychiatric hospitalizations? (specify)
_____
_____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Father's alcohol/drug use history _____
Have any of **father's** blood relatives ever had any psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, and psychiatric hospitalizations? (specify)
_____
_____

Name of person completing this questionnaire: _____
Relationship to Patient:

- o Self
- o Mother
- o Father
- o Spouse
- o Guardian
- o Other