Registration Sheet

Date:_____

Patient Name: _____
Last First M.I.

Date of Birth: _____-_____-_____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone :(____) _____-_____ can a message be left at this number? ___yes ___no

Work Phone :(____) _____-_____ can a message be left at this number? ___yes ___no

Ext.: _____

Mobile Phone :(____)_____-_____ can a message be left at this number? ___yes ___no

Pager :(____) _____-_____ E-mail Address_____

How do you prefer to be contacted? _____

Referred by:_____

<u>In Case of Emergency, Contact:</u>

Name:_____ Relationship:_____

Phone:_____

CHS Psychiatric Associates Medical History Self Report

Patient's Name: _____ **Date of Birth:** _____

Allergies to Food, Medication, Other:_____

Current Family Physician: _____**Date of Last Physical Exam:** _____

Are there currently or have there previously been problems with any of the following?

	Yes	No		Yes	No
Skin problems	☐	☐	Eating	☐	☐
Wounds not healing/easy bruising	☐	☐	Alcohol	☐	☐
Glaucoma/Vision	☐	☐	Street drugs	☐	☐
Hearing	☐	☐	High blood pressure	☐	☐
Headaches	☐	☐	Heart disease/Chest pain	☐	☐
Head injuries	☐	☐	Heartbeat irregularities	☐	☐
Black outs/Fainting	☐	☐	Rheumatic fever	☐	☐
Numbness/Tingling	☐	☐	Nausea/Vomiting	☐	☐
Thyroid problems	☐	☐	Ulcers	☐	☐
Blood sugar	☐	☐	Liver disease or jaundice	☐	☐
Sickle cell	☐	☐	Kidney/Bladder problems	☐	☐
HIV/AIDS	☐	☐	Pregnancy (If pregnant, due date _____)	☐	☐
Fatigue	☐	☐	Sexual function		
Anemia/Low blood count	☐	☐	Pain	☐	☐
Breathing/Shortness of breath	☐	☐	Daytime sleepiness	☐	☐
Fever	☐	☐	Sleeping too little	☐	☐
Cancer	☐	☐	Lead/Chemical exposure	☐	☐
Excessive movement during sleep	☐	☐	Seizures	☐	☐
Snoring	☐	☐	Change in Weight	☐	☐

Please describe:_____

_____

Have any family members had any of the following?

	Yes	No	Who
Depression	☐	☐	_____
Bipolar Disorder	☐	☐	_____
Suicide	☐	☐	_____
Schizophrenia	☐	☐	_____
Eating Disorder	☐	☐	_____
Anxiety Disorder	☐	☐	_____
Alcohol/Drug Problems	☐	☐	_____
ADHD	☐	☐	_____
Thyroid problems	☐	☐	_____
Asthma	☐	☐	_____
Diabetes	☐	☐	_____
Stroke	☐	☐	_____
Dementia/Senility	☐	☐	_____
Stomach Problems	☐	☐	_____
Seizures (what kind	☐	☐	_____
Heart Problems	☐	☐	_____
Cancer (what kind)	☐	☐	_____
High blood pressure	☐	☐	_____
Abnormal heart rhythm	☐	☐	_____
Sudden cardiac death	☐	☐	_____
Tics	☐	☐	_____

Have there been hospitalizations for any medical reasons such as illness, accidents, operations, or tests?

Reason for Hospitalization	Date	How Long?

Current Medications (including any over the counter or herbal preparations):

Name of Medication	Dosage	For what reason?	How Long?	Side effects (if any)

Other Psychiatric medications which have been taken in the past:

Name of Medication	Dosage	For what reason?	How Long?	Side effects (if any)

Psychiatric care in the past? (Such as psychiatrist, psychologist, social worker, nurse, counselor, or psychological testing)

For what reason?	When?	By Whom?	Type of Treatment	Were you hospitalized?

Currently using caffeine? ☐ **Yes** ☐ **No** **If yes, how much, how often** _____
Currently using cigarettes? ☐ **Yes** ☐ **No** **If yes, how much, how often** _____
Currently using alcohol? ☐ **Yes** ☐ **No** **If yes, how much, how often** _____

_____
Signature **Date**