BEHAVIORAL HEALTHCARE CONSULTANTS, LLC
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INTAKE/NEW PATIENT REGISTRATION FORM

Patient Demographics:

Last name:_____ First name: _____

Date of birth: ___/___/____ Marital status: _____ SS#_____

Street/Home address: _____

City: _____ State:_____ Zip code:_____

Home Phone:_____ (Okay to leave message? Y/N)

Cell:_____(Okay to leave message?Y/N)

Email: _____

Pharmacy name and telephone number: _____

Who referred you?_____Phone: _____

Employer/Occupation: _____

Emergency contact: Name: _____ Relationship:_____Phone: _____

HISTORY:

Reason for visit today: _____

ALLERGIES: **Reaction type:**

Medical History:

History of head injury/Stroke/Seizures/falls

Past history of surgeries:

Medication list:

Name	Dose	Date started and by whom	Date discontinued and why	Response

Any over the counter or herbal preparations being used:_____
_____
List names of other Physicians/Therapist treating you now/treated you in past:

Name: _____Number:_____Dates of treatment:_____
Name:_____Number:_____Dates of treatment:_____
Name:_____Number:_____Dates of treatment:_____

Females only: Are you pregnant, planning a pregnancy or nursing a child? Y/N (circle all that apply)

Do you smoke? Y/N How much? _____ Since how many years:_____

Do you drink alcohol? Y/N How much?_____ How often?_____ Since when?_____

Do you use any other drugs now or in the past? Y/N
Describe:_____

Family Psychiatric history:

Any family history of Depression/Bipolar disorder/Anxiety/Schizophrenia/Dementia/Alcohol abuse or drug abuse? Y/N

Describe:_____

Does anyone in your family take psychiatric medications (currently or in the past)?

Describe:_____