



INTEGRATED
MIND MEDICINE

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)	Social Security Number		
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone	Email Address		
Referred by		Primary Care Physician	Primary Care Physician Phone		
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone		
Employer/School Address	City	State	Zip	

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient
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Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number	
Insured's Address	City	State	Zip
Insured's Social Security Number	Insured's Birthdate		

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number	

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient
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Signature of Patient or Authorized Guardian

Date



INTEGRATED MIND MEDICINE

Name: _____ Age: _____ Sex: _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

Date symptoms started _____

Have you lost any days from work or school? Yes No

Medications

Have you ever taken the following medicines?

- SSRI (eg Prozac/fluoxetine, Paxil/paroxetine, Celexa/citalopram, Lexapro/escitalopram)
- Effexor/venlafaxine or Cymbalta/duloxetine
- Tricyclics (eg Elavil/amitriptyline, Pamelor/nortriptyline, Tofranil/imipramine, Anafranil/clomipramine)
- Wellbutrin/ bupropion
- Desyrel/trazodone, Serzone/nefazodone
- Mood stabilizers (eg Lithium, Tegretol/carbamazepine, Topamax/topiramate, Depakote/valproate, Lamictal/lamotrigine)
- Antipsychotic mood stabilizers (eg Seroquel/quetipine, Geodon/ziprasidone, Abilify/aripiprazole, Zyprexa/olanzapine, Haldol/haloperidol, Clozaril/clozapine, Prolixin/fluphenazine)
- Sleeping pills (eg Ambien/zolpidem, Desyrel/trazodone, Sonata/zaleplon, Restoril/temazepam)
- Anti-anxiety medicines (eg Ativan/lorazepam, Klonopin/clonazepam, Xanax/alprazolam, Valium/diazepam, Buspar/buspironone)
- ADHD medicines (eg Ritalin/Concerta/methylphenidate, Adderall/amphetamine, Strattera/atomoxetine)

List other medicines you are taking:

Past Psychiatric History

Check all that apply:

- ADHD
- Anxiety
- Bipolar
- Depression
- Eating Disorder
- Phobia(s)
- Obsessive Compulsive
- Pre-Menstrual Dysphoric Disorder/PMS
- Post Traumatic Stress
- Schizophrenia
- Schizoaffective Disorder
- Substance Abuse
- Suicide Attempt

Have you seen a psychiatrist, psychologist or therapist/counselor in the past?

Yes No When? _____

Allergies

Are you allergic to any of the following?

- ACE Inhibitors
- Adhesive Tape
- Anesthetics
- Aspirin
- Barbiturates (Sleeping Pills)
- Codeine
- Iodine (including contrast dye)
- Latex
- Penicillin
- NSAIDs (Ibuprofen, Naprosyn, Advil)
- Seizure Medicines
- Sulfa

Details/Reactions: _____

Lifestyle Factors

Has anyone in your home ever physically, emotionally or sexually abused you?

Yes No

Have you ever smoked?

Yes No # of years _____ # packs/day _____

Do you smoke now?

Yes No # packs/day _____

Do you use recreational drugs? (Including abuse of prescription drugs)

Yes No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Are you currently:

- Working Not Working by Choice Unemployed Disabled
- Retired Volunteering

Have you ever served in the military?

Yes No

How would you identify your sexual orientation?

- Straight/Heterosexual Lesbian/Gay/Homosexual Bisexual Asexual
- Transsexual Other Unsure/Questioning Prefer Not to Answer

Have you ever been arrested?

Yes No

Do you have any pending legal problems?

Yes No

Do you belong to a particular religion or spiritual group?

Yes No Please list: _____

Highest Educational Level Attained:

- Grade School High School Junior College
- Undergraduate College/University Graduate School

Name: _____ Age: _____ Sex: _____ Date of Appointment: _____

Past Medical History

Have you ever had any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |

Hospitalizations & Surgeries

Reason: _____ Date: _____

Have you ever had an EKG?

Yes No If yes, when? _____

Was the EKG: Normal Abnormal Not Sure

Women Only

Are you currently pregnant or think you may be pregnant?

Yes No

Are you planning to get pregnant in the near future?

Yes No

Birth Control Method:

- Condoms Pill Shot Patch Ring Under Skin
 IUD Tubal Ligation Vasectomy in Partner Not Applicable

Family History

Has anyone in your family (mother, father, siblings, grandparents) had a history of the following:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Post Traumatic Stress |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Suicide Attempts or Thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Obsessive Compulsive Disorder | |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Phobias | |

Review of Systems

Psychological

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anxiety Attacks | <input type="checkbox"/> Excessive Guilt | <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Avoidance/Avoidant Personality Disorder | <input type="checkbox"/> Excessive Worry | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Increased Irritability | <input type="checkbox"/> Thoughts of harming or killing someone |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Trouble concentrating |
| <input type="checkbox"/> Decrease Need For Sleep | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Increase in Risky Behavior | <input type="checkbox"/> Unable to enjoy activities |
| <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Loss of Interest in Most Things | |

General

- Chills
 Fever
 Night Sweats
 Weight Gain
 Weight Loss

Gastrointestinal

- Abdominal Cramping/Pain
 Acid Taste
 Bloating
 Diarrhea
 Frequent Belching
 Indigestion
 Nausea

Neurology

- Burning Pain
 Headache
 Seizures
 Tingling
 Tremor
 Visual Changes

Ear, Nose & Throat

- Hearing Problem
 Hoarseness
 Ringing in Ears

Cardiovascular

- Chest Pain
 Leg Swelling
 Lightheadedness
 Palpitations

Musculoskeletal

- Joint Pain
 Muscle Pain
 Weakness

Respiratory

- Chest Tightness
 Coughing
 Shortness of Breath
 Wheezing

Other: _____