Patient Registration Form

(Please Print)

Patient Demographics:

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Birth Date: _____ SSN: _____

Sex assigned at Birth: Male Female Gender Identity: _____

Address: _____

City/State/Zip: _____ County: _____

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

Email: _____

Birth Place: _____ United States Citizen: Yes No

Marital Status: Single Married Divorced Legally Separated Widowed Other

Patient Language: English Spanish Other_____ Interpreter Needed: Yes No

Ethnic Group: Hispanic or Latino Not Hispanic or Latino Decline

Race: American Indian or Alaska Native Black or African American White or Caucasian

Asian Native Hawaiian or Other Pacific Islander Other Decline

Religion: _____ Place of Worship: _____

Education: _____

Patient Primary Care Physician Information:

Primary Care Physician: _____ Phone: _____

Practice Location/Address: _____

Patient Employment Information:

Employment Status: Full Time Part Time Self-Employed Full Time/Student Part Time/Student
Military Duty Not Employed Disabled Retired

Employer: _____

Initial Health History Packet

Saint Luke's Behavioral Health Division

GENERAL INFORMATION

Name: _____ DOB: _____

Education level: _____

Reason for visit: _____

Referring doctor: _____

PSYCHIATRIC & MEDICAL HISTORY

Please check any current or past diagnoses given by a clinician:

ADHD/ADD		HIV/AIDS	
Alcoholism		Liver disease	
Anorexia nervosa		Neuropathy	
Anxiety		OCD	
Autism spectrum disorder		ODD (Oppositional defiance disorder)	
Bipolar disorder		Panic disorder	
Borderline personality disorder		Psychosis	
Bulimia nervosa		PTSD	
Cancer		Schizoaffective disorder	
Chronic pain		Seizures	
Depression		Substance abuse	
Head injury		Thyroid disease	
Other, please specify:			

Please list any past or current psychiatrist/s, psychologist/s or mental health provider/s (name/address/phone number):

_____

_____

_____

Please list any other doctor/s or specialist/s you see regularly (name, address, phone number):

_____

_____

Please list any family members that been diagnosed with any mental illness, substance abuse disorder, dementia or neurologic disorder. Please specify if family member is maternal or paternal if applicable.

_____

_____

Please check any psychiatric medications you have taken in the past. If checked, please indicate years taken and effect.

Medication		Years Taken	Effect
Antidepressants			
Anafranil (Clomipramine)			
Torfranil (Imipramine)			
Desyrel (Trazodone)			
Amytriptyline (Elavil)			
Nortriptyline (Pamelor)			
Norpramin (Desipramine)			
Doxepin			
Celexa (Citalopram)			
Lexapro (Escitalopram)			
Zoloft (Sertraline)			
Paxil (Paroxetine)			
Prozac (Fluoxetine)			
Luvox (Fluvoxamine)			
Viibryd (Vilazodone)			
Nefazodone			
Effexor (Venlafaxine)			
Pristiq (Desvenlefaxine)			
Savella (Milnacipran			
Cymbalta (Duloxetine)			
Wellbutrin/Zyban (Buproprion)			
Remeron (Mirtazepine)			
Marplan (Isocarboxazid)			

Nardil (Phenelzine)			
Parnate (Tranylcypromine)			
Em Sam (Selegiline)			
Anti-Anxiety			
Buspar (Buspirone)			
Neurontin (Gabapentin)			
Atarax/Vistaril (hydroxyzine)			
Ativan (Lorazepam)			
Xanax (Alprazolam)			
Klonopin (clonazepam)			
Valium (Diazepam)			
Librium (Chlordiazepoxide)			
Pindolol			
Inderal (Propranolol)			
Tenex/Intuniv (Guanfacine)			
Clonidine/Kapvay,(Catapress)			
Antipsychotics			
Abilify (Aripprazole)			
Saphris (Asenapine)			
Clozaril (Clozapine)			
Fanapt (Iloperidone)			
Latuda (Lurasidone)			
ZYprexa (Olanzapine)			
Invega (Paliperidone)			
Seroquel (Quetiapine)			
Risperdal (Risperidone)			
Chlorpromazine (Thorazine)			
Haldol (Haloperidone)			
Loxapine (Loxitane)			
Thioridizine (Mellaril)			
Mood Stabalizers			
Lithium (Eskalith)			
Depakote (Valproic Acid)			
Tegretol (Carbamazepine)			
Trileptal (Oxcarbazepine)			
Lamictal (Lamotrigine)			
Topamax (Topirimate)			
Neurontin (Gapapentin)			
Dilantin (Phenytoin)			

Stimulants/ ADHD Meds			
Provigil			
Nuvigil			
Adderall (Amphetamine)			
Vyvanse			
Ritalin			
Concerta/Metadate			
Sleep Medications			
Ambien (Zolpidem)			
Lunesta (Eszopiclone)			
Pro-Som (Estazolam)			
Resotril (Temazepam)			
Sonata (Zaleplon)			
Trazodone (Desyrel)			
Rozerem (ramelteon)			
Over the counter or herbal supplements:			
Tylenol PM			
Melatonin			
Fish oil/Oemga-3 fatty acids			
St. John's Wort			
SamE			
5HTP			
Other			
Dementia/Cognitive			
Aricept (Donezpril)			
Excelon			
Namenda (Memantine)			

SOCIAL HISTORY

Tobacco use history

Smoke tobacco (Check one):

Current every day smoker		Never smoker	
Current some days smoker		Passive smoke exposure-never smoker	
Former smoker			

If current or past smoker:

Start date: _____ Quit Date:_____

Type:_____ Packs/day:_____ **Smokeless tobacco (Check one):**

Never used		Current user		Former user Quit Date:	

Alcohol use history

Alcohol use (Circle one):

Yes	No

If yes, please indicate amount:

Drinks	Number Per Week
Glasses of wine	
Cans/bottles of beer	
Shots of liquor	
Standard drinks	

Substance use history

Drug use (Circle one):

Yes	No

If yes, indicate types:

_____

If yes, indicate use per week: _____

Sexual history

Sexually active (Circle one):

Yes	No	Not currently

If yes, indicate birth control/protection:_____

If yes, circle partner/s:

Female	Male

Sexual Orientation-Gender Identity

Would you like to identify your sexual orientation? (Circle one):

Yes	No

If yes, please circle one:

Lesbian	Gay
Heterosexual	Bisexual
Other	

Gender identity (Circle one):

Male	Female
Genderqueer	Additional category (specify)

Gender assigned at birth (Circle one):

Male	Female
Intersex	Additional category (specify)

Preferred pronoun (Check one):

He, Him, His	
She, Her, Hers	
They, Them, Theirs	
The Patient	

OTHER CONCERNS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

To be filled out by patient ONLY

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

To be filled out by patient ONLY

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____