CONFIDENTIAL HISTORY / PRE-REGISTRATION

Date:	-		
Patient Information			
Last	First	MI	DOB
Sex: M F Marital Status		SSN	TDL
Address			Zip
Home Phone #	V	Work #	
Employer	Referred by		
IF THE PATIENT IS A MINOR PLE	ASE COMPLETE T	HE FOLLOWING:	
Mother's Last	First	MI	DOB
Father's Last	First	MI	DOB
Who Does Child Live With?	Are parents	: Living together	Not living together
Legal Guardian:		Please prov	ide copy of court order.
Patient History			
Have you had previous psychiatric treatr	nent?Yes	s No	
Name and Phone # of previous practit	ioner:		
Date last Seen: *(If yes please complete a Authorizat)	May we cont	tact your last practitioner [edical Records so we mage	Yes No ay obtain records)
Are you currently under the care of a P	rimary Care Physicia	an?Yes _	No
Name and phone # of Physician:			
Hospitalizations: (Women do not need	to add normal pregna	ancies or child birth)	
If you have had any hospitalization: P	lease list them here:		
Reason for yourvisit here today:			