



Newport Center For
Behavioral Medicine

PATIENT REGISTRATION FORM
(Please Print Legibly)

Date: _____

Patient Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

Soc Sec: _____ Email: _____ CDL: _____

Sex: []Female []Male []Married []Single []Divorced []Widowed

* Employer: _____ Position: _____

* Parent/guardian, if patient is a minor

Work Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Work Email: _____

Emergency Contact: _____ Relationship: _____ Phone: () _____

Primary Care Physician: _____ Cell Phone: () _____

Who may we thank for referring you to our office? _____

Current Problems

Please provide a brief description of the major concerns that led you to seek treatment.

Previous Psychiatrist/Therapist

Name of the clinician:	Phone Number/Address	Treatment Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been hospitalized for psychiatric or substance abuse problems? No ____ Yes ____

Facility: _____ Dates: _____ Reason: _____

Facility: _____ Dates: _____ Reason: _____

Do you have any history of suicide attempts or assault? No ____ If yes, please describe:

Medications

Please list all current drugs/medications, including over-the-counter:

Name of medication:	Dose	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any previous psychiatric drugs/medications:

Name of medication:	Dose	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physical Health Status

Do you have any diagnosed medical conditions?

Medications taken for medical conditions:

Do you smoke? No ____ Yes, (#) ____ per day

Do you drink alcohol? No ____ Yes, (# drinks) ____ per week

Do you engage in any substance/drug use? No ____ If yes, please explain:

Do you exercise? Regularly ____ Occasionally ____ Rarely ____ Never ____

How is your diet? Very healthy ____ Questionably healthy ____ Not very healthy ____ Changes ____

How is your general health? Excellent ____ Good ____ Fair ____ Poor ____

Family History of Psychiatric Disorders

Have any family members had any psychiatric conditions? How were they treated?

(Please include parents, brothers, sisters, grandparents, aunts, uncles, children, and cousins)

Social/Occupational/Family Functioning

What is your social network?

No close friends ____ One close friend ____ Few friends ____ Many friends ____

How often do you make contact with friends?

Regularly ____ Occasionally ____ Infrequently ____ Never ____

Are you currently in a romantic relationship?

No ____ Yes, it is... Generally positive ____ Neutral ____ Problematic ____

What is your living situation?

Live alone ____ Live with others, with whom? _____

How do you feel about (select one) work/school?

Pleased ____ Mostly satisfied ____ Mixed ____ Mostly dissatisfied ____ Unhappy ____

Any major dissatisfaction with: Work ____ School ____ Other _____

If so, please explain _____

Please describe any hobbies or recreational activities: _____
