Waypoints Psychological services LLC

Navigating & charting life changes

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PATIENT REGISTRATION INFORMATION

Full Name: ______________________________ ___________________ ____________ **DOB** __________

Street Address ___________________________________ Apt/Unit # ______________

City/Town: _______________________________________ State: ___________ Zip Code _______________

Best # to reach you: _________________________ W H C Alternative #: ____________________ W H C

Religion: ___________________ Race: ____________________ Ethnicity: ___________________________

Marital Status: (circle one) Married Separated Divorced Widowed Single Have Significant Other

Employer: _______________________________________ Occupation:______________________________

Primary Care Physician ______________________________ Phone #: ______________________________

Street ______________________________ City/Town: _________________ State: ____ Zip Code: _______

1. Emergency Contact: Name: ____________________________________ Relationship: ______________

Street: ______________________________ City/Town: _________________ State: ____ Zip Code: ______

Phone #1: ____________________________ W H C **Phone #2**: ______________________________ W H C

2. Emergency Contact: Name: ____________________________________ Relationship: ______________

Street: ______________________________ City/Town: _________________ State: ____ Zip Code: ______

Phone #1: ____________________________ W H C **Phone #2:** ______________________________ W H C

Insurance Information:

Type of Insurance: _______________________________ Policy #: __________________________________

Subscriber: __________________________________ Relationship to You: __________________________

Subscriber's Employer: ____

Brief Overview:

Briefly describe the reason(s) for seeking services: ____

____

How long has this been going on? ____

Referred to practice by: ____

Have you ever had previous counseling or psychotherapy? Yes No

If "yes" by whom and when? ____

Reason for treatment? ____

Are you currently taking any psychotropic medications (eg., antidepressants, anti-anxiety, etc.)?

Yes No If "yes", list medications and current dosages(s): ____________________________________

____

Name of prescriber: _________________________________ phone#: ___________________________

Have you ever been psychiatrically hospitalized? Yes No If yes, when, where and for what? ______

____

Have you ever made a suicide attempt or had suicidal thoughts? Yes No If yes, please explain: ____

____

Please use the scale below to indicate your current level of distress with the following items:

	No Concern	Some	Moderate	Urgent
Feelings over a recent loss/death	_______	______	_______	_______
Relationship with family/friends	_______	______	_______	_______
Relationship with primary partner	_______	______	_______	_______
Sexual concerns	_______	______	_______	_______
Sexual orientation	_______	______	_______	_______
Survivor of abuse and/or trauma	_______	______	_______	_______
Racial/ethnic issues	_______	______	_______	_______
Low self-esteem	_______	______	_______	_______
Loneliness/isolation	_______	______	_______	_______
Depression/low mood	_______	______	_______	_______
Anxiety	_______	______	_______	_______
Fears/worries	_______	______	_______	_______
Sleep problems	_______	______	_______	_______
Eating problems	_______	______	_______	_______
Body image concerns	_______	______	_______	_______
Problems with alcohol/drugs	_______	______	_______	_______
Losing contact with reality	_______	______	_______	_______
Suicidal thoughts/attempts	_______	______	_______	_______
Homicidal thoughts/ attempts	_______	______	_______	_______

******** ***FOR OFFICE USE ONLY*** *********

Diagnosis: ______________________________________ *Date and Time of Initial Visit:* _______________