890 South Palafox Street, Suite 300 ● Pensacola, FL 32502 ● (850) 433-1656 Voice ● (850) 433-1996 Fax
7552 Navarre Parkway, Suite 43 ● Navarre, FL 32566 ● (850) 684-3884 Voice ● (850) 433-1996 Fax

New Patient Registration Form

Patient Information

Last Name	**Middle Initial**	**First Name**
Birth Date	**SSN**	**Email**
Address		**Apt #**
City	**State**	**Zip**
Preferred Contact Number	**Alternate Contact Number**	

Gender M F | **Marital Status** Single Married Divorced Widowed Life Partner Other: _______________

Race/Ethnicity Caucasian African American Hispanic American Indian Asian Other: ___________________

Emergency Contact Name	**Emergency Contact Number**

Are you on or applying for any type of disability or worker's compensation? If yes, explain:

Have you ever been convicted of a crime or involved in any legal proceedings? If yes, explain:

If patient is under 18, please complete the responsible party's information below

(Also complete this section if the patient has a Legal Guardian)

Last Name	**First Name**	
Birth Date	**Phone**	**Alt. Phone**
Address *(if different from above)*		**Apt #**
City	**State**	**Zip**

Current Medications

List ALL the medications currently prescribed to you by any doctor. Please include any vitamins and/or herbal supplements.

Medication Name *Example: Pristiq*	Strength *Example: 20 mg*	Times Taken Per Day *Example: 2 times daily*

Account # ______________________

Current Medications *(continued)*		

Past Psychiatric Medications

Please list all past psychiatric medications taken, dosage, length of time you took the medication and why you stopped taking it.

Medication Name *Example: Pristiq*	**Dosage** *Example: 20 mg*	**Length of Time Taken** *Example: 3 months*	**Why You Stopped Taking the Medication** *Example: It made me too drowsy*

Allergies

Please list any medication allergies below or check the space below if you have no known allergies.

______ I have no known drug allergies.

Medication	Reaction

Account # ________________________

Medical History

Please circle any condition below that applies to your personal medical history and briefly explain in space provided.

Diabetes	**Hypertension**	**High Cholesterol**
Migraines	**Chronic Pain**	**Gastro Esophageal Reflux**
Fibromyalgia	**IBS**	**Thyroid Disease (Hyper/Hypo)**
Heart Disease	**Head Injury**	**Cancer**
Seizures	**Sleep Apnea**	**Stroke**
Anxiety	**Depression**	**ADHD**
Alzheimer's	**Parkinson's**	**Alcoholism/Drug Abuse**
Other:	**Other:**	**Other:**

Have you had any recent changes in any of the following areas?

Weight	**Energy Level**	**Ability to Sleep**

Please list all of your prescribing physicians and their specialty: ____

____

Please list your most recent blood work tests and results: ____

____

Please list the date of any Psychiatric Inpatient Hospitalizations, name of the hospital, and reason for admission below.

Please list the problems or concerns you'd like to discuss with your doctor below.

Account # ______________________

Family History

Place a check to indicate any family members that have or have had any conditions below:	Father	Mother	Sons	Daughters	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
Diabetes												
High Blood Pressure												
Heart Disease												
Stroke												
Thyroid Disease												
Inherited/Genetic Disease (i.e. Alzheimer's, Parkison's, etc.)												
Seizures												
Kidney Disease												
Cancer												
Alcoholism/Drug Abuse												
Psychiatric Disorders												
Other:												
Other:												
Other:												
Please complete the information below for each family member notated above.												
Living or Deceased (L/D)												
If deceased, age at death												

Please provide any additional details: ____

____

____

Account # ________________________

Social History

Current Employment	Highest Level of Education Completed
If any, please describe your military background.	
Living Situation With Spouse/Partner With Parent(s) With Children Other: ______________________	
Exercise Habits (Describe the type and amount of exercise you do regularly and how often.)	
Caffeine Intake (Indicate the number of cups of each caffeine drink below you consume each week or indicate if not applicable.) Coffee: __________ Tea: __________ Cola: __________ Energy Drinks: __________ Other: __________	
Are you currently sexually active?	**If yes, are you trying for pregnancy?**
Do you use alcohol?	**If yes, please indicate type and amount consumed per week.**
Do you use tobacco?	**If yes, please indicate type and amount used per week.**
Do you, or have you ever taken drugs, legal or illegal, other than over-the-counter medications that were not prescribed for you? **If yes, please describe.**	

Please use this space to provide any additional information for your provider to review regarding your medications, medical history, or concerns you'd like to address.