New Patient Registration

Date:_____ Patient ID:_____

Please print legibly

Preferred Name:	Date of Birth (DOB):
Full Legal Name (First MI Last):	
Address:	

City:	State:	Zip Code:

Mobile Phone:	Home Phone:	Email Address:

Social Security Number:	

Demographics

Marital Status (Choose One):						Gender on Birth Certificate:		
Single ☐	Cohabiting ☐	Married ☐	Separated ☐	Divorce ☐	Widowed ☐	Female ☐	Male ☐	

Ethnic Origin:						
African American ☐	Asian American ☐	Caucasian (White) ☐	Hispanic or Latino ☐	Native American ☐	Pacific Islander ☐	Other

Student Status:			
Full Time ☐	Part Time ☐	N/A ☐	Name of School

Employment Status:			
Full Time ☐	Part Time ☐	N/A ☐	Name of Employer
Work Phone:			

Who do you have in your Support System?
Who referred you or how did you hear about us?

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Primary Care Physician Name:		Work Phone:
Physician Address:	City:	
Psychiatrist Name:		Work Phone:

Do you want us to coordinate with your medical doctors listed above?	Yes	No
Primary Care Physician	☐	☐
Psychiatrist	☐	☐

Emergency Contact Information

Emergency Contact Name:		Relationship:
Address:		City:
Mobile Phone:	Home Phone:	Email Address:

Financial Responsible Person

Responsible Person's Legal Name:		Relationship:	
Address:		City:	Zip:
Mobile Phone:	Home Phone:	Email Address:	

For Patients 18 years of age and in high school OR younger than 18 years of age list Parent/Guardian/Designated Representative(s):

Name:	Mobile Phone:	DOB:	Relationship:
Name:	Mobile Phone:	DOB:	Relationship:
Name:	Mobile Phone:	DOB:	Relationship:

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Please provide receptionists with your insurance card(s) so we can copy them for our records.

Primary Insurance Information

Insurance Company:		
Policy Number:	Group Number:	
Subscriber Name:	DOB:	Relationship to Patient:

Secondary Insurance Information (Leave blank if not applicable)

Insurance Company:		
Policy Number:	Group Number:	
Subscriber Name:	DOB:	Relationship to Patient:

Tertiary Insurance Information (Leave blank if not applicable)

Insurance Company:		
Policy Number:	Group Number:	
Subscriber Name:	DOB:	Relationship to Patient:

Disclaimer: Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 60-days for payment. Please remember you are ultimately financially responsible for payment. On day 60, if the bill has not been paid by your insurance carrier, we will charge the responsible party the billed amount. A refund for any payments made on these claims by your insurance carrier after 60-days will be refunded to the responsible party within 30-days.

The Caring Center of Wichita, LLC

MH Concerns Checklist

Name:	Date:

Check any of the following terms that apply to you.

- ☐ Depressed mood
- ☐ Lost interest
- ☐ Lack of energy or fatigue
- ☐ Weight gain or loss
- ☐ Unable to concentrate
- ☐ Excessive sleeping
- ☐ Difficulty sleeping
- ☐ Decreased need for sleep
- ☐ Pressure to keep talking
- ☐ Racing Thoughts
- ☐ Excessive risk-taking behavior
- ☐ Panic attacks
- ☐ Excessive fear of situation or objects
- ☐ Repetitive behaviors to reduce stress
- ☐ Witness/experience events threatening life or serious injury
- ☐ Excessive anxiety or worry
- ☐ Hear/see things others do not
- ☐ Memory problems or Memory loss
- ☐ Suicidal thoughts
- ☐ Significant ongoing physical pain
- ☐ Stomach problems
- ☐ Headaches
- ☐ Bowel problems
- ☐ Balance problems
- ☐ Seizure problems
- ☐ Learning/academic problems
- ☐ Stuttering problems
- ☐ Frequent problems with attention
- ☐ Frequent “on the go” behavior
- ☐ Temper
- ☐ Aggressive behavior towards others
- ☐ Destructive behaviors
- ☐ Frequent lying/deceitfulness
- ☐ Problems following rules
- ☐ Sexual problems
- ☐ Eating problems
- ☐ Nightmares
- ☐ Gambling problems
- ☐ Alcohol usage
- ☐ Drug usage
- ☐ Marital problems
- ☐ Divorce
- ☐ Separation
- ☐ Affair
- ☐ Problems with ex or spouse
- ☐ Relationship problems
- ☐ Parenting problems
- ☐ Problems with friends
- ☐ Problems with children
- ☐ Legal problems
- ☐ Work/job problems
- ☐ Financial problems
- ☐ School problems
- ☐ Shyness
- ☐ Anger
- ☐ Loneliness
- ☐ Insecurity
- ☐ Isolation

Any other concerns or Issues? (If there are no other concerns, please Indicate by "none")

Please look back over the concerns you have checked off and chose the ones that you most want help with.

This is a strictly confidential Patient Treatment Record. Disclosure or transfer is expressly prohibited by law.

The Caring Center of Wichita, LLC

Mental Health History

Name:	Date:

Have you ever been in counseling/therapy before? ☐ Yes ☐ No

If yes, did you find it helpful ☐ Yes ☐ No

Are you currently receiving mental health services? ☐ Yes ☐ No

If yes, please provide the following:

Practitioner	Type of Service

Have you ever been hospitalized for mental health concerns? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever been diagnosed with a mental illness? ☐ Yes ☐ No

If yes, Diagnosis_____ Date Diagnosed: _____

Has anyone in your family ever been diagnosed with a mental illness? ☐ Yes ☐ No

If yes, Relationship _____ Date Diagnosed: _____

Have you ever or are you currently engaging in self harm? ☐ Currently ☐ Past

Have you ever or are you currently contemplating suicide? ☐ Currently ☐ Past

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, please provide the following:

Date (MM/DD/YYYY)	Method	Age

Has anyone in your family ever attempted suicide? ☐ Yes ☐ No Relationship: _____

Has anyone in your family completed suicide? ☐ Yes ☐ No Relationship: _____

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Mental Health History

Substance Use History

Please indicate substances currently used over the past 6-months, how much you use at one time, how many times per day/week you use, age of first use, past usage, and length of time used.

Substance	Current	Amount	Frequency	Age	Past	Length
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						
Other:						

Have you ever believed your substance use was a problem for you? ☐ Yes ☐ No

Has anyone ever told you that they believed your substance use was a problem? ☐ Yes ☐ No

Have you ever had withdrawal symptoms when trying to stop using any substance? ☐ Yes ☐ No

Have you ever had problems with work, relationships, the law, etc. due to substance use? ☐Yes☐No

If yes, please explain: _____

_____

Have you ever participated in drug and alcohol treatment? ☐ Yes ☐ No

If yes, please provide the following:

Type of Treatment	From (MM/YYYY)	From (MM/YYYY)	Age

Do you currently or have you ever attended alcoholics or Narcotics Anonymous? ☐ Yes ☐ No

The Caring Center of Wichita, LLC
Mental Health History

Legal Information

Have you ever been arrested? ☐ Yes ☐ No

If yes, please provide the following:

Date (MM/DD/YYYY)	Reason	Age

Are you currently on parole or probation? ☐ Yes ☐ No

Have you ever been the victim of a crime? ☐ Yes ☐ No

If yes, please list date and briefly describe: _____

_____

_____

Are you currently involved in divorce or child custody proceedings? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Have you ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____