Journey to Recovery

Patient Registration Sheet

DEMOGRAPHIC INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Gender: _____

Primary Phone: _____ Alt Phone: _____

Marital Status: _____ SS#: _____ Drivers Lic: _____

Race: ____ White ____African-American ____ Hispanic ____ Asian Other: _____

Education Level: _____ non HS _____ HS/GED _____ Some college _____ College _____Graduate school

Employer: _____ May you be called there? _____

Emergency Contact: _____ Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

INSURANCE INFORMATION

Insurance Name: _____

Insurance ID: _____ Group Number: _____

DOB (if different from Patient): _____ Gender: _____ SSN: _____

Relationship to Patient: _____ Employer: _____

IF YOU HAVE SECONDARY INSURANCE PLEASE FAX THAT INFORMATION

AUTHORIZATION FOR TREATMENT

I voluntarily authorize treatment involving routine diagnostic procedures and medical/psychotherapeutic treatment considered appropriate by the patient's physician, nurse practitioner and/or therapist. I am aware that treatment often involves family therapy or education. I understand the physician, nurse practitioner and/or therapist will obtain my informed consent prior to treatment that are considered to include significant risks. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to med concerning the results of my treatments or examinations to be rendered.

Patient Signature: _____ Date: _____

Patient Name: _____

Acknowledgement of Review of Notice of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information (PHI) under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have been provided an opportunity to read and review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Authorization to Release Information

I hereby authorize Journey to Recovery and staff associated with the practice to release any information acquired in the course of my care to the insurance company that I am covered under and to any physicians and clinicians to whom in the course of treatment, I may agree to see at my physician or nurse practitioner's request. This authorization shall be in effect continuously from this date unless revoked in writing by me.

Authorization to pay benefits to Journey to Recovery

I hereby authorize and assign any payment directly to Journey to Recovery and any affiliated providers for any services rendered by these providers for my care. I understand that I am financially responsible for any unpaid balance not covered by this assignment of benefits. This authorization shall be in effect continuously from this date unless revoked in writing by me.

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

- ☐ Patient Refused to Sign
- ☐ Communication Barriers
- ☐ Emergency Situation
- ☐ Other: _____

PRESENTING PROBLEMS:

SYMPTOMS CHECKLIST

☐ Aggression	☐ Eating disorders	☐ Irritability	☐ Stress
☐ Alcohol abuse	☐ Elevated mood	☐ Loneliness	☐ Suicidal thoughts
☐ Anxiety	☐ Fatigue	☐ Memory problems	☐ Trembling
☐ Avoidance of people	☐ Fears	☐ Mood swings	☐ Weight Gain/Loss
☐ Chest pain	☐ Gambling	☐ Muscle tension	☐ Withdrawal
☐ Computer addiction	☐ Hallucinations	☐ Panic attacks	☐ Worrying
☐ Depression	☐ Headaches	☐ Racing thoughts	☐ Other Symptoms
☐ Difficulty thinking	☐ helplessness	☐ Restlessness/ On edge	☐ _____
☐ Difficulty concentrating	☐ Hopelessness	☐ Sexual addiction	☐ _____
☐ Dizziness	☐ Impulsivity	☐ Sexual difficulties	☐ _____
☐ Drug Abuse	☐ Indecisiveness	☐ Sleeping problems	☐ _____

CURRENT STRESSORS

☐ Marital conflict	☐ Poor peer relations	☐ Legal problems	☐ Victim of Abuse:	☐
☐ Separation/divorce	☐ Problems at work	☐ Health problems	☐ Physical	☐
☐ Conflict with:	☐ Job loss/change	☐ Recent Death	☐ Emotional	☐
☐ Children	☐ Problems at school	☐ Substance Abuse	☐ Sexual	☐
☐ Parents	☐ Recent move	☐ Housing Problem	☐	☐
☐ Siblings	☐ Financial problems	☐ Other: _____		

	CURRENT USE		PAST USE				
SUBSTANCE	YES	NO	YES	NO	AMOUNT	FREQUENCY	DATE LAST USED
Tobacco							
Caffeine							
Alcohol							
Marijuana							
Cocaine/Crack							
Amphetamines							
LSD							
?							
IV Drugs							

MEDICAL HISTORY

Name of Primary Care Physician: _____ Phone: _____

Last Visit _____

Do you have or ever had any of the following medical problems:

☐ Head injury	☐ Seizures	☐ Thyroid Problems	☐ Hypertension
☐ Heart disease	☐ Lung disease	☐ Liver disease	☐ Kidney disease
☐ Hepatitis	☐ TB	☐ Cancer	☐ Sexually transmitted disease
☐ HIV	☐ Diabetes	☐ Chronic Pain	☐ Memory problems
☐ Asthma	☐ Meningitis	☐ Loss of Consciousness	☐ Headaches
☐ Arthritis	☐ Hypoglycemia	☐ High fevers	

Please list any medications you are currently on: _____

_____

Any known drug allergies _____

_____

Do you have any type of belief system (moral, spiritual, etc.) that influences you? _____

_____