mindful URGENT CARE
Mental Health | Addiction

PATIENT REGISTRATION

APPOINTMENT DATE: _____

Patient Information

PATIENT NAME (AS IT APPEARS ON INSURANCE CARD) | PREFFERED NAME

GENDER ☐ M ☐ F Self-describe | DOB | PREFERRED PHONE | EMAIL

ADDRESS (RELATED TO INSURANCE CARD) | CITY | STATE | ZIP CODE

REFERRED BY | PRIMARY CARE PHYSICIAN | PRIMARY CARE PHYSICIAN PHONE

PHARMACY | PHARMACY PHONE | PHARMACY ADDRESS

EMERGENCY CONTACT

NAME | PHONE | RELATION TO PATIENT

Billing and Insurance

SKIP THIS SECTION IF WE HAVE YOUR INSURANCE CARD OR IF YOU UPLOADED TO ZOCDOC

INSURANCE COMPANY | PLAN NAME

PLAN NUMBER | GROUP NUMBER

Reason For Visit

WHAT BRINGS YOU TO THE OFFICE TODAY?

DATE SYMPTOMS STARTED | HAVE YOU LOST ANY DAYS FROM WORK OR SCHOOL? ☐ YES ☐ NO

HAVE YOU SEEN A PSYCHIATRIST, PSYCHOLOGIST OR THERAPIST/COUNSLER IN PAST? ☐ YES ☐ NO WHEN?

Past Psychiatric History

CHECK ALL THAT APPLY

- ☐ ADHD
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Eating Disorder
- ☐ Phobia(s)
- ☐ Obsessive Compulsive
- ☐ Pre-Menstrual Dysphoric Disorder / PMS
- ☐ Post Traumatic Stress
- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Substance Abuse
- ☐ Suicide Attempt
- ☐ Panic Disorder

Coordination of Care

DO YOU WANT US TO COMMINUCATE WITH

- ☐ Therapist
- ☐ Parent
- ☐ Family Member
- ☐ Doctor
- ☐ Spouse/Partner

Provide Contact Information

Lifestyle Factors

Abuse (sexual, physical, verbal) ☐ YES ☐ NO

Do you currently use nicotine? ☐ YES ☐ NO

Do you currently use cannibus? ☐ YES ☐ NO

Do you use any otherdrugs? (such as cocaine, heroine, abuse of prescription drugs, etc.) ☐ YES ☐ NO

TYPES | FREQUENCY

How much alcohol do you drink per week?

ARE YOU CURRENTLY: ☐ Working ☐ Not Working by Choice ☐ Unemployed ☐ Disabled ☐ Retired ☐ Volunteering

Women Only

Are you pregnant or think you may be pregnant? ☐ YES ☐ NO

Are you planning on becoming pregnant in the near future? ☐ YES ☐ NO

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Medications

DO YOU HAVE ANY DRUG ALLERGIES? ☐ YES ☐ NO

ARE YOU CURRENTLY TAKING

- ☐ **SSRI** (eg Prozac/fluoxetine, Paxil/paroxetine, Celexa/citalopram, Lexapro/escitalopram, Zoloft/sertraline)
- ☐ **SNRI** (eg Effexor/venlafaxine, Cymbalta/duloxetine, Pristiq)
- ☐ **Tricyclics/TCA** (eg Elavil/Amitriptyline, Pamelor/Nortriptyline, Tofranil/imipramine, Anafranil/clomipramine)
- ☐ **Other Antidepressants** (eg Wellbutrin/ buproprion, Desyrel/ trazodone, Serzone/nefazodone, Trintellix/vortioxetine)
- ☐ **Mood stabilizers** (eg Lithium, Tegretol/carbamazepine, Topamax/toprimate, Depakote/valproate, Lamictal/lamotrogine)
- ☐ **Antipsychotic mood stabilizers** (eg Seroquel/Quetiapine, Geodon/ziprasidone, Abilify/aripiprazole, Zyprexa/ olanzapine, Haldol/haloperidol, Clozaril/clozapine, Prolixin/ fluphenazine, Risperdal/risperidone)
- ☐ **Sleeping pills** (eg Ambien/zolpidem, Desyrel/trazodone, Sonata/zaleplon, Restoril/temazepam)
- ☐ **Anti-anxiety medicines** (eg Ativan/Lorazepam, Klonopin/ clonazepam, Xanax/alprazolam, Valium/diazepam, Buspar/ buspirone)
- ☐ **ADHD medicines** (eg Ritalin/Concerta/methylphenidate, Adderall/amphetamine,Strattera/atomoxetine)
- ☐ Other:_____

Hospitalizations & Rehabs

IN-PATIENT TREATMENT OR HOSPITALIZATIONS RELATED TO MENTAL HEALTH

Have you ever been hospitalized or visited the ER due to a mental health concern? ☐ YES ☐ NO
DATES:

Have you ever attended in-patient or out-patient rehab/detox? ☐ YES ☐ NO
DATES:

Have you ever had an EKG? ☐ YES ☐ NO
DATES:

Was the EKG: ☐ NORMAL ☐ ABNORMAL ☐ NOT SURE

Past Medical History

CHECK ALL THAT APPLY

- ☐ Anemia
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Head Injury
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Other:_____

Family History

CHECK ALL THAT APPLY

- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anger
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Obsessive Compulsive Disorder
- ☐ Phobias
- ☐ Post Traumatic Stress
- ☐ Schizophrenia
- ☐ Suicide Attempts or Thoughts
- ☐ Thyroid Disease
- ☐ Violence
- ☐ Other:_____

Details:

Legal

Is this visit court ordered? ☐ YES ☐ NO

Have you ever been arrested? ☐ YES ☐ NO

Do you have pending legal problems? ☐ YES ☐ NO

Are you currently on probation/parole? ☐ YES ☐ NO

Is this visit related to a child protective order? ☐ YES ☐ NO

Other

Is this visit related to a car accident? ☐ YES ☐ NO

Is this visit related to a disability claim? ☐ YES ☐ NO