BOCA RATON PSYCHIATRIC GROUP, P.A.

PLEASE PRINT **DATE ______________________**

[ ] Dr. [ ] Mr. [ ] Mrs. [ ] Miss [ ] Ms. [ ] Male [ ] Female

AGE _____

MARITAL STATUS: []SINGLE []MARRIED []WIDOWED [] DIVORCED[]SEPARATED

PATIENT'S LAST NAME ________________ FIRST ________________MIDDLE _______________

STREET ADDRESS ____ APT__________________

CITY _________________ STATE______ ZIP ______________REFERRED BY___________________

EMPLOYER ___________________________ EMPLOYER ADDRESS _________________________

HOME PHONE # _____________________ WORK # ______________CELL#____________________

DATE OF BIRTH _____________SS#_________________ DRIVER LICENSE # __________________

SECONDARY ADDRESS:
____

____

PERSON TO CONTACT IN CASE OF EMERGENCY __________________ PHONE ______________

FINANCIAL RESPONSIBILITY

GUARANTOR'S LAST NAME _________________ FIRST ________________ M_________________

ADDRESS ____________________________ CITY ______________ STATE _______ ZIP
____

DOB _____________________ SS# ___________________ DRIVER LIC #_______________________

EMPLOYER ___________________________________ PHONE ______________________________

IS THIS CASE RELATED TO ANY LITIGATION? []YES []NO
DOES A LAWYER REPRESENT YOU? []YES [] NO

INSURANCE INFORMATION
NAME OF INSURANCE COMPANY ____
PLEASE PRESENT YOUR CARD TO THE RECEPTIONIST

NAME ___________________________ BIRTHDATE __________ AGE ______ TODAY'S DATE _______________

REASON FOR VISIT TODAY? ____

MEDICAL HISTORY

ALLERGIES OR DRUG REACTIONS: ____

MEDICATIONS (PLEASE LIST ALL MEDICATIONS INCLUDING ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS & SUPPLEMENTS TAKEN IN THE PAST 3 MONTHS):

NOW? ____

IN THE PAST THREE MONTHS? ____

HABITS:

	CURRENT USE	PAST USE
TOBACCO	________________________	________________
ALCOHOL	________________________	________________
"RECREATIONAL DRUGS"	________________________	________________
CAFFEINE	________________________	________________

ILLNESS: (PAST AND PRESENT)

CARDIAC? Y ____ N ____ THYROID? Y ____ N ____ GLAUCOMA? Y ____ N ____
SEIZURES? Y ____ N ____ DIABETES? Y ____ N ____CHOLESTEROL PROBLEMS? Y____N_____
SURGERIES? ____
ACCIDENTS/HEAD INJURIES? ____
OTHER MEDICAL PROBLEMS? ____

FEMALES ONLY: ARE YOU PREGNANT? Y ____ N ___ PLANNING TO GET PREGNANT? Y ____ N _____

NUMBER OF PREGNANCIES _______________ MISCARRIAGES ________________ ABORTIONS ____________

PSYCHIATRIC HISTORY

PREVIOUS PSYCHIATRISTS/THERAPISTS: WHEN? ____

MEDICATIONS PRESCRIBED IN THE PAST? ____

PSYCHIATRIC HOSPITALIZATIONS: WHEN? ____________ WHY? __________________________

WHEN? ____________ WHY? ________________________

FAMILY HISTORY

PSYCHIATRIC PROBLEMS (IN YOUR FAMILY): ____

SUICIDE ATTEMPTS IN YOUR FAMILY? ____

SEIZURES ____THYROID DISEASE _______________________________

DRUG PROBLEMS? ____________________________________ ALCOHOL ABUSE PROBLEMS? ______________

Please be aware all medicines may have the potential to cause problems in pregnancy or with the developing fetus.

√	Check all that currently a problem for you	Clinician comments
	Sadness/depression	
	Irritability	
	Appetite change	
	Loss of energy	
	Difficulty concentrating	
	Loss of interest/pleasure in activities	
	Trouble falling asleep	
	Waking during the night	
	Early morning awakening (too early)	
	Declining school grades or work performance	
	Mood swings	
	Thoughts of hurting yourself or suicide	
	Thoughts of hurting others	
	Decreased need for sleep	
	Speeded up thoughts	
	Excessive energy	
	Excessive worry	
	Panic attacks	
	Fears/phobias	
	Repetitive thoughts/ideas/images	
	Need to repeat certain activities	
	Rituals/things needing to be "just so"	
	Flashbacks	
	Feeling others are against you	
	Belief that your thoughts are being controlled	
	Belief you have special powers	
	Receiving messages from radio or TV	
	Seeing or hearing things other people can not	
	Hearing voices	
	Overactivity	
	Short attention span	
	Distractibility	
	Impulsivity	
	Lying	
	Stealing	
	Oppositional or defiant	
	Temper problems	
	Legal problems	
	Aggression/violence	
	Alcohol or drug problems	
	Misuse of prescription drugs	
	Skipping School	
	Fear of becoming fat	
	Binge eating	
	Vomiting or using laxatives to lose weight	
	Problems with bowel or bladder control	
	Problems with family relationships	
	Problems with money	
	Problems with school/work	
	Concerns about sex	
	Memory problems	

Clinician signature/date ________________________