Dr. Michael Jones
Psychologist

8510 Evergreen Avenue
Suite 106
Indianapolis, IN 46240

(317) 778-8525

michael.jones@drmichaeljonespsych.com
drmichaeljonespsych.com

# Registration Form

## PATIENT INFORMATION

Patient's Name: ______________________________________________ Birth Date: ____________
(Last) (First) (Middle Initial)

Home Address: ____________________________________________________________
(Street / Box #) (City/State) (Zip)

Home Phone: __________________________ Cell Phone: _________________________________

Employer: _____________________________ Work Phone: ________________________________

Marital Status: ______________________ Male ______ Female ______

Primary Physician: _________________________ Phone: _________________________________

Primary Physician Address: ___________________________________________________________

Source of Referral: ____________________________________________________________________

## EMERGENCY CONTACT INFORMATION

Emergency Contact: _____________________________ Home Phone: _______________________

Address (if different from patient's): ___________________________________________
(Street / Box #) (City/State) (Zip)

Relationship to patient: __________________________

## INSURANCE INFORMATION

Primary Ins. Co. Name: _____________________________ Phone: _________________________

Policy Holder's Name: ______________________________ DOB: ____________________________

Relationship to patient: ____________________________ EDI / Payer ID: ___________________

Policy Holder's ID#: ________________________________ Group #: ________________________

Claims Address: ___________________________________________________________________

## Patient History Questionnaire

### Purpose of Evaluation

What are your primary questions and concerns?

### Past Medical History

| | Yes | No | Comments |
|---|---|---|---|
| Have you ever been diagnosed with a medical condition? Please list: | | | |
| Have you ever been hospitalized? If so, when and for what condition? | | | |
| Have you ever had surgery? If so, what for? | | | |
| Are you currently taking any medications? If so, please list medication and dosage. | | | |

### Current Medical Concerns

| | Yes | No | Comments |
|---|---|---|---|
| Do you have any allergies to medications? | | | |
| Do you have any sleep concerns? If so, please describe. | | | |
| Do you have any concerns with energy level? If so, please describe. | | | |
| Do you experience headaches? If so, with what frequency? | | | |
| Do you experience stomach pain? If so, with what frequency? | | | |

**Past Mental Health Treatment**

Please list any previous medications that you have been prescribed for mood, anxiety, or attention and any side-effects you experienced.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you ever received counseling or psychotherapy? If so, when and what was the name of the therapist?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Educational History**

Please **circle** your highest level of education achieved:

| | |
|---|---|
| Some High School | Associate's Degree |
| High School Diploma | Bachelor's Degree |
| Some College | Additional Post-secondary Education |

**Family History**

Please list the persons presently living in your home.

| Name | Sex | Birth Date | Relation to patient |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

During the past 12 months has your family experienced any of the following:

| | Yes | No | Comments |
|---|---|---|---|
| Death of a Family Member | | | |
| Serious Illness | | | |
| Marital Problems | | | |
| Unemployment | | | |
| Other(please describe) | | | |

Have any family members experienced any of the following?

| | Yes | No | Comments |
|---|---|---|---|
| Depression | | | |
| Anxiety | | | |
| ADHD | | | |
| Autism | | | |
| Bipolar disorder | | | |
| Schizophrenia | | | |
| Other mental health diagnoses | | | |
| Heart or blood pressure problems (if yes, please describe) | | | |
| Other medical problems (if yes, please describe) | | | |

Person Completing this Form: ______________________________________________

Relation to Patient: ________________