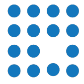

OCD·ANXIETY PROGRAM
OF SOUTHERN CALIFORNIA

Patient Registration Information

(PLEASE PRINT CLEARLY AND COMPLETE ALL PAGES)

PATIENT: (if responsible patient is not the responsible party; fill out information below) Date of Intake: ______________

LAST NAME______________________________________ FIRST NAME ________________________________ M. I. _________

ADDRESS ____ CITY____________________STATE _________ZIP ____________

TELEPHONE: HOME_________________________WORK________________________CELL ______________________________

EMAIL____

AGE _____ DATE OF BIRTH _______________SEX _______SOCIAL SECURITY NO. _________-____________-___________

REFERRAL SOURCE: ____

RELATIONSHIP STATUS: (circle) SINGLE MARRIED SEPARATED DIVORCED WIDOWED LIVE-IN PARTNER

STUDENT STATUS: (circle): FULL-TIME PART-TIME NONSTUDENT

Highest Degree Obtained: ___________________ Year: __________ Institution: _______________________________________

EMPLOYMENT STATUS: (circle) : FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

Date last worked: __________________________ Employer: _____________________ Position: _________________________

Emergency Contact: __________________________Relationship: _______________Telephone: __________________________

Financial Guarantor: __________________________Relationship: _______________Telephone: __________________________

PRIMARY INSURANCE COMPANY: ____

PATIENT'S INSURANCE ID#: ____

INSURANCE PLAN NAME: __________________________________INSURANCE GROUP NUMBER:_______________________

PREAUTHORIZATION NUMBER (If applicable): ____

RESPONSIBLE PARTY INFORMATION (Only fill out if responsible party different than above):

LAST NAME______________________________________ FIRST NAME ________________________________ M.I. _________

RELATIONSHIP TO PATIENT: Parent; Legal Guardian; Other ____

AGE _______ DATE OF BIRTH ____________SEX ______SOCIAL SECURITY NO. ___________-____________-___________

ADDRESS ____ CITY____________________STATE _________ZIP ______________

TELEPHONE: HOME_________________________WORK________________________CELL ______________________________

POLICYHOLDER'S INSURANCE ID#: ____
INSURANCE PLAN NAME: __________________________________ INSURANCE GROUP NUMBER: _________________________

HISTORY:
Do you have a history of:

1. A psychiatric diagnosis? YES NO AGE: _____ DESCRIBE:__________________________________
2. Substance use, abuse, dependence? YES NO AGE: _____ DESCRIBE:__________________________________
3. Traumatic Events? YES NO AGE: _____ DESCRIBE:__________________________________
4. Suicide Attempts? YES NO AGE: _____ DESCRIBE:__________________________________
5. Homicide Attempts? YES NO AGE: _____ DESCRIBE:__________________________________
6. Involvement in the legal system? YES NO AGE: _____ DESCRIBE:__________________________________

HISTORY OF TREATMENT:
Have you been in treatment (for mental health and/or drug/alcohol) before? YES NO
(If yes, please complete information below):
Outpatient Therapist: __________________________________(LPC, LCSW, PHD?) TELEPHONE: ________________________
Presenting problem? ____
How long have you been working with this provider? ____
Frequency of sessions: ____
Reason for termination: ____

Outpatient Psychiatrist: ____________________TELEPHONE: _____________________FAX:______________________
How long have you been working with this provider? _______ Frequency of sessions: _________________________

Have you been in any intensive treatment programs or been hospitalized?

REASON FOR TREATMENT?	WHEN (dates)?	WITH WHOM AND WHERE?	OUTCOME?

MEDICATIONS: (Please list medications you are presently taking):

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED FOR:

FAMILY HISTORY:
Please describe any family history of major medical or mental health concerns:
____
____

Medical Problems (Please list):
PHYSICAL/MEDICAL CONDITIONS (ANYTHING THAT REQUIRES THE ATTENTION OF A PHYSICIAN): _______________
____

DRUG ALLERGIES: ______________________________

FOOD ALLERGIES: ______________________________

RECENT MEDICAL PROCEDURES OR HOSPITALIZATIONS: ______________________________

____

PRESENTING PROBLEM: (WHY ARE YOU CURRENTLY SEEKING PSYCHOLOGICAL SERVICES)?

TREATMENT GOALS: