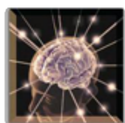


**MindSource Centre**

**Patient Registration Information** Date:________________

**PLEASE PROVIDE AS LEGIBLE AS POSSIBLE THE FOLLOWING INFORMATION**

Patient Name: _________________________________Date of Birth:_________________

Social Security Number:____________________________________ Sex: Male / Female

Street Address:_____________________________________________________________

City:_____________________________________ State: _________ Zip:______________

Home Phone:_________________________ Cell Phone:__________________________

Email Address:___________________________ Work Phone:______________________

Employer: __________________________ Occupation: __________________________

Marital Status:_______________________ Spouse's Name:_______________________

Referral Source: ___________________________________________________________

**Notify In Case of Emergency**

Name:_________________________________ Relationship:_____________________

Street Address:___________________________________________________________

City:______________________________________ State:_________ Zip:___________

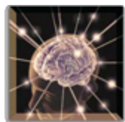
Primary Phone Number: _______________________ Work Phone:_________________

**Patients Under 18**

I,_____________________________________, swear that I am the legal custodial guardian of the child, ______________________________. Unless otherwise specified, NO information, including but not limited to: appointment information, medical records information, or any personal information shall be released to anyone other than the named guardian above.

This information is confidential and will be treated with respect. If at any time you wish to release information to anyone, including yourself, you will be required to sign a written release of information. Please be aware that Arizona law permits non-custodial parents access to their children's mental health and medical records. Please be aware that supplying our facility with false or misleading information is a felonious act and will be treated as such.

Parent/Guardian Signature:_________________________________



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**Responsible Party/Primary Card Holder**

Name: ______________________________________ Date of Birth:______________

Relationship:________________ Social Security Number:_______________________

Address:_____________________________________________________________

City:_________________________________State:____________Zip:____________

Primary Phone:_________________________ Work Phone:_____________________

**Insurance Information**

Primary Behavioral Health Insurance: ______________________________ Or Self Pay

Identification Number:__________________________ Group Number:_____________

Insurance Provider (Mental Health) Phone Number:_____________________________

Authorization Number (If Applicable):_________________________________________

Secondary Behavioral Health Insurance:______________________________________

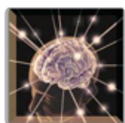
Identification Number:_________________________ Group Number:______________

Insurance Provider (Mental Health) Phone Number:_____________________________

**I authorize the release of any of my medical, psychiatric or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefits or mental health benefits to the physician or supplier of services rendered. I fully understand that if my insurance denies payment for any services defined as non-covered service, I will be responsible for any amount due. I further understand if my account gets referred to or placed with a collection agency that I will be fully responsible for all fees assessed with collections.**

Print Name:____________________________________ Date:___________________

Sign:__________________________________________________________________



MindSource Centre

## Medical History

Patient Name:___________________________________ Date of Birth:____________

Name of Primary Care physician: ____________________________

Medication Allergies:

Any Surgeries (continue on back if necessary):

### Have you ever had any of the following? Please circle all that apply

Epilepsy or Seizures

Stroke or TIA

Head Injury

Loss of Consciousness

Glaucoma

Difficulty Hearing

Tinnitus or Chronic Ear Ringing

Frequent Headaches

Heart Attack or Angina

Any Heart Problems

Ankle swelling

High Blood Pressure

Bleeding or Clotting Disorders

Currently on Blood Thinners

Coughing up blood

Asthma

Exposure to Tuberculosis

Lung Disease (other than Asthma)

Allergies

Hepatitis (A, B, C)

GERD or Acid Reflux

Stomach Issues

Irritable Bowel Syndrome (IBS)

Recent Blood in Stool

Recent Dark Black/Tarry Stool

Frequent Constipation

Regular Diarrhea

HIV Positive or AIDS

Cancer (Specify:________________)

High Cholesterol

Diabetes

Thyroid Issues

Changes in Hair Growth Patterns

Heavy Menstrual Periods

Night Sweats

Difficulty Urinating

Incontinence

Blood in Urine

Kidney Disease

Arthritis

Swollen Glands

Skin Rashes

Trouble Sleeping

Dieting

Attempted Suicide (Number of times:_________)

Eating Disorder

Smoke or Nicotine Addiction

Use Illicit Drugs

Alcohol Abuse

Medication Abuse

Pregnant

Sexually Active

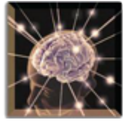
Low or High Libido

Difficulty Achieving Orgasm

Difficulty with Arousal/Erections

Date of Last Pap Smear:_______________

Date of Last Blood Work:______________



MindSource Centre

### SSRI's & Others
Fetzima / l-milnacipran
Brintellix / Vortioxetine
Viibryd / vilzoddone
Prozac / fluoxetine
Paxil / paroxetine
Zolof t / sertaline
Celexa / citalopram
Lexapro / s-citalopram
Luvox / fluvoxamine
Cymbalta / duloxetine
Effexor / venlafaxine
Effexor XR
Pristiq / desvenlafaxine
Wellbutrin / buproprion
Wellbutrin SR / buproprion SR
Wellbutrin XL
Zyban / buproprion
Remeron / mirtazapine
Serzone / nefazodone
Reboxetine (Canada)
Stablon (UK)
Savella / milnacipran
Valdoxan
Vit D3 400-800 IU

### ADJUNTIVE & SGA'S
Risperdal / risperidone
Zyprexa / olanzapine
Seroquel / quetiapine
Clozaril / clozapine
Geodone / ziprasidone
Abilify / aripiprazole
Latuda / lurasidone
Fanapt / lloperidone
Saphris

Vitamin E 1600 IU
Amino acids / tarvil

### TYPICAL AP'S

### ANTI ANXIETY AGENTS
Xanax / alprazolam
Ativan / lorazepam
Klonopin / clonazepam
Serax / oxazepm
Tranxene / clorazepate
Librium / chlordiazepoxide
Valium / diazepam
Other BZD

Theonine

### SLEEP AIDS
Desyrel / Trazodone
Ambien / zolpidem
Sonata / zaleplon
Lunesta / eszopiclone
Xyrem / sodium oxybate
Prosom / estazolam
Restoril / temazepam
Dalmane / fluazepam
Somnote / chloral hydrate
Halcion / triazolam
Rozerem / ramelteon
Doral / quazepam
Melatonin
Valerian
Benadryl / diphenhydramine
L-TRP / tryptophan
Hydroxy-TRP

### SEXUAL DYSFUNCTION AGENTS
Viagra / sildenafil
Levitra / vardenafil
Cialis / fadalafil
CP Testosterone
1% / androgel / androderm
Dream cream / Reed's pharmacy

### TRICYCLIC ANTIDEPRESSANT(TCA'S)
Anafranil / clompramine
Pamelor / nortriptyline
Elavil / amitriptyline
Nopramin / desipramine
Tofranil / Imipramine
Sinequan / doxepin
Vivactil / protriptyline
Ludiomil / maprotyline
Surmontil / Trimipramine

### MAOI'S
Parnate / tranylcypramine
Nardil / phenelzine
Marplan / isocarboxazid
Eldepryl / selegiline
EMSAM patch

### MOOD STABILIZERS / AED'S
Lithium / Eskalith CR / Lithobid
Equetro / CBZ-ER
Tegretol / carbamazepine
Carbitrol
Trileptol / oxcarbamazepine
Depakote ER
Lamictal / lamotragine
Neurotin / Gabapentin
Lyrica / pregabalin
Topamax / topiramate
Gabitril / tiagabine
Dilantin / phenytoin
Primidone
Mexitil

### STIMULANTS, ECT
Vyvanse
Intuniv
Dexedrine / dexroamphetamine
Desoxyn / methamphetamine
Provigil / modafenil
Nuvigil / armodafenil
Ritalin / methylphenidate
Ritalin SR/LA
Daytrana Ritalin patch
Adderal
Adderal XR
Concerta / methylphenidate ER
Cylert
Strattera / atamoxetine
Focalin

### AUGMENTERS
Lithium / Eskalith CR / Lithobid
Cytomel / T3
Lamictal / lamotragine
Buspar / lamotragine
Pindolol
Marinol / dronabinol
Folate
Fish oil / omega 3 fatty acids
Vitamin B12

### ALTERNATIVE TREATMENTS
St. John's Wort
SAME 400mg BID
Transcranial Magnetic Stimulation
Vagal Nerve Stimulation
ECT
Buprenorphiphine

### DRY MOUTH
Urecholine / betanechol
Orajel
Biotene
Pilocarpine / salagen

### SWEATING
Clonidine

### BRUXISM
Requip
Buspar

### Nightmares
Prazosin

### DRUG ABUSE TREATMENTS
Campral / acamprosate
Revia / Naltrexone
Antabuse / disulfuram
Suboxone / buprenorphine / naloxone
Subutex / buprenorphone
Chantix / varenicline
Vivitrol / naltrexone

Please circle all medications you have ever taken.

Patient Name:_______________________________________________ Date:_______________