Sage Neuroscience Center

Patient Information Sheet

Date: _____

Patient Name: _____

Last **First** **Middle**

Male **Female** **Date of Birth:** _____ **SS#:** _____

Street Address: _____

City/State/Zip: _____

Home Phone #: _____ **Work #:** _____

Cell Phone #: _____ **Preferred Number to Call:** _____

Marital Status: **Married** **Widowed** **Divorced** **Single** **Domestic Partner**

How Were You Referred to this Clinic? **Self** **Family** **Primary Doctor** **Therapist** **Insurance**

Occupation: _____

Patient's Employer: _____

Address: _____

Spouse/Significant Other's Name: _____ **SS#:** _____

Spouse/SO's Employer: _____

Address: _____

Emergency Contact Person: _____**Relationship:**_____

Address: _____

Phone #'s: _____

Primary Insurance Company: _____

Address: _____

Policy Holder's Name: _____**Date of Birth:** _____

ID Number: _____**Relationship:** _____

Policy Holders Address: _____

Policy Holders Employer: _____ **Phone:** _____

Address: _____

Secondary Insurance Company: _____

Address: _____

Policy Holder's Name: _____**Date of Birth:** _____

ID Number: _____ **Relationship**: _____

Primary Care Physician: _____**Phone/Fax:** _____

Therapist: _____ **Phone/Fax:** _____

Do you give Sage Neuroscience Center and its providers permission to inform your primary care doctor, therapist, or other medical providers of your diagnosis and medication changes we make for you? Any further information or detail will be discussed with you prior to being released. Sign below if you agree.

Yes **No** _____

Signature **Date**

MEDICAL HISTORY

Please explain the reason for your visit today: _____

_____

Does this visit pertain to worker's compensation, FMLA, or disability? Yes No

SEVERE Medication Allergies and Adverse Reactions: _____

_____

Current Psychiatric Meds, Dose/Frequency:

_____

_____

_____

_____

Other Medications You Take:

_____

_____

_____

_____

Past Psychiatric Medications, include dose and duration of time you took them:

_____

_____

_____

_____

_____

_____

Have you, or are you, being treated for any of the following or are you currently having symptoms related to any of the following?

None
Migraines, Headaches, Dizziness
Head Trauma
Stroke
Vision Problems/Loss
Hearing Loss or Ringing in Ears
Allergies, Seasonal or Other
Heart Attack
High or Low Blood Pressure
Other Heart Conditions
Asthma
Gastric Reflux or Ulcers
Pancreatic or Gall Bladder Disease
Other Digestive Problems
Urinary Problems
Sexual Dysfunction
Thyroid Problems
Diabetes
Cancer
Bleeding Problems/Easy Bruising
Skin Problems
Back or Joint pains/Arthritis
Nerve Numbness or Sensitivity
Seizures
Muscle Weakness/Injury
Arthritis
Menstruation Irregularity
Hysterectomy
HIV
Hepatitis
Insomnia
Sleep Apnea
Other Neurological Disorder(s)
Autoimmune Disorder(s)
Chronic Pain (please specify below)
Currently Pregnant
Breastfeeding

Please explain any of the checked items above:_____

_____

_____

Current height:_____ **Current weight:** _____

Current level of pain: (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

Describe, Type and Location: _____

When was your last visit to your primary care doctor? _____

Have you ever been hospitalized? _____

If so, when and for what reason? _____

Have you had any past surgeries? _____

Who raised you? ____Parent(s) ____Grandparent(s) ____Foster Care ____Other

Were you adopted? ____ Yes ____ No

How many siblings do you have? _____Brother(s) _____ Sister(s) ____ Any step/half siblings?

What is the highest level of education you completed? _____

Were you ever diagnosed or treated for learning disabilities as a child? _____

_____

Have you worked with a counselor or psychiatrist in the past? _____

How long, and what was the focus of treatment? _____

_____

Personal Psychiatric History (check all that apply):

None
Depression
Psychosis/Schizophrenia
Learning Disabilities
Attention Deficit Disorder
Alcohol Addictions
Drug Addictions
Other Addictions
Suicide Attempts
Mania or Bipolar Disorder
Anger
Anxiety/Panic
Post Traumatic Stress Disorder
Obsessive Compulsive Disorder
Other

Please explain any of the above items you checked:

_____

_____

_____

Do you have a history of any past or current legal problems? Please Explain: _____

_____

Family Psychiatric History (check all that apply):

None
Depression
Psychosis/Schizophrenia
Learning Disabilities
Attention Deficit Disorder
Alcohol Addictions
Drug Addictions
Other Addictions
Suicide
Suicide Attempts
Mania or Bipolar Disorder
Anger
Anxiety/Panic
Post Traumatic Stress Disorder
Obsessive Compulsive Disorder
Other

Please explain any of the above items you checked and note your relation to the individual:

_____

_____

_____