Sage Neuroscience Center
7850 Jefferson St. NE Suite 300 Albuquerque NM, 87109
Phone 505-884-1114 Fax 505-856-6320

Patient Information Sheet

Areas in bold are required. Please give as much information as possible.

Patient Name: _____
Last **First** Middle

__Male __Female Date of Birth: _____ SS#: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: _____ Work #: _____ ext:_____

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

Marital Status: __Married __Widowed __Divorced __Single __Domestic Partner
Ethnicity: __Caucasian __Hispanic __Other
How Were You Referred? __Self __Friend __Family __Primary Doctor __Therapist __Insurance

Services needed? __Counseling/Therapy __Medication Management __Suboxone __TMS

Occupation: _____

Patient's Employer: _____

Address:_____

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

Spouse/SO's Employer: _____

Address: _____ Phone #_____

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

Address: _____ **Phone #:** _____

INSURANCE INFORMATION

I will ____self pay -OR- ___Primary Insurance Company: _____
Policy Holder's Name: _____ **Date of Birth:** _____

Relationship to Insured Person: __Self __Spouse __Child/Parent Group #_____

ID Number: _____ (failure to provide ID# may result in delay in processing your paperwork)

Policy Holder's Address: _____ SS#: _____

Policy Holder's Employer: _____ Phone: _____

Do you have secondary insurance? __Yes __No Insurance Co. _____

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

Relationship: _____ Group #_____ **ID Number:** _____

Primary Care Physician: _____ Phone/Fax: _____

Therapist: _____ Phone/Fax: _____

Do you give Sage Neuroscience Center and its providers permission to inform your primary care physician, 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. Please mark & sign below.

__Yes __No _____ _____
Signature **Date**

_____

Does this visit pertain to __Worker's Compensation, __FMLA, or __Disability? __Yes __No

MEDICATION HISTORY

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 now or in the past been treated for, or have symptoms of any of the following conditions?

Personal Psychiatric History (check all that apply):

__Autism Spectrum
__Alcohol Addictions
__Anger
__Anxiety/Panic
__Attention Deficit Disorder
__Depression
__Drug Addictions
__Learning Disabilities
__Mania or Bipolar Disorder
__Obsessive Compulsive Disorder
__Other Addictions
__Post Traumatic Stress Disorder
__Psychosis/Schizophrenia
__Suicide Attempts
__Other: _____

Please explain any of the above items you checked: _____

_____

_____

Current Height: _____ Current Weight: _____

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

Describe type of pain and location: _____

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

Have you ever been hospitalized? __Yes __No If yes, 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 or half siblings? _____

What is the highest level of education you've completed? _____

Were you ever diagnosed or treated for learning disabilities as a child? __ Yes ___ No

If yes, when and what was the diagnosis? _____

_____

Have you worked with a counselor or psychiatrist in the past? __ Yes __ No

If yes, when, how long, and what was the focus of treatment? _____

_____

Do you have a history of any past or current legal problems? __ Yes __ No

If yes, please explain: _____

_____

Family Psychiatric History (check all that apply):

__Autism Spectrum
__Anger
__Attention Deficit Disorder
__Drug Addictions
__Mania or Bipolar Disorder
__Other Addictions
__Psychosis/Schizophrenia
__Suicide Attempts
__Alcohol Addictions
__Anxiety/Panic
__Depression
__Learning Disabilities
__Obsessive Compulsive Disorder
__Post Traumatic Stress Disorder
__Suicide
__Other _____

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

_____

_____

_____