

Provider: \_\_\_\_\_

**Strong Integrated Behavioral Health, LLC**  
**Phone: (541)393-5983 Fax: (541)393-5984**

### ADULT REGISTRATION FORM AND INITIAL QUESTIONNAIRE

Thank you for taking the time to complete your intake form in its entirety. This will provide useful information to our providers in completing your intake session and planning your evaluation and/or treatment.

Date: _____		
Name: _____		
Address: _____		
Phone Number(s): Home _____ Cell _____ Work _____ Which number would you like us to contact you and/or leave messages? _____ Would you like your appointment reminders to come to you in the form of a call or a text? And at what number? _____		
Email Address: _____		
Date of Birth: _____ Nationality: _____ Racial/Ethnic: Asian/Pacific, African American, Hispanic/Latin, Native, Multi-ethnic, White American	Age: _____ Religion: _____	Gender Identity: Other: _____ Woman, Man, Transgender, Genderqueer Sexual Identity: Gay, Heterosexual, Lesbian, Bisexual, Pansexual, Queer, Other Pronouns: _____
Social Security Number (SS#): _____		
Marital Status/Partner Information: _____		
By whom were you referred to this office? _____		

<b>Insurance Information: Primary</b>		
Insurance Company: _____	Phone: _____	
Subscriber's Name: _____	Subscriber's DOB: _____	
ID# _____	Group # _____	
Relationship to Patient: Self _____ Spouse _____ Child _____ Parent _____ Other _____		
Employer: _____		

<b>Insurance Information: Secondary</b>		
Insurance Company: _____	Phone: _____	
Subscriber's Name: _____	Subscriber's DOB: _____	
ID# _____	Group # _____	
Relationship to Patient: Self _____ Spouse _____ Child _____ Parent _____ Other _____		
Employer: _____		

Provider: \_\_\_\_\_

<b>Nearest Friend or Relative not living with you in case of an emergency:</b>		
Name & Relationship: _____		
Address: _____		
Phone Number: _____		
<b>Who lives with you?</b>		
Name:	Relationship:	Age:
1.		
2.		
3.		
4.		
5.		
6.		

<b>Employer:</b>
<b>Occupation:</b>
<b>Highest level of schooling obtained:</b>

<b>What brings you in today?</b>

<b>Medical History</b>		
<b>Y</b>	<b>N</b>	Have you had major health problems? (Explain)
<b>Y</b>	<b>N</b>	Have you had vision or hearing problems?
<b>Y</b>	<b>N</b>	Have you had a serious head injury or been unconscious? (Explain)
<b>Y</b>	<b>N</b>	Have you ever engaged in self harm as a way of coping? If so, describe:
<b>Y</b>	<b>N</b>	Have you ever chronically dieted, restricted your food intake or food variety severely, purged, compulsively exercised or binged? Please describe:
<b>Y</b>	<b>N</b>	Have you ever experienced anyone else physically assaulting you _____, sexual harassment or stalking, _____ sexually abusing you _____, rape or sexual assault _____?

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<b>Mental Health History</b>		
<b>Y</b>	<b>N</b>	Have you ever participated in counseling or therapy in the past? If so, when, with who, and for what types of problems?
<b>Y</b>	<b>N</b>	Have you ever been seen by a psychiatrist? (Give names and dates)
<b>Y</b>	<b>N</b>	Have you ever been hospitalized for mental health treatments? (Give places and dates)
<b>Y</b>	<b>N</b>	Do you have a history of suicidal behavior? (Describe)
<b>Y</b>	<b>N</b>	Do you have a history of violence or aggression? (Describe)
<b>Y</b>	<b>N</b>	Do you have a history of abusing drugs or alcohol? (Describe)

		<b>Family History of:</b>	<b>Mother</b>	<b>Father</b>	<b>Other Relative (please specify)</b>
<b>Y</b>	<b>N</b>	Depression			
<b>Y</b>	<b>N</b>	Bipolar Disorder (Manic Depression)			
<b>Y</b>	<b>N</b>	Anxiety			
<b>Y</b>	<b>N</b>	Schizophrenia			
<b>Y</b>	<b>N</b>	Autism or Developmental Disorder			
<b>Y</b>	<b>N</b>	Tics or Tourette's Syndrome			
<b>Y</b>	<b>N</b>	Obsessive Compulsive Disorder (OCD)			
<b>Y</b>	<b>N</b>	ADHD/Hyperactivity			
<b>Y</b>	<b>N</b>	Substance or Alcohol Abuse			
<b>Y</b>	<b>N</b>	Learning Disability			
<b>Y</b>	<b>N</b>	Anorexia/Bulimia/Eating Disorder			
<b>Y</b>	<b>N</b>	Other emotional or mental problem (please specify)			

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Please list your primary care provider and any other health care providers that might be relevant to your treatment. (This office will not contact these individuals unless you sign a release of information).

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Please list any medication(s) you are currently taking:

Name of medication

Dose and time of day

Reason for medication

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