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.

<table>
<tr><td colspan="3">Date:</td></tr>
<tr><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td colspan="3">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:</td></tr>
<tr><td>Date of Birth: _____

Preferred Language: _____.

Nationality: _____

Racial/Ethnic: Asian/Pacific, African American, Hispanic/Latin, Native, Multi-ethnic, White American</td><td>Age: _____

Religion: _____</td><td>Gender Identity: Other: _____
Woman, Man, Transgender, Genderqueer

Sexual Identity: Gay, Heterosexual, Lesbian, Bisexual, Pansexual, Queer, Other

Pronouns:</td></tr>
<tr><td colspan="2">Social Security Number (SS#):</td><td></td></tr>
<tr><td colspan="3">Marital Status/Partner Information:</td></tr>
<tr><td colspan="3">By whom were you referred to this office?</td></tr>
</table>

Insurance Information: Primary
Insurance Company: _____ Phone: _____
Subscriber's Name: _____ Subscriber's DOB: _____
ID#_____ Group #_____
Relationship to Patient: Self_____ Spouse_____ Child_____ Parent_____ Other_____
Employer: _____

Provider:_____

Insurance Information: Secondary
Insurance Company: _____ Phone: _____
Subscriber's Name: _____ Subscriber's DOB: _____
ID#_____ Group #_____
Relationship to Patient: Self_____ Spouse_____ Child_____ Parent_____ Other_____
Employer: _____

Nearest Friend or Relative not living with you in case of an emergency:
Name & Relationship: _____
Address: _____
_____
Phone Number:

Who lives with you?

Name:	Relationship:	Age:
1.		
2.		
3.		
4.		
5.		
6.		

Employer:
Occupation:
Highest level of schooling obtained:

What brings you in today?

Medical History

Y	**N**	Have you had major health problems? (Explain)
Y	**N**	Have you had vision or hearing problems?
Y	**N**	Have you had a serious head injury or been unconscious? (Explain)
Y	**N**	Have you ever engaged in self harm as a way of coping? If so, describe:

Y	**N**	Have you ever chronically dieted, restricted your food intake or food variety severely, purged, compulsively exercised or binged? Please describe:
Y	**N**	Have you ever experienced anyone else physically assaulting you_____, sexual harassment or stalking, _____ sexually abusing you_____, rape or sexual assault_____?

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

		Family History of:	**Mother**	**Father**	**Other Relative (please specify)**
Y	**N**	Depression			
Y	**N**	Bipolar Disorder (Manic Depression)			
Y	**N**	Anxiety			
Y	**N**	Schizophrenia			
Y	**N**	Autism or Developmental Disorder			
Y	**N**	Tics or Tourette's Syndrome			
Y	**N**	Obsessive Compulsive Disorder (OCD)			

Provider:_____

Y	**N**	ADHD/Hyperactivity			
Y	**N**	Substance or Alcohol Abuse			
Y	**N**	Learning Disability			
Y	**N**	Anorexia/Bulimia/Eating Disorder			
Y	**N**	Other emotional or mental problem (please specify)			

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).

_____

_____

_____

_____

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

Name of medication Dose and time of day Reason for medication

_____

_____

_____

_____

_____