Dr. Renee Bonin & Associates

Patient Registration Today's Date: _____

Patient's Full Name: _____Birthdate:_____

Spouse's Name (if applicable):_____Birthdate:_____

Parent's Name (if applicable):_____Birthdate:_____

Patient's Address: _____

City, State, Zip: _____

Patient's Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed

Patient: ___Male ___Female Employer/School & Phone: _____

Patient SS#(if 18 years or older) or parents SS#: _____

Home Phone: _____ Cell Phone: _____

Referred by: _____

Reason for Appointment: _____

Veteran: ___ Yes ___ No Ethnicity: _____ Religion: _____

Primary Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Email Address: _____

Emergency Contact Name & Phone Number: _____

Appointment Reminder: ___Phone Message ___E-mail

INSURANCE

Primary Insurance: _____ Member ID#: _____

Name of Insured: _____ Birthdate: _____

Insured's SS#: _____

Insurance Company Phone #: _____ Group#: _____

Secondary Insurance: _____ Member ID#: _____

Name of Insured: _____ Birthdate: _____

Insured's SS#: _____

Insurance Company Phone #: _____ Group#: _____

Patient Information

Name:_____ DOB:_____ Age:_____

Address:_____ City:_____ State:_____
Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Place of Employment:_____ Occupation:_____

Primary Care Physician:_____

PRESENTING CONCERN:
Who referred you to my office?
Describe briefly your present symptoms:
Please list the names of other practitioners/mental health providers you have seen for this problem:
Psychiatric Hospitalizations (include where, when, & for what reason):

Who currently lives in your household?

Name	Relation	Age

CURRENT MEDICATIONS
Drug allergies: ❑ No ❑ Yes To

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**
1.	
2.	
3.	
4.	
5.	

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	

Other medical conditions (please list):

PERSONAL HISTORY
Were there problems with your birth? (specify)
Where were your born & raised?
What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree
Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other
What is your current or past occupation?
Are you currently working? : ❑ Yes ❑ No Hours/week: If not, are you ❑ retired ❑ disabled ❑ sick leave? _____
Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?_____
Have you ever had legal problems? (specify)
Religion:

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ( ) Yes ( ) No
Schizophrenia ( ) Yes ( ) No
Depression ( ) Yes ( ) No
Post-traumatic stress ( ) Yes ( ) No
Anxiety ( ) Yes ( ) No
Alcohol abuse ( ) Yes ( ) No
Anger ( ) Yes ( ) No
Other substance abuse ( ) Yes ( ) No
Suicide ( ) Yes ( ) No
Violence ( ) Yes ( ) No

If yes, please list each?_____

_____
_

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
_____

How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long_____
_____

Other Information:

Please list any other information you would like your Doctor to have that was not addressed in this questionnaire:

_____

_____

_____

_____

_____