NEW DIRECTIONS TREAMENT CENTER

REGISTRATION FORM

(Please Print)

Today's Date:	Account Number	PCP:

PATIENT INFORMATION

Patient's last name First Middle Maiden				Marital Status Sing ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐ Partner ☐
Email Address Appointment Reminder OK ☐	Birth date:	Age	Sex ☐M ☐F	Social Security Number
Street address:				Home Phone Message OK ☐ ( )
P.O. box:	City:	State:	ZIP Code:	Cell Phone Message OK ☐ ( )
Occupation:	Employer:			Work Phone Message OK ☐ ( )
Referred By	Address			Phone
Other family members seen here				

EMERGENCY INFORMATION

Spouse	Home Phone ( )	Cell Phone ( )	Work Phone ( )
Nearest Relative Other Than Spouse	Address	Home Phone ( ) Cell Phone ( ) Work Phone ( )	
Person to Contact in Emergency	Home Phone ( )	Cell Phone ( )	Work Phone ( )

CONSENT FOR TREATMENT

I voluntarily consent to outpatient psychiatric care encompassing diagnostic and medical and psychological treatment by my physician,therapist, or their assistants or designees, as may be necessary in their judgment. I am aware that the practice of medicine and therapy is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

_____ _____

Patient/Guardian signature Date Witness Date

Patient is unable to consent because of ☐ Minor ☐ Other_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize New Directions Treatment Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PERSON RESPONSIBLE FOR THE BILL

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )
Employer:	Employer address:		Employer phone no.: ( )

I agree to be financially responsibiilie for all fees incurred by _____ for New Directions Treatment Center services regardless of whether or not these services are covered by insurance. I understand that insurance is a contract between the patient or policy holder and the insurance company , and that failure of the insurance company to approve or cover the services does not relieve me of responsibility for the fees.

Signature	Date	Witness	Date
_____ Responsible Party		_____	

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Employer if Group Coverage	Policy Number	Group Number
Policyholder Name(If different from Patient	Policyholder Social Security Number	Policyholder Date of Birth	Relationship to Patient

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company	Employer if Group Coverage	Policy Number	Group Number
Policyholder Name(If Other Than Patient)	Policyholder Social Security Number	Policyholder Date of Birth	Relationship to Patient

PREAUTHORIZATION FOR VISITS

DOES YOUR INSURANCE REQUIRE AN AUTHORIZATION FOR MENTAL HEALTH SERVICES? ☐YES ☐ NO

DO YOU HAVE THE AUTHORIZATION FOR TODAY'S VISIT WITH YOU? ☐YES ☐ NO

AUTHORIZATION TO BILL INSURANCE COMPANIES

PLEASE READ AND SIGN

I AUTHORIZE NEW DIRECTIONS TREATMENT CENTER TO RELEASE INFORMATION AS MAY BE NEEDED TO INSURANCE COMPANIES AND CLAIMS PROCESSORS FOR PROCESSING INSURANCE CLAIMS. I UNDERSTAND THAT ALL FEES ARE DUE AND PAYABLE BY ME AND SHOULD THE INSURANCE COMPANY DENY PAYMENT, THEN THE RESPONSIBILITY LIES SOLELY WITH ME TO PAY IN FULL. SHOULD COLLECTION PROCEEDINGS BE REQUIRED, I GIVE MY PERMISSION FOR INFORMATION TO BE RELEASED TO CREDIT BUREAUS, COLLECTION AGENCIES AND ATTORNEYS FOR THE PURPOSE OF FACILrrATING COLLECTION. I FURTHER AGREE TO PAY ADDITIONAL COSTS INVOLVED IN THE COLLECTION PROCESS.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND OTHER HEALTH PLANS TO NEW DIRECTIONS TREATMENT CENTER.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES OF THIS FORM. I HAVE READ AND UNDERSTOOD THEM.

_____ Signed (Patient, or parent if under 18 years of age)

_____ Date

NEW DIRECTIONS

The Treatment Center For Anxiety and Depression

2990 Bethesda Place, Suite 602 A, Winston-Salem, NC 27103
(336) 768-8281 • FAX (336) 768-5685

NAME _____ DATE ____/____/_____ HEIGHT_____ WEIGHT_____

DATE OF BIRTH____/____/____ JOB _____ HOW LONG?_____YRS

PREVIOUS PSYCHIATRIC TREATMENT

DATE	CLINICIAN	REASON	LENGTH OF TREATMENT	HOSPITALIZED?

CURRENT SYMPTOMS

APPETITE

- ☐ TOO MUCH
- ☐ TOO LITTLE
- ☐ WEIGHT GAIN _____ LBS
- ☐ WEIGHT LOSS_____LBS
- ☐ BINGING
- ☐ VOMITING
- ☐ LAXATIVE ABUSE
- ☐ PREOCCUPAIED WITH WEIGHT OR BODY APPEARANCE

MOOD

- ☐ ELEVATED
- ☐ SAD OR DEPRESSED
- ☐ CHANGEABLE
- HOW OFTEN?_____
- ☐ BETTER IN AM
- ☐ BETTER IN PM
- ☐ BETTER IN SUMMER
- ☐ BETTER IN WINTER
- ☐ ANGRY/IRRITABLE/ EXPLOSIVE
- ☐ SUICIDAL PLANS
- ☐ WISHES FOR DEATH
- ☐ SUICIDAL THOUGHTS
- ☐ PAST SELF INJURY/ATTEMPT
- ☐ THOUGHTS OF DEATH

ACTIVITY

- ☐ EXCESSIVE
- ☐ CAUSES ME PROBLEMS
- ☐ EXCESSIVE MONEY SPENT
- ☐ EASILY DISTRACTED
- ☐ COMES AND GOES
- ☐ POOR CONCENTRATION
- ☐ SOMETIMES OUT OF CONTROL
- ☐ CAN NOT COMPLETE TASKS

SLEEP

- ☐ TOO MUCH
- ☐ TOO LITTLE
- ☐ I FEEL LITTLE NEED FOR SLEEP
- ☐ NEED MORE SLEEP
- ☐ DIFFICULTY FALLING ASLEEP
- ☐ LOUD SNORING
- ☐ DIFFICULTY STAYING ASLEEP
- ☐ DAYTIME SLEEPINESS
- ☐ LEG MOVEMENTS OR FEELINGS INTERFERE WITH SLEEP
- ☐ SLEEPINESS INTERFERES WITH DRIVING

ENERGY

- ☐ TOO MUCH
- ☐ TOO LITTLE
- ☐ VERY CHANGEABLE

ANXIETY

- ☐ ATTACKS OF PANIC OR FEAR
- ☐ SHORTNESS OF BREATH
- ☐ DIFFICULTY SWALLOWING
- ☐ NUMBNESS OR TINGLING
- ☐ RAPID HEART RATE
- ☐ DIZZINESS/BALANCE LOSS
- ☐ WORRY THAT A DISASTER WILL HAPPEN TO ME OR FAMILY
- ☐ TROUBLING OR UNWANTED THOUGHTS /URGES /ACTIONS
- ☐ REPETITIVE BEHAVIOR
- ☐ FEELING UNREAL
- ☐ WORRY OVER HEALTH
- ☐ FEAR OF LOSING CONTROL
- ☐ FEAR OF HEIGHT
- ☐ FEAR OF BEING CLOSED IN
- ☐ OTHER FEARS _____

IS THERE ANY VIOLENCE IN YOUR HOME? ☐ NO ☐ YES _____

FAMILY HISTORY

PSYCHIATRIC PROBLEMS, ALCOHOL ABUSE, DRUG ABUSE, OR LEGAL PROBLEMS

MOTHER_____ FATHER_____

BROTHERS_____ SISTERS_____

GRANDPARENTS_____

AUNTS AND UNCLES_____

FIRST COUSINS_____

CHILDREN_____

GENERAL HEALTH

LAST PHYSICAL EXAM DATE_____ RESULTS_____

CURRENT MEDICAL PROBLEMS	DOCTOR	ANY MEDICINES PRESCRIBED

PREVIOUS MEDICAL HOSPITALIZATIONS

_____

DATE

ALLERGIES TO MEDICINES OR FOOD

☐ NONE _____

☐ ALLERGIC TO: _____

_____

ALCOHOL USED NUMBER OF DRINKS PER WEEK _____ USAGE OR PROBLEMS IN THE PAST?_____

ANY NON-PRESCRIPTION DRUG USE?_____ USAGE OR PROBLEMS IN THE PAST?_____

LEGAL PROBLEMS ☐ NO ☐ YES_____

HEART AND LUNGS

☐ CHEST PAIN
☐ IRREGULAR RHYTHM
☐ HEART ATTACKS
☐ TROUBLE BREATHING
☐ HARD TO LIE FLAT
☐ BLOOD CLOTS

BOWELS

☐ REGULAR ☐ IRREGULAR
☐ BLOOD IN STOOL
☐ CONSTIPATION ☐ DIARRHEA
MOVEMENTS EVERY _____ DAYS
☐ OTHER _____

HEARING AND VISION

☐ HEARING PROBLEMS OR CHANGES?
☐ CHANGES IN VISION?
☐ GLAUCOMA
☐ PAIN IN EYES OR EARS
☐ OTHER_____

GLANDULAR TROUBLE

☐ THYROID ☐ PARATHYROID
☐ PITUITARY ☐ ADRENAL
☐ THYMUS ☐ LYMPH
☐ OVARIES ☐ TESTES
☐ CHANGE IN SKIN OR HAIR TEXTURE
INTOLERANCE TO: ☐ HEAT ☐ COLD

SKIN

☐ ANY CHANGES?_____
☐ SWELLING IN HANDS, FEET, OR LEGS
☐ SKIN DISEASES OR PROBLEMS?_____
_____

NERVOUS SYSTEM

☐ SEVERE HEADACHES
HOW LONG?_____ HOW OFTEN?_____
☐ SEIZURES OR FITS ☐ FAINTING SPELLS
☐ NUMBNESS ☐ WEAKNESS
☐ UNCONSCIOUS AFTER HEAD INJURY
☐ OTHER_____

BONES AND JOINTS

☐ ARTHRITIS ☐ GOUT
☐ OSTEOPOROSIS
☐ OTHER _____

KIDNEYS AND BLADDER

☐ INFECTIONS ☐ STONES
☐ TROUBLE STARTING STREAM
☐ TROUBLE STOPPING STREAM
☐ WETTING AT NIGHT OR DURING DAY
☐ SEXUALLY TRANSMITTED DISEASE
☐ PROSTATE PROBLEM

WOMEN'S HEALTH

☐ POST PARTUM DEPRESSION
☐ IRREGULAR PERIODS
☐ MENSTRUAL PROBLEM:_____
☐ BREAST PROBLEMS_____
☐ BIRTH CONTROL PILLS
☐ LAST MENSTRUAL PERIOD_____
☐ TERMINATED PREGNANCY

FAMILY MEDICAL HISTORY

MOTHER'S AGE _____ HEALTH _____ FATHER'S AGE _____ HEALTH_____

OTHER _____

PATIENT
SIGNATURE_____DATE___/___/___

REVIEWED_____DATE___/___/___
REVIEWED_____DATE___/___/___

New Directions Treatment Center 602-A Bethesda Court Winston-Salem, NC 27104 Phone 336-768-8281 Fax 336 768-5685