NORTHERN VIRGINIA INSTITUTE OF PSYCHIATRY
5537 HEMPSTEAD WAY
SPRINGFIELD, VIRGINIA 22151
TELEPHONE 703-922-8484

REGISTRATION

PLEASE PRINT. All information obtained here and contained in these records will be held in strictest confidence.

No information will be released to other parties or persons without your prior consent authorizing us to release that information to that specific person. Confidential information will only be released without your permission if:

1. there is immediate danger to life, or
2. a valid court order is received for this information.
3. and for insurance billing

NAME: ____ BIRTHDATE: _________________

PRESENT ADDRESS: ____

CITY: _______________________________ STATE: __________________ ZIP: ___________________

HOME TELEPHONE NUMBER: _________________________ LISTED: _____ UNLISTED_________

PLACE OF EMPLOYMENT: ____

WORK TELEPHONE NUMBER (S): _____________________ ______________________________

SOCIAL SECURITY NUMBER_________ _____ _________

EMEGENCY CONTACT NAME AND TELEPHONE NUMBER: ______________________________
____

MEDICAL INSURANCE

INSURANCE COMPANY NAME: _______________________ENROLLMENT DATE: ____________

INSURANCE I.D. NUMBER: ____

GROUP NUMBER: _______________________ SERVICE NUMBER: ___________________________

SUBSCRIBER FULL NAME: ____
OTHER INSURANCE? ____

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT IF YOU ARE NOT COVERED BY ANY INSURANCE COMPANY: ____

Please note that it is our policy to charge the full fee for an appointment, which has been missed, or an appointment, which has been canceled with less that 72 hours notice.

YOUR SIGNATURE: _______________________________________ DATE: ____________________

HOW DID YOU HEAR OF US?
_____ PHYSICIAN ____________________________
(name)_____ NO. VA YELLOW PAGES
_____OTHER____(please indicate)

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PERSONAL AND FAMILY HISTORY

PRESENT OCCUPATION:____

EMPLOYED BY:____

WORK ADDRESS:____

YEARS AT THIS OCCUPATION:__________________ HOURS PER WEEK:_________________

I AM NOW:_____________SINGLE_____________ WIDOWED__________ SEPERATED (for how long____?)

_____________MARRIED___________DIVORCED (for how long______?)

PRESENT LIVING ARANGEMENTS:

______ I PRESENTLY LIVE ALONE.

______ I PRESENTLY LIVE WITH SPOUSE NAMED:___________________________________

AGES OF CHILDREN, IF ANY: BOYS: _____ _____ _____ _____

GIRLS: _____ _____ _____ _____

SPOUSE'S OCCUPATION:____

EMPLOYER:________________________ADDRES:____

____________________________________ PHONE NUMBER:___________________________________

I PRESENTLY LIVE WITH RELATIVES OR FRIENDS. LIST RELATIONSHIP AND AGE (S) OF ANYONE IN YOUR PRESENT HOUSEHOLD NOT LISTED ABOVE:

RELATIONSHIP:____

AGE: _______ _______ _______

PAST PERSONAL HISTORY: family background

BIRTHPLACE (city, state):___________________________AGE:_________________

FATHER'S NAME:_______________________ MOTHER'S NAME___________ AGE:_______

OCCUPATION:_________________________ OCCUPATION:___________________________

PRESENT ILLNESSES:___________________ PRESENT ILLNESSES:_____________________

_______________________________________ ____

_______________________________________ ____

CAUSE OF DEATH IF DECEASED:________ CAUSE OF DEATH IF DECEASED:____________

_______________________________________ ____

_______________________________________ ____

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PAST PERSONAL HISTORY (continued)

Please list PRESENT ages of brothers and sisters you lived with when you were growing up, beginning with the oldest, and listing yourself, but circle your own age. If any of your brothers or sisters are now dead, please list the year they died next to their age at that time. If any had psychiatric problems, please check the space below their name.

(DO NOT SHOW YOUR NAME OR THAT OF ANYONE ELSE, UNLESS THAT INFORMATION IS SPECIFICALLY REQUESTED.)

BROTHERS (ages): _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Psych. Problems: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

SISTERS (age): _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Psych. Problems: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

YOUR EDUCATION LEVEL: Circle highest grade completed.

5 6 7 8 9 10 11 12 COLLEGE 1 2 3 4

LIST ANY DEGREES:____
ANY MAJOR (specialty):____

YOUR MEDICAL HISTORY:

NAME, ADDRESS AND PHONE NUMBER OF FAMILY PHYSICIAN:

________________________ __________________________ ______________________

________________________ __________________________ ______________________

OTHER PHYSICIANS YOU HAVE CONSULTED, OR CLINICS YOU HAVE ATTENDED IN THE PAST YEAR:

NAME	ADDRESS & PHONE NUMBER	PROBLEM

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YOUR MEDICAL HISTORY (continued):

PAST HOSPITALIZATIONS, if any. List the most recent first.

DATE	NUMBER OF DAYS	NAME OF HOSPITAL	NAME OF DOCTOR	REASON
______	________	_____________________	____________________	_________
______	________	_____________________	____________________	________
______	________	_____________________	____________________	_________
______	________	_____________________	____________________	_________

PAST PSYCHIATRIC TREATMENT, 9if any). List name of psychiatrist or clinic starting with the most recent:

APPROX. DATE STARTED	LENGTH OF TREATMENT	NAME OF PSYCHIATRIST, CLINIC OR HOSPITAL
__________	____________	____
__________	____________	____
__________	____________	____

ALLERGIES : List any medications or substances you have ever had an allergic reaction to:

NAME OF MEDICINE	TYPE OF REACTION
___________________	____
___________________	____
___________________	____

______ AS FAR AS I KNOW, I AM NOT ALLERGIC TO ANY MEDICATION OR SUBSTANCE.

PRESENT MEDICATIONS: (List names of any medication you are presently taking.)

NAME	DOSAGE	HOW OFTEN	HOW LONG	NAME OF THE PHYSICIAN
__________	_______	___________	__________	______________________________
__________	_______	___________	__________	______________________________
__________	_______	___________	__________	______________________________
__________	_______	___________	__________	______________________________

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YOUR MEDICAL HISTORY: (continued)

Please check YES or NO to indicate if you have or have not ever experienced any of the following:

YES		NO
____	HEADACHES THAT LASTED MORE THAN A DAY	____
____	DOUBLE VISION (SEEING DOUBLE)	____
____	FAINTING SPELLS	____
____	SIEZURES, FITS, OR CONVULSIONS	____
____	ANY HEAD INJURY AFTER WHICH YOU WERE UNCONSCIOUS	____
____	DIFFICULTY FALLING ASLEEP MOE THAN ONE NIGHT IN A ROW	____
____	LOSS OF APPETITE FOR MORE THAN A WEEK	____
____	FEELING SAD OR BLUE FOR A WEEK OR MORE	____
____	FEELING TIRED FOR A WEEK OR MORE	____
____	LOSS OF MEMORY	____
____	CHEST PAIN	____
____	STOMACH PAIN THAT LASTED MORE THAN A WEEK	____
____	SUSPENDED FROM SCHOOL	____
____	LOST A JOB	____
____	HAD MORE THAN YOUR USUALAMOUNT OF ENERGY FOR A WEEK OR MORE	____
____	DRANK MORE ALCOHOL THAN YOU THOUGHT YOU SHOULD	____
____	FELT SAD AFTER THE DEATH OF SOMEONE YOU LIKED	____
____	HAD TROUBLE BREATHING	____
____	BEEN TOLD YOU HAD HIGH BLOOD PRESSURE OR HEART TROUBLE	____
____	BEEN TOLD YOU HAD A LOW BLOOD COUNT	____
____	BEEN TOLD YOU HAD DIABETES	____

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MEDICATION:

Please check if you have ever used, or have ever taken, any of the drugs or medications listed below:

___	Aldomet	___	Reserpine	___	Serpasil	___	Aldochlor
___	Aldoril	___	Butiserpazide	___	Butiserpine	___	Diupres
___	Diutensin-R	___	Eskaserp	___	Exna-R	___	Hydromos-R
___	Hydropes	___	Metatensin	___	Naquivil	___	Rau-Sed
___	Regrotron	___	Renese-R	___	Salutensin	___	Ser-Ap-Es
___	Solfo-Serpine	___	Unitensin-R	___	Hydrocortisone	___	Steroids
___	Librium	___	Valium	___	Miltown	___	Merprobamate
___	Librax	___	Serax	___	Libritabs	___	SK-Bamate
___	Equanil	___	Xanax	___	Deprol	___	Paradione
___	Dilantin	___	Phenobarbital	___	Mysoline	___	Mesantoin
___	Tegretol	___	Mebaral	___	Tridione	___	Deprol
___	Depakote	___	Aventyl	___	Elavil	___	Parnate
___	Etrafon	___	Nardil	___	Norpramin	___	Tofranil
___	Pertofrane	___	Presamine	___	Sinequan	___	Lithium
___	Triavil	___	Vivactil	___	Vistaril	___	Prolixin
___	Haldol	___	Atarax	___	Clozaril	___	Stelazine
___	Compazine	___	Mellaril	___	Serentil	___	Trilafon
___	Quide	___	Risperdol	___	Triavil	___	Loxitane
___	Thorazine	___	Tindal	___	Vicodin	___	Levo-Dromoran
___	Navane	___	Taractan	___	Dolophine	___	Pantopon
___	Daxolin	___	Dilaudid	___	Numorphan	___	Alprazolam
___	Demerol	___	Nisentil	___	Darvon	___	Talwin
___	Mepergan	___	Percodan	___	Quaalude	___	Talwin
___	Percobarb	___	Doriden	___	Sominex	___	Phenergan
___	Seconal	___	Dalmane	___	Parest	___	Phen cyclidine
___	Nodular	___	Valmid	___	Marijuana	___	Desyrel
___	Placidyl	___	Methadone	___	Purple Haze	___	Prozac
___	Alcohol	___	Killer Weed	___	K. W.	___	Crystal
___	PCP	___	Wacky Weed	___	Ritalin	___	Angel dust
___	Crystal THC	___	Tenuate	___	Methedrine	___	Amphetamine
___	Dexedrine	___	“uppers”	___	Paxil	___	Methamphetamine
___	Speed	___	Supergrass	___	Fluoxetine	___	Cocaine
___	Black Beauty	___	Antabuse	___	Parlodel	___	Crack Cocaine
___	Sleeping pills	___	Wellbutrin	___	Synthroid	___	Zoloft
	___	Trazodone	___	L-Thyroxine	Other:		