



# LEGACY CENTER

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## Patient Registration Form

### PATIENT INFORMATION

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

List all Phone #'s you authorize Legacy to leave you messages: \_\_\_\_\_

E-mail: \_\_\_\_\_

I authorize Legacy to send Newsletters and/or program updates via e-mail and/or mail:  Yes  No

### INSURANCE DATA

Insurance Company Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### REFERRAL INFORMATION

Referral Source \_\_\_\_\_

Briefly describe the reason for the referral: \_\_\_\_\_

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## FAMILY HISTORY

List family members living in your home:

Name	Gender	Age	Relationship to Patient

Are there learning or education problems with any of your siblings, parents, extended family? Please describe the nature of problems? \_\_\_\_\_

\_\_\_\_\_

Are there mental health problems with any of your siblings, parents, extended family? Describe the nature of problems? \_\_\_\_\_

\_\_\_\_\_

Are there behavior problems with siblings, parents, extended family? \_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

Provider Prescribing Medication: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Medication			
Type	Dosage	Date Began	Date Ended

Describe any significant illnesses, surgeries, head injuries, and/or allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

List concerns regarding your vision: \_\_\_\_\_

List concerns regarding your hearing: \_\_\_\_\_

**TREATMENT HISTORY**

Evaluation/Counseling Provider	Type of Service (e.g., counseling, occupational therapy, physical therapy, speech therapy, etc.)	Dates of Service

## BEHAVIOR HISTORY

Concerns regarding your sleep patterns: \_\_\_\_\_

\_\_\_\_\_

Concerns regarding your appetite: \_\_\_\_\_

\_\_\_\_\_

List some of your strengths: \_\_\_\_\_

\_\_\_\_\_

Describe your typical mood: \_\_\_\_\_

\_\_\_\_\_

List your main counseling and treatment goals:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_