Patient Registration Information Date:_____

PLEASE PROVIDE AS LEGIBLE AS POSSIBLE THE FOLLOWING INFORMATION

Patient Name: _____Date of Birth:_____

Social Security Number:_____ Sex: Male / Female

Street Address:_____

City:_____ State: _____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____ Work Phone:_____

Employer: _____ Occupation: _____

Marital Status:_____ Spouse's Name:_____

Referral Source: _____

Notify In Case of Emergency

Name:_____ Relationship:_____

Street Address:_____

City:_____ State:_____ Zip:_____

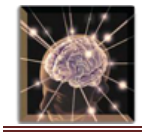
Primary Phone Number: _____ Work Phone:_____

Patients Under 18

I,_____, swear that I am the legal custodial guardian of the child, _____. Unless otherwise specified, NO information, including but not limited to: appointment information, medical records information, or any personal information shall be released to anyone other than the named guardian above.

This information is confidential and will be treated with respect. If at any time you wish to release information to anyone, including yourself, you will be required to sign a written release of information. Please be aware that Arizona law permits non-custodial parents access to their children's mental health and medical records. Please be aware that supplying our facility with false or misleading information is a felonious act and will be treated as such.

Parent/Guardian Signature:_____



MindSource Centre

Responsible Party/Primary Card Holder

Name: _____ Date of Birth:_____

Relationship:_____ Social Security Number:_____

Address:_____

City:_____State:_____Zip:_____

Primary Phone:_____ Work Phone:_____

Insurance Information

Primary Behavioral Health Insurance: _____ Or Self Pay

Identification Number:_____ Group Number:_____

Insurance Provider (Mental Health) Phone Number:_____

Authorization Number (If Applicable):_____

Secondary Behavioral Health Insurance:_____

Identification Number:_____ Group Number:_____

Insurance Provider (Mental Health) Phone Number:_____

I authorize the release of any of my medical, psychiatric or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefits or mental health benefits to the physician or supplier of services rendered. I fully understand that if my insurance denies payment for any services defined as non-covered service, I will be responsible for any amount due. I further understand if my account gets referred to or placed with a collection agency that I will be fully responsible for all fees assessed with collections.

Print Name:_____ Date:_____

Sign:_____

Medical History

Patient Name:_____ Date of Birth:_____

Name of Primary Care physician: _____

Medication Allergies:

Any Surgeries (continue on back if necessary):

Have you ever had any of the following? Please circle all that apply

Epilepsy or Seizures
Stroke or TIA
Head Injury
Loss of Consciousness
Glaucoma
Difficulty Hearing
Tinnitus or Chronic Ear Ringing
Frequent Headaches
Heart Attack or Angina
Any Heart Problems
Ankle swelling
High Blood Pressure
Bleeding or Clotting Disorders
Currently on Blood Thinners
Coughing up blood
Asthma
Exposure to Tuberculosis
Lung Disease (other than Asthma)
Allergies
Hepatitis (A, B, C)
GERD or Acid Reflux
Stomach Issues
Irritable Bowel Syndrome (IBS)
Recent Blood in Stool
Recent Dark Black/Tarry Stool
Frequent Constipation
Regular Diarrhea
HIV Positive or AIDS
Cancer (Specify:_____)

High Cholesterol
Diabetes
Thyroid Issues
Changes in Hair Growth Patterns
Heavy Menstrual Periods
Night Sweats
Difficulty Urinating
Incontinence
Blood in Urine
Kidney Disease
Arthritis
Swollen Glands
Skin Rashes
Trouble Sleeping
Dieting
Attempted Suicide (Number of times:_____)
Eating Disorder
Smoke or Nicotine Addiction
Use Illicit Drugs
Alcohol Abuse
Medication Abuse
Pregnant
Sexually Active
Low or High Libido
Difficulty Achieving Orgasm
Difficulty with Arousal/Erections
Date of Last Pap Smear:_____
Date of Last Blood Work:_____

MindSource Centre

SSRI's & Others
Fetzima / I-milnacipran
Brintellix / Vortioxetine
Viibryd / vilzoddone
Prozac / fluoxetine
Paxil / paroxetine
Zolof t / sertaline
Celexa / citalopram
Lexapro / s-citalopram
Luvox / fluvoxamine
Cymbalta / duloxetine
Effexor / venlafaxine
Effexor XR
Pristiq / desvenlafaxine
Wellbutrin / buproprion
Wellbutrin SR / buproprion SR
Wellbutrin XL
Zyban / buproprion
Remeron / mirtazapine
Serzone / nefazodone
Reboxetine (Canada)
Stablon (UK)
Savella / milnacipran
Valdoxan
Vit D3 400-800 IU

ADJUNTIVE & SGA'S
Risperdal / risperidone
Zyprexa / olanzapine
Seroquel / quetiapine
Clozaril / clozapine
Geodone / ziprasidone
Abilify / aripiprazole
Latuda / lurasidone
Fanapt / lloperidone
Saphris

Vitamin E 1600 IU
Amino acids / tarvil

TYPICAL AP'S

ANTI ANXIETY AGENTS
Xanax / alprazolam
Ativan / lorazepam
Klonopin / clonazepam
Serax / oxazepm
Tranxene / clorazepate
Librium / chlordiazepoxide
Valium / diazepam
Other BZD

Theonine

SLEEP AIDS
Desyrel / Trazodone
Ambien / zolpidem
Sonata / zaleplon
Lunesta / eszopiclone
Xyrem / sodium oxybate
Prosom / estazolam
Restoril / temazepam
Dalmane / fluazepam
Somnote / chloral hydrate
Halcion / triazolam
Rozerem / ramelteon
Doral / quazepam
Melatonin
Valerian
Benadryl / diphenhydramine
L-TRP / tryptophan
Hydroxy-TRP

SEXUAL DYSFUNCTION AGENTS
Viagra / sildenafil
Levitra / vardenafil
Cialis / fadalafil
CP Testosterone
1% / androgel / androderm
Dream cream / Reed's pharmacy

TRICYCLIC ANTIDEPRESSANT(TCA'S)
Anafranil / clompramine
Pamelor / nortriptyline
Elavil / amitriptyline
Nopramin / desipramine
Tofranil / Imipramine
Sinequan / doxepin
Vivactil / protriptyline
Ludiomil / maprotyline
Surmontil / Trimipramine

MAOI'S
Parnate / tranylcypramine
Nardil / phenelzine
Marplan / isocarboxazid
Eldepryl / selegiline
EMSAM patch

MOOD STABILIZERS / AED'S
Lithium / Eskalith CR / Lithobid
Equetro / CBZ-ER
Tegretol / carbamazepine
Carbitrol
Trileptol / oxcarbamazepine
Depakote ER
Lamictal / lamotragine
Neurotin / Gabapentin
Lyrica / pregabalin
Topamax / topiramate
Gabitril / tiagabine
Dilantin / phenytoin
Primidone
Mexitil

STIMULANTS, ECT
Vyvanse
Intuniv
Dexedrine / dexroamphetamine
Desoxyn / methamphetamine
Provigil / modafenil
Nuvigil / armodafenil
Ritalin / methylphenidate
Ritalin SR/LA
Daytrana Ritalin patch
Adderal
Adderal XR
Concerta / methylphenidate ER
Cylert
Strattera / atamoxetine
Focalin

AUGMENTERS
Lithium / Eskalith CR / Lithobid
Cytomel / T3
Lamictal / lamotragine
Buspar / lamotragine
Pindolol
Marinol / dronabinol
Folate
Fish oil / omega 3 fatty acids
Vitamin B12

ALTERNATIVE TREATMENTS
St. John's Wort
SAME 400mg BID
Transcranial Magnetic Stimulation
Vagal Nerve Stimulation
ECT
Buprenorphiphine

DRY MOUTH
Urecholine / betanechol
Orajel
Biotene
Pilocarpine / salagen

SWEATING
Clonidine

BRUXISM
Requip
Buspar

Nightmares
Prazosin

DRUG ABUSE TREATMENTS
Campral / acamprosate
Revia / Naltrexone
Antabuse / disulfuram
Suboxone / buprenorphine / naloxone
Subutex / buprenorphone
Chantix / varenicline
Vivitrol / naltrexone

Patient Name:_____ Date:_____