THE QUEEN'S MEDICAL CENTER

Queen's Counseling Services, Kaheiheimalie Building, 3rd Floor
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QueensCounselingServices@queens.org

Queen's Counseling Services PRE-REGISTRATION FORM

To register with the clinic, complete this form and email to **QueensCounselingServices@queens.org** or print and mail to the above address. If you are having trouble filling out the form properly on your phone or computer, you may need to download Adobe Acrobat Reader (free app). We look forward to meeting you!

Demographic Information			
Today's Date:			
Legal Name:		SSN:	
Date of Birth:	Age:	Gender:	
Phone Number:		Marital Status:	
Email:		-	
Address:			
Describe your current living arrangements:			
Emergency Contact Name and number:			
Past Treatment Information			
Have you ever received mental health treatment before: - If YES please answer below			
When?			
What for?			
What Provider?			
What helped?			
Do you have Case Management Services - What agency?			
Have you had any past psychiatric hospitalizations? - When?			
Any past residential substance use treatment? - When/where?			
Current Reason for Seeking Treatment			
Briefly describe the reason you are currently seeking treatment:			
When did this begin?			
What makes it worse?			
What makes it better?			
What change can we help you make in yourself? (Goals for treatment)			

Personal Information			
Do you have children? -	How many?	Ages:	
What do you consider some of your strengths?			
Highest Level of Education Completed:			
List people that are helpful for you:			
Employment status: ☐ Fulltime ☐ Part-time ☐ Not currently working ☐ Caring for family			
Primary Care Physician:		Phone#:	
When was your last visit:			
Do you have medical insurance? -	Company:	Member ID:	
Policy holder name (if different than patient):		Group #:	
Please list any current medical problems:			
Have you been a victim of abuse? ☐ Physical ☐ Sexual ☐ Verbal ☐ Emotional ☐ Psychological			
Are you currently being threatened, hurt, or abused by anyone -			
Do you feel safe in your home -			
Do you use drugs or alcohol? -	If yes please list below		

Substance	How often	Date of recent use

Do you have family members that have struggled with an emotional or mental disorder? -	
If Yes please list below:	
Relation	Disorder

Please list any medications are you currently taking below prescribed/non-prescribed			
Medication name	Start Date	Dose and schedule	Reason prescribed

Please list any additional information you would like us to know: