

COMPASSIONATE MENTAL HEALTH NURSING INC.  
Address: 5050 Palo Verde St, Suite 103I, Montclair, CA 91763  
Phone: (714) 262-4778 | Fax: (863) 228-8446

### Patient Registration

#### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender:  Male,  Female,  Transgender,  Gay,  Lesbian,  Non-binary  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_  
Primary Phone to Contact:  Home,  Cell,  Work  
Email: \_\_\_\_\_

**Responsible Party**  Self,  Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_

#### Emergency Contact

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

#### Insurance Information

Primary Insurance \_\_\_\_\_  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

## Intake Form

### How did you hear about our practice?

- Insurance platform (Headway, Alma, etc.)
  - Google / Website
  - Referral (provider, therapist, friend)
  - Other: \_\_\_\_\_
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### Reason for seeking care (brief):

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### Preferred pharmacy (name and address):

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### Have you seen a mental health provider before?

- No
  - Yes → When and for what reason?
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### Current and past psychiatric medications (include dose if known):


### Other prescription medications you currently take:


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### Have you ever been admitted to a psychiatric hospital?

- No
  - Yes → Reason and approximate date:
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**Do you currently use alcohol and/or recreational drugs?**

If yes, describe your relationship to these substances.

- No
  - Yes
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**Have you ever been treated or gotten recovery support for concerns related to substance use or abuse?**

If yes, describe your experience(s) with substance use or abuse.

- No
  - Yes
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**Is there a history of mental illness in your family? Yes or no.**

If yes, please describe the history of mental illness in your family.

- No
  - Yes
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**Describe your current living situation.**

Do you live alone or with others? Do you live with family members?

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**If you are in a relationship, describe the nature of the relationship and how long you've been together.**

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**What else would you like me to know?**

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