Xenia Protopopescu MD PhD
NYU BHP / 1 Park Avenue, 8th Floor / NY, NY 10016
tel 646-363-6590

CLIENT REGISTRATION

Date _____/_____/_____ Name _____

Preferred phone: _____ [ ] cell [ ] home [ ] work [ ] other

Permission to leave detailed messages on this phone? [ ] yes [ ] no

Other phone: _____ [ ] cell [ ] home [ ] work [ ] other

Permission to leave detailed messages on this phone? [ ] yes [ ] no

Mailing Address: _____

Street Address, if different: _____

Email address: _____ Gender [ ] male [ ] female

Age _____ Date of Birth ____/_____/____ Social Security number_____-_____-_____

Relationship Status [ ] single [ ] married/partner [ ] separated [ ] divorced [ ] widowed

Referred by: _____ Phone: _____

Address: _____

Current Therapist: _____ Phone: _____

Primary Care Provider/other: _____ Phone: _____

PCP Address: _____

May we exchange information with your treating physicians to coordinate your care?

Therapist [ ] yes [ ] no PCP [ ] yes [ ] no OB/GYN [ ] yes [ ] no

Pharmacy: _____ Phone:_____

Emergency contact:_____ Phone:_____

Person responsible for payment, if other than client:

_____

Relationship:_____ Phone:_____

Address:_____

MEDICAL HISTORY

Previously diagnosed medical conditions:

_____

_____

_____

Any history of head injury? _____

Allergies (indicate what sort of reaction to each medication):

_____

_____

Medications you are currently taking (continue on back if needed):

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Psychiatric medications in the past (indicate if any were especially helpful or caused problems):

_____

_____

_____

How many days in a week do you drink alcohol (e.g. beer, wine, cocktails)?

_____

How many alcoholic drinks do you drink in a day? Typical:_____

Max:_____

Any history of blackouts from alcohol?

_____

Any history withdrawal symptoms (e.g. tremors, seizures)?

_____

Has alcohol ever caused problems for you?

_____

How many caffeinated beverages (coffee, Coke/Pepsi/etc.) do you drink each day?

_____

Do you or have you ever smoked?_____

Packs per day?_____ Years smoked?_____ Date quit? _____

Have you ever used (please circle)?

Marijuana Cocaine Heroin Ecstasy LSD Mushrooms PCP Ketamine Opiates

other:_____

Has use of any of the above caused problems for you?

_____

PRIOR PSYCHIATRIC TREATMENT

Please describe any prior psychiatric treatment, including any hospitalizations and substance abuse treatment:

_____

_____

_____

_____

_____

Why are you seeking help at this time?

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

_____

_____

_____

EDUCATION

Degree(s) earned

_____

Any learning problems in school?

_____

Any behavioral or hyperactivity problems in school?

_____

RECENT WORK HISTORY

_____

_____

_____

Current Occupation?

_____ Employer?

_____

FAMILY INFORMATION

	Name	Living with you	Medical History	Age Deceased	Current Age
Spouse or partner					
Children					
Mother					
Father					
Siblings					

Is there anyone else living with you not mentioned above?

_____

Does anyone in your family have psychiatric illness (anxiety, depression, substance, or other diagnoses)?

_____

Do you have difficulties in any of your relationships?

_____

Symptom Checklist

Please check the column that best describes how frequently you have experienced each of the symptoms below.

Symptom	Never	Rarely	Sometimes	Often
Depressed Mood				
Difficulty sleeping				
Overeating				
Decreased appetite				
Difficulty concentrating				
Low energy				
Low self-esteem				
Wanting to harm yourself				
Harm to self				
Premenstrual symptoms				
Mood swings				
Unusually high energy				
Excessive risk-taking				
Difficulty controlling anger				
Wanting to harm others				
Hearing things not there				
Seeing things not there				
Anxiety				
Feeling panicked				
Intense Fears (planes, heights,				
Fear of social situations				
Fear of leaving the house				
Fear of being sick				
Fear of dying				
Physical pain				
Doing things over and over				
Frequent nightmares				
Difficulty with memory				
Feeling detached from others				
Sexual difficulties				
Fear of being overweight				
Vomiting/purging				
Addictive behavior				