Abigail Enelow Myers

MN, ARNP

2910 E. Madison Street, #206

Seattle, WA 98112

R E G I S T R A T I O N

Date: ________________________ DSM V/ICD 10: ____________________

Name: ____

Address: ____

City, State, Zip: ____

Cell phone: ________________________________ OK to leave message? _______________

Home phone: ________________________________ OK to leave message? _______________

Email: ____

Date of birth: ______________________________

Emergency contact name and phone: ____

____

Occupation: ____

Employed? __________________ Employer: ____

At-home parent? _____________ Maternity leave? _____________ Retired? _____________

Referred by: ____

Abigail Enelow Myers, MN, ARNP

ASSIGNMENT AND RELEASE:

I, the undersigned, certify that I have insurance coverage with ______________________

and assign all insurance payments directly to Abigail Enelow Myers, MN, ARNP, for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the provider to release all information necessary to secure payment of benefits.

Signature/Date: ____

INSURANCE:

Primary subscriber:_______________________________ Date of birth:________________

Insurance company: ____
(We bill Regence and Premera)

For other insurance, payment is due upon service and statement will be provided

Subscriber number (include letters):____

Group number: __________________________________

Insurance company phone number: ____

Abigail Enelow Myers, MN, ARNP

HEALTH HISTORY:

Please describe your main reasons for coming in today: ________________________________

____

____

____

____

Primary care provider: ____

OB/Midwife (if applicable): ____

Medical diagnoses and Medications currently taken (non psychiatric):

Medical problems:	Non-psychiatric medications:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Allergies to medications? ____

Date of last blood draw: ________________________

Thyroid checked? ____________________________ Normal / Abnomral

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Have you ever been diagnosed with or suspected of having any of the following (include approximate dates):

1. Depression: ______ Dates (approximate): ______________________________
2. Anxiety:______ Date of diagnosis: ______________________________
3. Bipolar disorder: ______ Date of diagnosis: ______________________________
4. OCD:______ Date of diagnosis: ______________________________
5. Alcoholism and/or other drug addiction (specify): ______________________________
6. Eating disorder: Anorexia: ______Bulimia: ______Binge eating: ______Dates: __________
7. Panic disorder: ______ Dates: ______________________ ____________
8. Self-harm (specify cutting or other): ______________________ Dates: __________
9. Postpartum depression/anxiety: ________________ Dates:______________________
10. ADD/ADHD: ________________ Dates: __________
11. PTSD: ________________ Dates: ______________

Are you currently in therapy? ______

OK to contact?_______ *If so, you will need to sign a release (ROI)*

Therapist's name and phone:____

History of therapy (include dates):

____

____

Current psychiatric medications (dosages, how long, who prescribed):

____

____

____

Past psychiatric medications (dosages, dates, who prescribed):

____

____

____

____

____

Have you ever been hospitalized for psychiatric reasons? (yes/no/dates):

____

____

Have you ever had suicidal thoughts or suicide attempts? (yes/no/dates):

____

____

Alcohol/drug history (yours): ______________________________

____

____

Current alcohol use per day: __________ Per week: ________ Binge drinking?: ______

Have you thought you should cut back? ________________________

Current marijuana use per day: _________ Per week: _______

Other current recreational drugs: ________________________

Have you thought you should cut back? ________________________

RELATIONSHIPS:

married: _______ partnered: ______ divorced: ______ widowed: _____ single: _____

Length of current relationship: ________________________

How happy/satisfied with the relationship? ________________________

____

____

If you have children, please give ages, gender, health of each (specify biological, adopted, step):

____

____________________ ____________________

____________________ ____________________

Anything else you'd like to add? ________________________

____

____

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FAMILY MENTAL HEALTH HISTORY:

Parents (married/divorced/widowed):________________________________

If divorced, how old were you? ________________________________

If parents and/or siblings are deceased, please list your and their age at death and cause:

____

____

Your siblings and their ages (include and specify half- and step-siblings): ________________

____

____

List any **blood relatives** who have been **diagnosed with or suspected of having** any of the following:

1. Depression: ________________________________
2. Anxiety:________________________________
3. Bipolar disorder: ________________________________
4. OCD:________________________________
5. Alcoholism and/or other drug addiction (specify):____________________
6. Suicide: ________________________________
7. Eating disorders: ________________________________
8. Panic disorder: ________________________________
9. Self-harm (specify cutting or other): ________________________
10. Postpartum depression:________________________________
11. ADD/ADHD: ________________________________
12. PTSD: ________________________________

List medical diseases that run in your family: ________________________

____

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