FRONTIER HEALTH AND WELLNESS, LLC

Patient Registration Form – Adult

Date			
Patient Full Legal Name (First, Middle Initial, Last)	Prefix	Suffix	Previous Name(s)/Alias:
Previous Name(s):	Date of Birth	Age	Sex
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other	Preferred Pronoun	Gender Identity	
Patient Preferred Phone Number Can we leave a Voicemail? ☐ Yes ☐ No	Secondary Number: ☐ Home ☐ Work ☐ Other	Last 4 of SS#	
Physical Address	City, State	Zip Code	
Mailing Address	City, State	Zip Code	
Occupation	Employer	Contact Number	

Reason for choosing Frontier Health and Wellness ☐ Recommendation from Family/Friend ☐ Location/Convenience ☐ Referral from Another Provider ☐ Search Engine ☐ Insurance ☐ Other		
If referred by hospital or clinician, please list who:		
Preferred Pharmacy	Address	Contact Number
Emergency Contact	Relationship	Contact Number

Please Do Not Include Information on Denali KidCare, Medicaid, or Medicare - We Do Not Accept These Plans

Financially Responsible Party (if other than patient)	Address	Contact Number

Primary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name If same, please do not complete the next 2 rows	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patient's Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4
Secondary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name If same, please do not complete the next 2 rows	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patient's Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4

I certify that my answers are true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to my provider. I understand that I am financially responsible for any balance accrued. I also authorize Frontier Health and Wellness and/or its Contracted Providers to release any information required to process my claims.

Patient Signature: _____ Date:_____

Frontier Health and Wellness

Patient History Questionnaire (Adult)

To better assist our providers, we are asking that you complete the following questionnaire prior to your initial appointment. If you need more space, please feel free to add pages as needed.

Patient Name: _____ Date of Birth: _____

Please provide a list of your previous (last 5 years) and current medical and mental health providers

Provider Type	Provider Name	Clinic/Hospital Name	Phone Number	Location (City/State)
Primary Care Provider N/A				
Previous Primary Care Provider (last 5 years) N/A				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) N/A				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) N/A				
Therapy N/A				
Psychiatry N/A				
Neuropsych Testing N/A				
Other: N/A				
Other: N/A				

Please list all the medications you are currently taking: ☐ N/A

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all of your previous psychiatric medication: ☐ N/A

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all supplements/over the counter medications you are currently taking: __ N/A

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list any of your known allergies as well as the reaction that occurs: ☐ **No known allergies**

Allergen	Severity of Reaction			Type of Reaction
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	

Current or previous substance use: ☐ N/A

Substance	Frequency of Use					
Caffeine	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Tobacco/Vaping	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Alcohol	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Opioids/ Prescription Drugs	Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	__ Tried it once or twice	☐ Never
Marijuana	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Hallucinogens	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Amphetamines	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Other:	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never

Frontier Health and Wellness

Patient History Questionnaire (Adult)

Family Medical History: __ N/A

Medical Condition	Patient or Family History	Please list the Family Member(s) affected
Anemia	☐ Patient ☐ Family History	
Asthma/Respiratory Concerns	☐ Patient ☐ Family History	
Cancer	☐ Patient ☐ Family History	
Chronic Fatigue	☐ Patient ☐ Family History	
Concussion(s) or TBI	☐ Patient ☐ Family History	
Diabetes	☐ Patient ☐ Family History	
Epilepsy/Seizures	☐ Patient ☐ Family History	
Heart Disease/Condition	☐ Patient ☐ Family History	
High Blood Pressure	☐ Patient ☐ Family History	
Insomnia	☐ Patient ☐ Family History	
Stomach/ GI Problems	☐ Patient ☐ Family History	
Stroke	☐ Patient ☐ Family History	
Substance Abuse	☐ Patient ☐ Family History	
Thyroid Disease	☐ Patient ☐ Family History	

Psychiatric history: ☐ N/A

Psychiatric Condition	Patient or Family History	Please list the Family Member(s) affected
ADHD	☐ Patient ☐ Family History	
Anger	☐ Patient ☐ Family History	
Anxiety	☐ Patient ☐ Family History	
Bi-Polar Disorder	☐ Patient ☐ Family History	
Depression	☐ Patient ☐ Family History	
Inpatient Psychiatric Care	☐ Patient ☐ Family History	
OCD	☐ Patient ☐ Family History	
PTSD	☐ Patient ☐ Family History	
Schizophrenia	☐ Patient ☐ Family History	
Suicide	☐ Patient ☐ Family History	

Please list any of your surgical history or hospitalizations | N/A

Surgery/Reason for Hospitalization	Date(s)	Hospital	Doctor/Attending	Location (City, State)

Have you had any bloodwork completed within the last 6 months (if yes, who ordered the labs to be drawn): ☐ Yes ☐ No

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Frontier Health and Wellness

Presenting Problems and Symptoms Checklist - Adult

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Sad most of the day				
Not interested in activities that used to be fun				
Cannot fall asleep most of the time				
Sleeping more than usual				
Loss of energy				
Do not spend as much time with friends as usual				
Do not bathe or clean self regularly				
Eating more than usual				
Blaming self				
Acting angry much of the time				
Acting unusually happy much of the time				
At times needing little or no sleep				
An Increase in Intrusive and Unwanted Sexual Behavior				
Talking so fast it is hard to understand				
Tense, nervous, worrying much of the time				
Panic Attacks: heart pounding, can't breathe, sweating				

_____ _____

Client Name (Print) Date

Frontier Health and Wellness

Presenting Problems and Symptoms Checklist - Adult

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Saw or had something bad or scary happen				
Often remembering something bad or scary happening				
Having bad dreams over and over				
Easily upset when reminded of something bad or scary				
Staying away from or will not talk about things that remind you of something bad or scary that happened				
Jumpy or scared easily				
Doing things over and over without a clear reason i.e. washing hands, touching things, checking locked doors				
Having problems paying attention				
Easily distracted				
Often forgetful				
Often fidgeting with hands or feet				
Lots of physical movement				
Talking a lot				
Problems at work				
Often acting without thinking				
Often loses temper				

_____ _____

Client Name (Print) Date

Frontier Health and Wellness

Presenting Problems Checklist - Adult

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Often found arguing				
Difficulties following rules or directions				
Bullying, threatening or intimidating others				
Starting physical fights				
Destroying property				
Stealing				
Lying				
Abandoning responsibilities				
Cruelty to others				
Fire setting				
Disciplinary actions at work				
Change in work performance				
Uncomfortable making eye contact with others				
Having problems communicating				
Repeating same movements over and over (i.e. wringing hands, rocking back and forth, snapping fingers)				
Difficulty noticing when others are trying to speak or interact with you				
No interest in making friends or interacting with others				

_____ _____

Client Name: Date

Frontier Health and Wellness

Presenting Problems Checklist - Adult

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Difficulties calming down when upset				
Unchangeable beliefs or ideas that others don't get/tolerate				
Hearing voices when no one is there				
Seeing things when nothing is there				
Voices tell you to harm self				
Voices tell you to harm others				
Talking with words that do not make sense to others				
People say you show little emotion on your face				
Refusal to maintain adequate body weight within normal range				
Very scared of gaining weight				
Others tell me I'm skinny but I still feel fat				
At times I eat way too much food				
People tell me I exercise way too much				
I take laxatives to lose weight				
I force myself to vomit				

_____ _____

Client Name Date