REGISTRATION
(PLEASE PRINT)

RAKESH JAIN, MD
2500 W William Cannon Drive, Suite 505
Austin, TX 78745
(512) 249-5001

Date _____ Preferred Contact Number _____ OK to leave message? ☐ Yes ☐ No

CLIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If married: Spouse Name _____ Spouse Age _____ Spouse Occupation _____

Client Employed by _____ Client Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Chief Complaint: _____

_____

_____

_____

PSYCHIATRIC HISTORY

Please list past hospitilizations/dates for psychiatric and substance abuse treatment:

Date	Facility (Name, City and State)	Type of Treatment

Please list any previous psychiatric conditions you have been diagnosed with in the past:

_____

_____

_____

Please list any family members with a history of psychiatric conditions:

Relationship	Condition

Are you currently under medical care for any reason? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

PSYCHIATRIC MEDICATIONS

Please list all past and current psychiatric/mental health medications you have taken or are taking:

Medication(s), Herb(s), or Supplement(s)	Dose (mg's, etc.)	Prescriber	Current	Past
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

CURRENT AND PREVIOUS HEALTHCARE PROVIDERS

Please list your current/previous healthcare providers below:

	CURRENT Provider Name	Phone	Fax
Primary Care Physician:			
Psychiatrist:			
Psychotherapist:			

	PREVIOUS Provider Name	Phone	Fax
Primary Care Physician:			
Psychiatrist:			
Psychotherapist:			

WOMEN ONLY

Please check any of the following that apply:

- ☐ I am pregnant (or trying to become pregnant)
- ☐ I have regular menstral periods
- ☐ I am perimenopausal
- ☐ I am menopausal
- ☐ I had a hysterectomy

	Yes	No
I have experienced variations in mood or anxiety level related to your menstraul period	☐	☐
I have experienced postpartum depression	☐	☐

SIGNATURE	DATE