CARE-LA

10323 Santa Monica Blvd., Suites 102 & 103
Los Angeles, CA 90025
(424) 421-CARE

PATIENT INFORMATION FORM

PERSONAL

Patient Name: _____

DOB: _____ Gender: _____ Pronouns: _____

Home Address: _____ Phone # Cell:_____

_____ Phone # Hm: _____

Email: _____

EMPLOYER

Employer: _____ Phone #: _____

Address: _____

EMERGENCY

In Case of Emergency Notify: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Psychiatrist: _____ Phone #: _____

MEDICAL PROBLEMS

MEDICATIONS PAST / PRESENT

PLEASE CIRCLE OR CHECK THE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sadness or Depression	☐	☐	☐	☐	Memory Problems	☐	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	☐	Compulsive Behavior	☐	☐	☐	☐
Sleep Problems	☐	☐	☐	☐	Feelings of Hostility	☐	☐	☐	☐
Change in Appetite	☐	☐	☐	☐	Acts of Violence	☐	☐	☐	☐
Weight Change	☐	☐	☐	☐	Social Isolation	☐	☐	☐	☐
Inability to Concentrate	☐	☐	☐	☐	Strange Thoughts	☐	☐	☐	☐
Obsessive Thoughts	☐	☐	☐	☐	Sexual Problems	☐	☐	☐	☐
Tension/Anxiety	☐	☐	☐	☐	Panic Attacks	☐	☐	☐	☐

PSYCHIATRIC HOSPITALIZATIONS (Please Circle or Check): ☐ YES ☐ NO

If yes, how many times? _____

What were the circumstances? _____

_____

_____

SUBSTANCE USE ASSESSMENT (Please Circle or Check):

Alcohol Use: ☐ Never ☐ 1-4 per month ☐ 2-3 per week ☐ Daily

Level of consumption: ☐ None ☐ 1-2 per sitting ☐ 3-4 per sitting ☐ 5 + per sitting

Substances of use: ☐ None ☐ Cocaine ☐ Marijuana ☐ Sedatives ☐ Stimulants ☐ Opiates ☐ Hallucinogens

Frequency of use: ☐ Never ☐ 1-4 per month ☐ 2-3 per week ☐ Daily

HOME LIFE:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Partner Name:

You & your spouse/partner's occupations:

Children's names and ages (if applicable)

Have there been any recent changes at home, such as separations, financial or home instabilities, changes in relationships, recent moves:

Have you, or anyone in the family, experienced any deaths, significant accidents, injuries, or hospitalizations? Please describe:

Have you experienced/witnessed any of the following: domestic violence, physical abuse, verbal abuse, or sexual abuse?

List and describe any family history of psychological or learning problems:

Please list any therapists or specialists that your child has seen previously:

SYMPTOMS:

Please check off all that apply:

- ☐ Seems depressed or blue
- ☐ Has little interest or pleasure in doing things
- ☐ Has difficulty falling asleep
- ☐ Has difficulty staying asleep through the night
- ☐ Not sleeping on his/her own
- ☐ Seems tired or has little energy
- ☐ Seems active or has too much energy
- ☐ Overeats
- ☐ Feels bad about himself/herself
- ☐ Has trouble concentrating
- ☐ Is forgetful
- ☐ Worries all the time
- ☐ Has panic attacks
- ☐ Cries more than expected for his/her age
- ☐ Has hallucinations or delusions
- ☐ Is Impulsive
- ☐ Cannot sit still
- ☐ Aggressive
- ☐ Uninterested in peers
- ☐ Picked on or bullied by peers
- ☐ Oppositional
- ☐ Difficult to discipline

Charges are due upon services rendered. I understand that I am financially responsible for the charges incurred for treatment including those not covered by my insurance plan(s).

The charge is made for the time reserved unless canceled a full 24 hours in advance.
Psychiatry appointments need to be canceled 48 hours in advance.

Patient Name: (printed)_____

Signature: _____ Date: _____

Witness: _____ Date: _____