CARE-LA

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

PERSONAL

Patient Name: ____

DOB: ____________ Gender: ______________ Pronouns: ____________

Accompanying Parent Name (If minor): ______________________________________

School and Grade (If minor): ____

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	0	1	2	3	Memory Problems	0	1	2	3
Suicidal Thoughts	0	1	2	3	Compulsive Behavior	0	1	2	3
Sleep Problems	0	1	2	3	Feelings of Hostility	0	1	2	3
Change in Appetite	0	1	2	3	Acts of Violence	0	1	2	3
Weight Change	0	1	2	3	Social Isolation	0	1	2	3
Inability to Concentrate	0	1	2	3	Strange Thoughts	0	1	2	3
Obsessive Thoughts	0	1	2	3	Sexual Problems	0	1	2	3
Tension/Anxiety	0	1	2	3	Panic Attacks	0	1	2	3

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			

INFORMATION ABOUT PARENTS:

☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Names:

Occupations:

HOME LIFE:

Language(s) spoken at home:

Siblings' names and ages (if applicable)

Does the child have any other caregivers (e.g., baby sitter, nanny, grandparent) and how much time do they spend with your child?

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

Has your child, or anyone in the family, experienced any deaths, significant accidents, injuries, or hospitalizations? Please describe:

Has your child experienced any of the following: witnessed domestic violence, physical abuse, verbal abuse, or sexual abuse?

Has either parent had problems with substance abuse or addiction?

DEVELOPMENTAL HISTORY:

Is your child:
□ biological □ adopted □ via surrogate

Describe any illnesses or complications that mother experienced during her pregnancy:

The child’s birth was:
□ full-term □ pre-term: (# of weeks) ______________
□ uncomplicated □ complicated: (describe) ______________________

Did the mother experience any post-partum depression?

Did the child reach developmental milestones on-time? If not, please describe below:

Describe any regional center or early intervention services that your child has received:

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

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

EDUCATIONAL HISTORY:

Current school:

Has the child's teacher had any complaints about his/her behavior, learning or social skills? If so, explain:

Please list any other schools the child has attended, and reasons for leaving:

Does your child receive any special education services?

Describe your child's friendships with others at school:

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 (Guardian if minor): ____

Signature: ____ Date: _____________________

Witness: ____ Date: _____________________