AZITA AFSHAR, PSY.D.

INTAKE/REGISTRATION FORM

Patient Information:

Name: _____

Date of Appointment:_____

Ethnicity: _____

Age:_____Birth Date:_____

Occupation: _____

Sex: _____ Female _____ Male

Sexual Orientation: _____

Referral Source:_____

Home Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____E-mail_____

Emergency Contact Name:_____ Number: _____

Intake Information

Primary Care Physician Name, Number and Address:

_____

_____

_____

_____

Are you taking any medications: Yes_____No_____

If yes, please list:

Medication Condition Prescribing Physician Dose Start Date

_____

_____

_____

_____

_____

What has brought you to therapy?

_____

_____

_____

_____

On the scale following please estimate the severity of your symptoms:

___Mildly upsetting ___Moderately upsetting ___Very severe ___Extremely severe

___Totally incapacitating

When did the problem(s) begin (give dates):

_____

_____

_____

Please describe significant event(s) occurring at that time, or since then which may relate to the development or maintenance of the problem(s):

_____

_____

_____

Have you been in psychotherapy before or received any prior professional assistance for the problem(s)? If so, please give name(s), professional title(s), date of treatments and results:

_____

_____

_____

_____

Please check any of the following that apply to you:

___Impulsive reactions ___Concentration problems

___Sleep disturbances ___Compulsions or Obsessions

___Excessive crying ___Outbursts of temper

___Feelings of hopelessness ___Eating problems (restrictive or binge type)

___Unmotivated ___Loss of Appetite

___Drink too much (please indicate below how often and date of last drinking episode):

___Take drugs (please indicate below which drugs you take and date of last use):

___Preoccupation w/ body-image ___Social withdrawal

___Panic/anxiety attacks ___Insomnia

___Sexual problems ___Academic/vocational problems

___Suicide attempts ___Bereavement/grief

___Chronic pain ___Procrastination

___Take too many risks ___Domestic/partner abuse or violence

___Childhood abuse history ___Sexual abuse history/trauma

___Social oppression ___Suicidal thoughts

___Self-worth challenges ___Use of prescription medications (outside of prescribed purpose)

In general, how often do you experience the things that you marked above:

_____ Daily _____ Weekly ____ Monthly

Is there a history of mental health diagnoses or concerns in your family? If yes, please list below:

_____

_____

_____

_____

Do you have any current concerns about your physical health? Please specify:_____

_____

_____

Have you ever been hospitalized? If so, please provide dates and reason(s) for hospitalization:

_____

_____

_____

_____

Previous suicidal gestures, attempts or thoughts: Yes_____No_____

If you marked "yes," please indicate when and how often it occurred, how long it lasted, and how or if it was resolved:

_____

_____

_____

_____

Current suicidal thoughts, gestures, plans or attempts: Yes_____ No_____

If you marked "yes," please indicate whether or not you can currently trust to stay safe with yourself and any precipitating events or triggers that may have lead up to this feeling, thought or plan:

_____

_____

_____

Do you have any allergies? If so, please specify:

_____

Insurance Information

If you wish to use your insurance benefits, please read and sign the Authorization to Release Information to Insurance form and complete the following information:

Patient's Name: _____

Patient's Birthdate:_____

Patient's ID or Policy Number:_____

Group Number:_____First Effective Date of Coverage:_____

Policy Holder's Name:_____

Policy Holder's Birthdate:_____

Policy Holder's Address:_____

City:_____State:_____Zip:_____

Policy Holder's Employer:_____

Employer Address:_____

City:_____State:_____Zip:_____

Insurance Company Name:_____ Phone Number:_____

Address:_____