AZITA AFSHAR, PSY.D.

INTAKE/REGISTRATION FORM

Patient Information:

Name: _____

Current Date: _____

Ethnicity: _____

Age:_____Birth Date:_____

Occupation: _____

Preferred Gender: _____

Administered Sex: _____

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
___Eating problems
___Unmotivated
___Drink too much
___Take drugs
___Vomiting
___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
___Abuse of prescription medications

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:

_____

_____

_____

_____

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:_____

Address:_____

Phone:_____