DADOYAN BEHAVIORAL MEDICAL GROUP
INTAKE FORM

First Name: _____ Middle Initial _____ Last Name_____

Home Address_____
Street City State Zip
Home Telephone _____ Is it okay to call? Yes _____ No _____
Work Phone_____ Is it okay to call? Yes _____ No _____
Cell Phone _____ Is it okay to call? Yes _____ No _____
For Appointment reminder calls is it ok to leave a voice message? Yes _____ No _____
*Social Security Number_____ Birthdate _____ Age _____
Male _____ Female _____ Marital Status S____ M____ W____ D____
Client Status: Employed _____ Full Time Student _____ Part Time Student _____
Highest Degree of Education _____ Religion _____
Employer_____ Occupation _____
Name of spouse _____
Work Phone_____ Is it okay to call? Yes _____ No _____
Cell Phone _____ Is it okay to call? Yes _____ No _____

Person responsible for deductible, coinsurance, and copayments if other than client:_____
Address _____
Street City State Zip
Did you contact your insurance company to verify your benefits and let them know you were coming? _____
Deductible/year $_____ Has it been met?_____ Copayment/coinsurance/visit $_____ or _____%
Did you receive an authorization number from your insurance company? Yes_____ No_____
Authorization number _____ Number of visits _____
Primary Care Physician_____ Phone: _____
Address _____
Date of last visit _____
Did you get a referral from your Primary Care Physician if required by your ins. co.? Yes_____ No_____

Insurance Information		For Secondary Ins. Only	
Policy Holder's ID/SS#	_____	Policy Holder's ID/SS#	_____
Ins Co. Name	_____	Ins. Co. Name	_____
Policy Holder's Name	_____	Policy Holder's Name	_____
Relationship to client	_____	Relationship to client	_____
Policy Holder's Address	_____	Policy Holder's Address	_____
	_____		_____
Policy/Group #	_____	Policy/Group #	_____
Policy Holder's DOB	_____	Policy Holder's DOB	_____
Male _____ Female _____		Male _____Female _____	

Referring source:_____
How did you hear about our practice? _____
May we thank your referral source? Yes _____ No____ If yes, referral address_____
Did you search for more information about us on the internet? _____
Did you use a search engine? Yahoo _____, Google _____, AltaVista _____, Other _____
Did you visit our website? _____ For what purpose? _____
When you decided to call us, where did you get our phone number?_____
What is the main reason you are requesting a consultation or treatment? _____
_____
_____
_____

Current Symptoms Checklist (check once for any symptoms present, twice for major symptoms)

( ) Depressed Mood	( ) Racing thoughts	( ) Excessive Worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety
( ) Sleep pattern disturbance	( ) Increased risky behavior	( ) Avoidance
( ) Loss of interest	( ) Increased libido	( ) Hallucinations
( ) Concentration / forgetfulness	( ) Decrease need for sleep	( ) Suspiciousness
( ) Change in appetite	( ) Excessive energy	( ) Crying Spells
( ) Excessive Guilt	( ) Increased irritability	( ) Fatigue

Recent Stressful Life Events: _____

_____

_____

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Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No
If YES, please answer the following. If NO, please skip to next section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (then being strongest) how strong is your desire to kill yourself currently?

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Have you ever tried to kill or harm others? If yes, please explain_____

_____

Do you have access to guns? If yes, please explain. _____

List any current medications (Psych and Non-Psych Medications, including supplements) and how often you take them: (if none, write none)

Medication	Daily Dose	Condition	Starting Date

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Date Hospitalized Where

_____

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Psychiatric Hospitalization ( ) Yes ( ) No If yes, please describe for what reason, when and where.

Reason Date Hospitalized Where

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Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar Disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol Abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other Substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who is treated, what medications did they take, and how effective was the treatment?

_____

_____

Family History of Suicide: _____

Family History of Homicide:_____

Legal History: _____

Have you ever been arrested? _____

Do you have any pending legal problems? ( ) Yes ( ) No If yes, please specify _____

_____

Signature _____ Date _____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____ Date _____

Reviewed by _____ Date _____

Race		
Caucasian	African American	Asian American
Hispanic	Native American	Other
Religion		
Protestant	Catholic	Jewish
Muslim	Hindu	Other
Residence		
House	Apartment	Room
Dormitory	Hotel	Hospital
Other		

Gender	Marital	Status
Female	Never married	Living cooperatively
Male	Married	Divorced
Occupation	If married, how many times?	If divorced, how many times?
	1 2 3 Othe	1 2 3 Other
	Separated	Widow/widower
	Marriage annulled	Other

Education (please specify highest level c	completed)	
High school and earlier (circle one)	College/university (circle one)	Graduate school (circle one)
6th or earlier 7th 8th 9th 10th 11th 12th	1 2 3 4 5 Other	BA BS MA MS MBA PHD Other

Please state the principal reason you are requesting a consultation or treatment.

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_____ If necessary, use another sheet of paper.

Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers who have treated you as you can. Also, please provide the kinds of treatment you have received, including names of medications and your response to them.

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Drinking (Alcohol Use)

How many drinks do you consume in the average day?
At what time of day do you have your first drink?

What is the most you have had to drink in a 24-hour period during the last year?

- ○ Check if you ever felt that you were, or someone told you that you were, drinking too much?

  If "yes," under what circumstances?

Drugs of Abuse

Check if you have taken any of the following drugs.

- ○ None
- ○ Marijuana
- ○ Amphetamines/speed
- ○ Heroin/Opiates
- ○ PCP
- ○ LSD/Hallucinogens
- ○ Cocaine/Crack
- ○ Barbiturates/Sedatives/Downers

If you checked one or more of the drugs, under what circumstances did you take it(them)?

When did you most heavily use drugs? When was the last time you took such drugs?

Personal History

Check any items that apply to you and explain.

- ○ Mother's pregnancy with you was abnormal
- ○ Mother's delivery of you was abnormal

Check if during childhood you—

- ○ were afraid to go to school
- ○ had difficulty w/ reading, writing, or arithmetic/math
- ○ were truant
- ○ failed or repeated a grade had frequent falls
- ○ were awkward at games
- ○ wet bed after age 5
- ○ had tics
- ○ had trouble with eyes
- ○ were (are) left handed
- ○ mispronounced words, had a lisp, stutter/stammer
- ○ had nightmares, disturbed sleep, fear of the dark
- ○ ran away from home
- ○ were cruel to animals
- ○ often lied to families or others set fires
- ○ moved often
- ○ were exposed to incest
- ○ were promiscuous

Comments

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Medical History

Weight and Height

What is your current weight in pounds? lb.

- ○ Check if your weight has increased or decreased by more than 10 pounds during the last 5 years.

If checked, explain circumstances.

What is your height in inches? in.

Sleep

Check if you—

- ○ have difficulty falling asleep
- ○ have difficulty waking up and falling back to sleep
- ○ are tired on waking
- ○ have bad dreams, wet bed, sleepwalk, or other sleep disturbances

Smoking

- ○ Check if you smoke.

If checked, how much and for how long?

Caffeine

- ○ Check if you drink coffee, tea, or colas.

If checked, how much?

- ○ Check if you believe you are sensitive to caffeine.

Allergies

List all allergies. Be sure to include medication allergies.

Comments

Medical Problems	
Age when first occurred	List all past and present medical problems as well as any surgery or accidents.

Females—Menstrual History

- ○ Check if your periods are irregular.

If checked, explain.

What is the duration of your periods?

What is the date of your last period?

- ○ Check if there is any pain or discomfort with your periods.
- ○ Check if your moods, depression, irritability, or irrationality change with your periods.

If checked, how?

- ○ Check if you are taking an oral contraceptive.

If checked, which one and for how long?

- ○ If taking an oral contraceptive, check if it affects your mood.

Comments

DADOYAN BEHAVIORAL MEDICAL GROUP INC.

I, (Print Name) _____ acknowledge that I have

received a copy of Dadoyan Behavioral Medical Group Inc. NOTICE OF PRIVACY PRACTICES, and I acknowledge

that I have read and understand its contents.

_____ _____

Signature Date

DADOYAN BEHAVIORAL MEDICAL GROUP

Missed Appointment and Late Cancellation Policy

If you are unable to keep a scheduled appointment with Dadoyan Behavioral Medical Group, please give 24 hours advance notice.

Missed appointments and late cancelations are subject to $100.00 charge.

To cancel an appointment please call (818) 461-8911 or (855) 838-8484

If less than 24 hours notices is given and we are unable to fill your time slot, you will be expected to pay a cancellation fee of one hundred dollar ($100.00); this cancelation fee is not covered by your insurance company.

BY SIGNING BELOW YOU ACKNOWLEDGE THE FOLLOWING

- I understand the contents of this missed appointment and cancellation policy and agree to its conditions.
- I will be responsible to pay the fee assigned as a result of a missed appointment or late cancellation.

_____ _____

PRINTED NAME DATE

_____

SIGNATURE