PLEASE FILL IN COMPLETELY AND PRINT CLEARLY Date _____

Name _____

Preferred Name _____

Address _____

City _____ State ___ Zip _____

Birthdate _____ Age ____ Gender __

Phone Numbers Can messages be left at this number?

Home _____ ☐Yes ☐No

Work _____ ☐Yes ☐No

Cell _____ ☐Yes ☐No

Email Address _____

Marital Status _____ Employment _____

Referred by_____

PAYMENT INFORMATION

Person responsible for payment

☐ Self ☐Other (Includes Primary Cardholder if you plan to file with insurance)

Name _____ Relationship _____

Address _____

City _____ State ___ Zip _____

Phone Numbers

Home _____

Work _____

Cell _____

Birthdate_____

I would like an insurance claim form ☐

Company & Address _____

ID# _____

Group# _____

I have Medicare ☐ Yes (Please sign contract for patients with Medicare)

☐ No

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Address _____

City _____ State ___ Zip _____

Phone Numbers

Home _____

Work _____

Cell _____

Name _____ Relationship _____

Address _____

City _____ State ___ Zip _____

Phone Numbers

Home _____

Work _____

Cell _____

Name_____

CONCERNS

What is your main reason for seeking treatment?

_____

_____

What other concerns do you have?

_____

_____

MEDICATIONS

Please list all medications you are taking, including non-psychiatric medications, over-the-counter medications, herbals and supplements, and other medications not prescribed for you

Name of medication	How much you take	How often you take it

Are you **allergic** to any medications? ☐Yes ☐No

Name of medication	What happens when you take it

Pharmacy_____ Phone_____

Name_____

PREVIOUS PSYCHIATRIC TREATMENT

Have you been diagnosed with a psychiatric condition before? ☐Yes ☐No
Please list

_____
_____
_____
_____

Have you taken psychiatric medications in the past? ☐Yes ☐No
Please list (Refer to information sheet)

_____
_____
_____
_____

Have you seen a psychiatrist before? ☐Yes ☐No
Please list

_____
_____
_____
_____

Have you been in therapy before? ☐Yes ☐No
Please list

_____
_____
_____
_____

Have you been hospitalized in a psychiatric facility before? ☐Yes ☐No
Please list

_____
_____
_____
_____

Name_____

MEDICAL PROBLEMS

What medical problems do you **currently** have? (Refer to information sheet)

_____

_____

What medical problems have you had in the **past**? (Refer to information sheet)

_____

_____

What medical or psychiatric problems run in your **family**? (Refer to information sheet)

_____

_____

Women

Last Menstrual Period_____

Is there any chance you might currently be pregnant? ☐Yes ☐No

Past Pregnancies_____

Primary Care Doctor_____

Address_____

City_____ State___ Zip_____

Phone_____

Date of last examination_____

RELATIONSHIPS

Marital Status_____ Have you been married before? ☐Yes ☐No

Name of Spouse or Significant Other _____

How long have you been together?_____ Do you have any children? ☐Yes ☐No

Name(s) of Child(ren)_____

_____

Who lives at home with you?_____

_____

Who else is important to you?_____

_____

With which cultural or ethnic group do you identify?_____

Do you have any sexual concerns? ☐Yes ☐No

Have you ever been the victim of abuse? ☐Yes ☐No

If so, was it ☐Verbal ☐Emotional ☐Physical ☐Sexual

Name_____

EDUCATION AND EMPLOYMENT

Highest education level_____ Are you in school? ☐Yes ☐No

Did you have problems in school with…

…learning? ☐Yes ☐No
…behavior? ☐Yes ☐No
…getting along with other people? ☐Yes ☐No

Are you currently employed? ☐Yes ☐No

Employer_____

Occupation_____

Previous Employment_____

_____

Have you have problems at work with…

…being able to perform the work? ☐Yes ☐No
…getting along with other people? ☐Yes ☐No

LEISURE AND RECREATION

What are your hobbies or areas of interest?_____

_____

_____

Do you have the opportunity to participate in these activities? ☐Yes ☐No

SPIRITUALITY AND RELIGION

How important to you are spiritual concerns?

☐Not very ☐A little ☐Moderate ☐Very

Are you currently affiliated with a spiritual or religious group? ☐Yes ☐No

Please describe_____

Were you raised within a spiritual or religious group? ☐Yes ☐No

Please describe_____

Name_____

SUBSTANCE USE

Have you ever drunk caffeine? ☐Yes ☐No
Have you been drinking caffeine in the last month? ☐Yes ☐No
If so, how much?_____

Have you ever smoked cigarettes or used other tobacco products? ☐Yes ☐No
Have you been smoking or using tobacco in the last 6 months? ☐Yes ☐No
If so, how much?_____
Has smoking/tobacco ever caused you problems? ☐Yes ☐No
If so, was it with
☐Not being able to stop /losing control ☐Relationships
☐Work ☐Legal ☐Other

Have you ever drunk alcohol? ☐Yes ☐No
Have you been drinking alcohol in the last 6 months? ☐Yes ☐No
If so, how much?_____
Has alcohol ever caused you problems? ☐Yes ☐No
If so, was it with
☐Not being able to stop /losing control ☐Relationships
☐Work ☐Legal ☐Other

Have you ever used drugs? ☐Yes ☐No
If so, which one(s)_____
Have you been using drugs in the last 6 months? ☐Yes ☐No
If so, which one(s)?_____

How much have you been using?_____
Have drugs ever caused you problems? ☐Yes ☐No
If so, was it with
☐Not being able to stop /losing control ☐Relationships
☐Work ☐Legal ☐Other

LEGAL

Do you **currently** have legal problems?

_____

_____

Have you had legal problems in the **past**?

_____

_____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM. PLEASE USE THE SPACE ON THE BACK TO PROVIDE ANY OTHER INFORMATION THAT YOU THINK IS IMPORTANT FOR DR. MUI TO KNOW.

Consent to Treatment

I, _____, voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Dr. Mui and her designated associates or assistants believe are necessary for my care. I understand that treatment may be discontinued at any time by either party.

Patient **X**_____ Date_____

Patient's Representative **X**_____ Date_____

Acknowledgement of Payment Responsibility

I, _____, understand that I am responsible for payment at the time of service. Nonpayment for services may be grounds for termination of treatment.

*Please note that patients with Medicare must review the Contract for Patients with Medicare.

Patient **X**_____ Date_____

Patient's Representative **X**_____ Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices for Protected Health Information. I may ask Dr. Mui questions about the notice at any time.

Patient **X**_____ Date_____

Patient's Representative **X**_____ Date_____