LAGUNA BEHAVIORAL

28281 Crown Valley Parkway, Suite 140
Laguna Niguel, CA 92677

Phone: (949) 367-1200
Fax: (949) 367-1300

NEW PATIENT INFORMATION - ADULTS

CLIENT INFORMATION

Patient's Name:_________________________ Today's Date:_________________________

Other Names: _________________________

Date of Birth:_________________________ Age: _________________________

Address: _________________________
Street Apartment City State ZIP

E-mail Address: _________________________

May we contact you via e-mail ( ) yes ( ) no

PHONE NUMBER (S) Home (______)__________ Work (______)__________

May we call you/leave a message ...at home ( ) yes ( ) no ...at work ( ) yes ( ) no
on your cell: (______)__________ ( ) yes ( ) no

Marital status: ( ) single ( ) separated ( ) divorced ( ) widowed ( ) living together ( ) married

Employer/School: _________________________ Occupation:_________________________

Primary Care Physician: _________________________ Phone Number: (______)__________

WHO REFERRED YOU TO US?
( ) Friend ( ) Health Plan/EAP ( ) Family Member ( ) Medical Doctor ( ) Web/Other

INSURANCE INFORMATION

Health plan/ insurance_________________________ Policy ID #_________________________

Subscriber name_________________________ Subscriber social security_________________________

Employer_________________________

PERSON TO BE CONTACTED IN CASE OF AN EMERGENCY

Name_________________________ Home phone number (______)__________

Relationship_________________________ Work phone number (______)__________

Address if different from above:

____

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PRESENTING PROBLEM (S):
Please describe your reasons for seeking counseling:

____

____

Was there an event that made these issues or problems surface? **YES** **NO**
If yes please describe:

____

____

Please indicate which of the following issues or problems are you currently experiencing and would like to work on in treatment. You may choose more than one.

______Depression
______Anxiety/Panic
______Controlling stress
______Loss of loved one
______Problems at school
______Problems at work
______Suicidal Thoughts
______Paranoid Thoughts
______Insomnia/Oversleep
______Crying
______Unable to Concentrate
______Spending Sprees
_______Lack of friends
_______Loneliness
_______Problems coping
_______Abuse/victimization
_______Financial problems
_______Legal matters
_______Irritability
_______Homicidal Thoughts
_______Headaches
_______Withdrawal
_______Discipline Issues
_______Hallucinations (Hearing/Seeing Things)
_______Marriage/relationship problems
_______Sexuality/sexual issue
_______Family conflict
_______Behavioral problems
_______Eliminating a drug/alcohol habit
_______Police/Probation Involvement
_______Racing Thoughts
_______Increased/Decreased Appetite
_______Rages/Aggression
_______Communication Issues
_______Flashbacks
______Eliminating another habit (overspending, overeating, gambling, etc.)
_____Other: ____
(Please indicate)

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	No Effect	**Little Effect**	**Some Effect**	**Much Effect**	**Significant Effect**	**Not Applicable**
Marriage/relationship	1	2	3	4	5	
Family	1	2	3	4	5	
Job/school performance	1	2	3	4	5	
Friendships	1	2	3	4	5	
Financial situation	1	2	3	4	5	
Physical health	1	2	3	4	5	
Anxiety level/nerves	1	2	3	4	5	
Food	1	2	3	4	5	
Eating habits	1	2	3	4	5	
Sleeping habits	1	2	3	4	5	
Sexual functioning	1	2	3	4	5	
Ability to concentrate	1	2	3	4	5	
Ability to control	1	2	3	4	5	
Your temper	1	2	3	4	5	

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If you have any medical problems, please describe them below:

____

____

Psychiatric History:

Have you seen a psychiatrist or therapist in the past? **YES NO**
Please list below

____

Have you ever been diagnosed with a psychiatric or mental health disorder? **YES NO**

Depression	**Y N**	Schizophrenia	**Y N**
Bipolar Disorder	**Y N**	Schizoaffective	**Y N**
Anxiety	**Y N**	Psychosis	**Y N**
Panic Attacks	**Y N**	Attention Deficit/Hyperactivity Disorder	**Y N**
Social Anxiety	**Y N**	Learning Disorder	**Y N**
Post traumatic	**Y N**		
Stress Disorder	**Y N**	Dementia	**Y N**
Anorexia	**Y N**	Pathological Gambling	**Y N**
Bulimia	**Y N**	Alcohol or drug abuse	**Y N**
Addictions of any kind	**Y N**		

Have you ever been hospitalized for mental health treatment? YES NO

If you indicated yes, please explain:

____

____

____

Please circle the psychiatric medication that you have taken in the past:

Buspar – buspirone
Celexa – citalopram
Cymbalta – duloxetine
Effexor – venlafaxine
Lexapro – escitalopram
Luvox – fluvoxamine

Pristiq – Desvenlafaxine
Paxil – paroxetine
Prozac – fluoxetine
Remeron – mirtazapine
Wellbutrin – buproprion
Zoloft – sertraline
Elavil – amitriptyline
Pamelor – nortriptyline

Ambien – zolpidem
Lunesta – eszopiclone
Rozerem – ramelteon
Desyrel – trazadone

Valium – diazepam
Xanax – alprazolam
Ativan – lorazepam
Klonopin – clonazepam

Vyvanse - Lisdexamfetamine
Ritalin - Methylphenidate
Adderall - Amphetamine
or Dextroamphetamine

Depakote – divalproex
Lithium – eskalith
Tegretol – carbamazepine
Lamictal – lamotrigine

Others

Abilify – aripiprazole
Clozaril – clozapine
Geodon – ziprasidone
Risperdal – risperidone
Seroquel – quetiapine
Zyprexa – olanzapine
Haldol – haloporaldol
Trilafon – perphenazine

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Please list any additional psychiatric medication that you have taken in the past:

____

Family Psychiatric History and Medical History

Have any of your family members suffered from any of the above listed psychiatric disorders? Please explain:

____

____

Current or Chronic Illnesses:

____

____

Please list current medications and doses including over the counter medications and herbs and vitamins:

____

____

Allergies and reaction:

____

Have you ever abused drugs or alcohol before? **YES** **NO**

If yes, please describe:	Substance	Amount	Frequency
	____________	____________	____________
	____________	____________	____________
	____________	____________	____________

Have you ever received substance abuse treatment of any kind before? **YES** **NO**

Do you have a history of blackouts, seizures, or withdrawal symptoms? **YES** **NO**

Do you use tobacco products and if so how much? ____

How often and what kind of caffeinated beverages do you use? ______________________________

How many beer, glasses of wine, mixed drinks, and shots do you typically have in an average week?

____

Have you ever felt that you need to cut down on your drinking? **YES** **NO**

Have people criticized your drinking? **YES** **NO**

Have you ever felt guilty about your drinking? **YES** **NO**

Have you ever felt a need to have a drink in the morning to steady your nerves? **YES** **NO**

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Have you ever had a DUI? **YES** **NO**

Do you smoke marijuana or use any other drugs and how often? ____________________________________

Are you currently involved in any legal problems? **YES** **NO** Please explain if answered yes:

____

Social History:

Where did you grow up and explain your family of origin (parents, siblings) and briefly describe your childhood:

____

Have you been a victim of abuse? **YES** **NO**

____

Current Living situation: ____

Do you feel safe in your current living situation? **YES** **NO** ____________________________________

Marital History and number and ages of children if applicable____

Education and current employment____

Current support systems____

Please list any additional information that you think I should know or that you would like to discuss at today's visit.

What are your goals for psychiatric treatment?

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OFFICE POLICIES AND AGREEMENT FOR GENERAL MENTAL HEALTH SERVICES

CONFIDENTIALITY

It is understood that all information between client and psychiatrist(s) and/or therapist(s) is held strictly confidential, and the psychiatrist(s) and/or therapist(s) will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State laws;
2. The client presents an imminent danger to self,
3. The client presents an imminent danger to others;
4. Child/elder abuse/neglect is suspected;
5. If a judge determines that our discussions are not confidential, a judge may request specific information,
6. As requested by a court-appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the psychiatrist (s) and/or therapist (s) is required by law to inform potential victims and legal authorities so that protective measures can be taken. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family.

CONSENT FOR TREATMENT

I authorize and request that my psychiatrist(s) and/or therapist(s) at Laguna Behavioral/Adel Eldahmy, MD Inc. carry out psychiatric evaluations, psychological exams, treatments, and/or diagnostic procedures during the course of my care as a patient.

RELEASE OF INFORMATION

I authorize the release of information for claims, certification/case management, and other purposes related to the benefits of my health plan.

NOTICE OF PRIVACY PRACTICES

A notice of privacy practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA), describing how information about you may be used and disclosed and how you can get access to this information is provided to you. Please review it carefully. By signing below, you agree to the following: I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

I understand and agree to all of the above information.

____
Patient's Name (printed)

______________________________ ____________________
Patient/Responsible Party's Signature **Date**

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FINANCIAL TERMS

The fees for all services are negotiated between Laguna Behavioral/Adel Eldahmy, MD Inc. and your insurance carrier or managed care company. In general, you will not be asked to pay more than your co-pay/deductible as set in your insurance plan and explained in your insurance plan manual. In some cases you may request additional services not covered by your insurance plan.

*At the time of service, if we are not able to verify and get full information regarding the patient's insurance, he/she is responsible for the full contracted rate and will be given a receipt to submit to his/her insurance.
*With certain selected insurance companies the patient will be responsible for the full contracted rate and will be given a receipt to submit to his/her insurance.

Document copy services/medical record processing fees will be charged at $30.00 per request and the patient will be responsible for $35.00 charge per returned check.

All fees are to be paid at the time of service.

Certain health insurance plans have pre-arranged contracted fee arrangements that are different than the amounts quoted. Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for the visit and your provider will be paid directly by the carrier. **The patient will be responsible for any deductibles and co-payments at the time of service**. If you are not eligible at the time of services are rendered, you are responsible for payment or if your insurance carrier does not authorize the services, you are responsible for payment of the quoted fees or the rate negotiated with your insurance carrier, whichever applies.

REPORT WRITING

Please note depending on the report writing there may be a minimum charge of $50.00 for 1 page or less. Each additional page will be an extra $50.00.

LITIGATION CHARGES

If I am required to attend a deposition, hearing or other legal proceeding you will be billed for my time, which includes preparation and travel time, as well as the time I spend at the legal proceeding.

CANCELLATION/MISSED APPOINTMENTS

Scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24 hours notice, the patient will be charged a $50.00 No show/Last Minute Cancellation Fee. This charge cannot be billed to your insurance plan.

Please sign to indicate that you have carefully read and agree to the above conditions.

____
Print Patient Name

____________________________________ ______________________
Signature of Person Financially Responsible **Date**