

CARE-LA

10323 Santa Monica Blvd., Suites 102 & 103
Los Angeles, CA 90025
(424) 421-CARE

INFORMATION FORM

PERSONAL

Patient Name: _____ DOB: _____ Male: _____ Female: _____

Accompanying Parent Name (If minor): _____

School and Grade (If minor): _____

Home Address: _____ Phone # Cell: _____

_____ Phone # Hm: _____

Email: _____

EMPLOYER

Employer: _____ Phone #: _____

Address: _____

EMERGENCY

In Case of Emergency Notify: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Psychiatrist: _____ Phone #: _____

MEDICAL PROBLEMS

MEDICATIONS PAST / PRESENT

PLEASE CIRCLE THE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sadness or Depression	0	1	2	3	Memory Problems	0	1	2	3
Suicidal Thoughts	0	1	2	3	Compulsive Behavior	0	1	2	3
Sleep Problems	0	1	2	3	Feelings of Hostility	0	1	2	3
Change in Appetite	0	1	2	3	Acts of Violence	0	1	2	3
Weight Change	0	1	2	3	Social Isolation	0	1	2	3
Inability to Concentrate	0	1	2	3	Strange Thoughts	0	1	2	3
Obsessive Thoughts	0	1	2	3	Sexual Problems	0	1	2	3
Tension/Anxiety	0	1	2	3	Panic Attacks	0	1	2	3

PSYCHIATRIC HOSPITALIZATIONS (Please Circle):

YES

NO

If yes, how many times? _____

What were the circumstances? _____

SUBSTANCE USE ASSESSMENT (Please Circle):

Alcohol Use:	Never	1-4 per month	2-3 per week	Daily
Level of consumption:	None	1-2 per sitting	3-4 per sitting	5 + per sitting
Substances of use:	None	Cocaine, Marijuana, Sedatives, Stimulants, Opiates, Hallucinogens		
Frequency of use:	Never	1-4 per month	2-3 per week	Daily

INFORMATION ABOUT PARENTS:

☐ Married ☒ Separated ☒ Divorced ☒ Widowed

Names:

Occupations:

HOME LIFE:

Language(s) spoken at home:

Siblings' names and ages (if applicable)

Does the child have any other caregivers (e.g., baby sitter, nanny, grandparent) and how much time do they spend with your child?

Have there been any recent changes at home, such as separations, financial or home instabilities, changes in caregivers, or recent moves:

Has your child, or anyone in the family, experienced any deaths, significant accidents, injuries, or hospitalizations? Please describe:

Has your child experienced any of the following: witnessed domestic violence, physical abuse, verbal abuse, or sexual abuse?

Has either parent had problems with substance abuse or addiction?

DEVELOPMENTAL HISTORY:

Is your child:

☐ biological ☐ adopted ☐ via surrogate

Describe any illnesses or complications that mother experienced during her pregnancy:

The child's birth was:

☐ full-term ☐ pre-term: (# of weeks) _____
☐ uncomplicated ☐ complicated: (describe) _____

Did the mother experience any post-partum depression?

Did the child reach developmental milestones on-time? If not, please describe below:

Describe any regional center or early intervention services that your child has received:

List and describe any family history of psychological or learning problems:

Please list any therapists or specialists that your child has seen previously:

EDUCATIONAL HISTORY:

Current school:

Has the child's teacher had any complaints about his/her behavior, learning or social skills? If so, explain:

Please list any other schools the child has attended, and reasons for leaving:

Does your child receive any special education services?

Describe your child's friendships with others at school:

SYMPTOMS:

Please check off all that apply

- ☐ 4 Seems depressed or blue
- ☐ 4 Has little interest or pleasure in doing things
- ☐ 4 Has difficulty falling asleep
- ☐ 4 Has difficulty staying asleep through the night
- ☐ 4 Not sleeping on his/her own
- ☐ 4 Seems tired or has little energy
- ☐ 4 Seems active or has too much energy
- ☐ 4 Overeats
- ☐ 4 Feels bad about himself/herself
- ☐ 4 Has trouble concentrating
- ☐ 4 Is forgetful
- ☐ 4 Worries all the time
- ☐ 4 Has panic attacks
- ☐ 4 Cries more than expected for his/her age
- ☐ 4 Has hallucinations or delusions
- ☐ 4 Is Impulsive
- ☐ 4 Cannot sit still
- ☐ 4 Aggressive
- ☐ 4 Uninterested in peers
- ☐ 4 Picked on or bullied by peers
- ☐ 4 Oppositional
- ☐ 4 Difficult to discipline

Charges are due upon services rendered. I understand that I am financially responsible for the charges incurred for treatment including those not covered by my insurance plan(s).

The charge is made for the time reserved unless full 24 hours advanced notice is received.

Patient Name (Guardian if minor): _____

Signature: _____ Date: _____

Witness: _____ Date: _____