Darakjian Psychiatry

Ara Darakjian, MD
236 W. Mountain St. Suite 109-E
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www.darakjianpsych.com
P: (626) 600 – 1994
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Patient Information

TODAY'S DATE _____ **REFERRAL SOURCE** _____
NAME _____ **NICKNAME** _____ **SSN** _____
DATE OF BIRTH _____ **AGE** _____ **GENDER** _____ **ETHNICITY** _____
ADDRESS _____
Street *(Apartment #)* *City* *State* *Zip Code*

PHONE NUMBERS: **(Please only list phone numbers/email/fax that it is ok for provider to contact you and leave message)*
Home ( ) _____
Cell ( ) _____
Work ( ) _____

EMAIL ADDRESS: _____ **FAX NUMBER:** _____

A. MARITAL STATUS ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

B. LIVING WITH SPOUSE/PARTNER? ☐ Yes ☐ No **NUMBER OF YEARS TOGETHER** _____
C. EMPLOYER/SCHOOL _____ **OCCUPATION** _____
D. HIGHEST LEVEL OF EDUCATION _____
E. CHILDREN ☐ Yes ☐ No **AGES OF CHILDREN** _____
**(Please circle ages of children living in home)*
PRIMARY CARE PHYSICIAN _____ **HOSPITAL/CLINIC** _____
(a) ADDRESS _____
(b) PHONE NUMBER ( ) _____ **FAX NUMBER** ( ) _____
EMERGENCY CONTACT(S):
(1) NAME _____ **(2) NAME** _____
PHONE NUMBER ( ) _____ **PHONE NUMBER** ( ) _____
RELATIONSHIP TO PT _____ **RELATIONSHIP TO PT** _____

Insurance company information:
Name of insurance company: _____
Address of insurance company: _____
Policy Holder's ID #: _____ **Policy Holder's Group #:** _____
Name or Type of Plan: ☐ **PPO** ☐ **Indemnity** ☐ **HMO** ☐ **EAP** ☐ **Other:** _____
Phone number for verification of benefits (on back of card): _____
Does your plan cover mental health care with a psychiatrist? ☐ **Yes** ☐ **No**
Does your plan cover psychiatric medications? ☐ **Yes** ☐ **No**
Name of primary care physician: _____ **Phone #: (** **)**_____
Effective from: **(date)**
Effective to: **(date)**

TYPE OF HELP DESIRED:

☐ Psychiatric Evaluation ☐ Medication management ☐ Individual Therapy ☐ Family/Couple's Counseling

1. Major reason(s) for seeking help at this time: _____

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_____
_____

2. How long have you had these problems or symptoms? _____
_____

3. How often do they occur? _____
_____

4. List the people, activities, groups, and hobbies that are supportive to you/your family: _____
_____
_____

5. What are your goals for treatment? _____
_____
_____

6. What treatments have you tried already? _____
_____
_____

7. Are you currently taking any medications for medical problems (including over-the-counter and herbal)? ☐ Yes ☐ No
If yes, please list: _____
_____
_____

8. Do you have any serious or chronic medical conditions (including past surgeries)? ☐ Yes ☐ No
If yes, date(s) and details: _____
_____
_____

9. Do you have a history of serious accidents or injuries, head injury, loss of consciousness, or seizures? ☐ Yes ☐ No
If yes, date(s) and details: _____
_____

10. Past and Current Psychological/Psychiatric Treatment:

Counseling or Psychotherapy

Yes ☐ No ☐

	Therapist (MD, PhD, MFT, etc.)	*Type of therapy*	*Dates*	*Helpful (Y/N)*
1.				
2.				
3.				
4.				

Psychiatric Medications

Yes ☐ No ☐

	Name of Medication?	*Prescribed by*	*Year*	*Helpful (Y/N)*
1.				
2.				
3.				
4.				

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Psychiatric Hospitalizations

Yes ☐ No ☐

	Where?	*Admission Reason?*	*Year*	*Helpful (Y/N)*
1.				
2.				
3.				
4.				

Addiction Rehab/ Treatment

Yes ☐ No ☐

	Where?	*Admission Reason?*	*Year*	*Helpful (Y/N)*
1.				
2.				
3.				
4.				

Any additional information that you feel is pertinent: