STATE OF MIND WELLNESS CENTER

2629 Townsgate Road • Suite 210 • Westlake Village, CA • 91361
805-835-4401 805-835-4909 • www.stateofmindwellness.center

New Patient Evaluation Form

Please fill out the following confidential intake form to the best of your ability and complete prior to your first appointment. Your answers are saved as you go, so you don't need to finish it all in one sitting. Submit the form only when you have answered all that you can. If you are uncomfortable answering any of these questions, please feel free to leave them blank and we can discuss them in more detail at our initial evaluation.

1. **Please enter patient information:**

First Name: _____ Middle: _____ Last Name: _____ Date of Birth: _____

Preferred Name (if different): _____ Email Address: _____ Cell Phone: _____

Street Address: _____ Home Phone: _____ Work Phone: _____

City, State & Zip: _____ Additional Phone: _____

Preferred Method of Contact:
- ○ Mobile Phone ○ Email
- ○ Home Phone ○ Work Phone
- ○ Additional Phone

2. **How did you hear about Dr. Priya Parmar and State of Mind Wellness Center?**

_____

3. **Emergency Contact Information:**

Emergency Contact Name (first and last): _____ Relationship to Patient: _____ Contact Phone: _____

4. **Preferred Pharmacy:**

Pharmacy Name & Details: _____ Pharmacy Phone: _____

5. **Health Insurance Information:**

Primary Health Insurance Company: _____ Insurance ID: _____

Name of Policy Holder (first and last): _____ Relationship to Patient: _____ Date of Birth: _____

6. Purpose of Consultation (please describe your reasons for seeking treatment at this time):

_____

_____

_____

_____

7. Presenting Symptoms (please check all that apply):

- ☐ Depressed or sad mood
- ☐ Sleeping too much or not enough
- ☐ Feeling agitated or sluggish
- ☐ Feeling guilty or worthless
- ☐ Thoughts of death or suicide
- ☐ Decreased need for sleep or going for days without sleep
- ☐ Racing thoughts
- ☐ Trying to do or accomplish way too much in one day
- ☐ Seeing or hearing things that may not be real
- ☐ Feeling like people are watching you or out to get you
- ☐ Panic attacks
- ☐ Extreme or unreasonable fears
- ☐ Cannot prevent repetitive thoughts
- ☐ Body overreacts to "stress"
- ☐ Always on guard or never feel safe
- ☐ Difficulty enjoying usual activities
- ☐ Unintentional weight gain or weight loss
- ☐ Lacking energy or always tired
- ☐ Poor focus or concentration
- ☐ Inflated self-esteem
- ☐ Excessive talking
- ☐ Feeling highly distractable
- ☐ Impulsive behavior
- ☐ Often tense or unable to relax
- ☐ Excessive worrying
- ☐ Afraid or unable to leave the house
- ☐ Intense fear of social situations
- ☐ Cannot prevent repetitive behaviors
- ☐ Intrusive or upsetting memories of past events
- ☐ Other:

If other, please describe:

_____

8. Current Life Problems Affecting You (please check all that apply):

- ☐ Problems with family
- ☐ Problems with friends or community
- ☐ Educational problems
- ☐ Occupational or job problems
- ☐ Housing problems
- ☐ Financial or economic problems
- ☐ Problems with the law or legal system
- ☐ Destructive/violent thoughts or behaviors
- ☐ Anger outbursts
- ☐ Attempts to hurt, harm, or mutilate self
- ☐ Discipline problems at work
- ☐ Careless or high-risk behaviors
- ☐ Other:

If other, please describe:

_____

9. Are there any outside physicians/therapists/providers that should be authorized to communicate and/or collaborate with Dr. Priya Parmar and State of Mind Wellness Center?

- ○ Yes
- ○ No

10. If yes, please specify how many authorization forms are needed?

_____

Past Psychiatric History

11. Have you ever been hospitalized for psychiatric reasons?

- ○ Yes
- ○ No

12. If yes, please describe and include dates to the best of your ability:

_____
_____
_____
_____

13. Have you ever seen a psychiatrist on an outpatient basis?

- ○ Yes
- ○ No

14. If yes, please describe, including psychiatrist names, and date ranges to the best of your ability:

_____
_____
_____
_____

15. Have you ever received counseling or psychotherapy in the past?

- ○ Yes
- ○ No

16. If yes, please describe, including therapist names, and date ranges to the best of your ability:

_____
_____
_____
_____

17. Are you currently taking any medications prescribed for psychiatric conditions?

- ○ Yes
- ○ No

18. If yes, please do your best to list current psychiatric medications along with dosages, frequency taken, and any side effects experienced:

	Medication Name	Dosage	Frequency	Side Effects
1				
2				
3				

19. Have you taken any medications prescribed for psychiatric conditions in the past?

- Yes
- No

20. If yes, please do your best to list past psychiatric medications along with dosages, frequency taken, and any side effects experienced:

	Medication Name	Dosage	Frequency	Side Effects
1				
2				
3				

General Medical History

21. Do you have a primary care physician/provider?

- Yes
- No

22. If yes, please list the name, phone number, and address of your provider:

Provider's Name: _____ Phone Number: _____

Address: _____ City, State & Zip: _____

23. Date of last physical exam: _____ Date of last lab work: _____

24. Do you have any past and/or current medical problems?

- Yes
- No

25. If yes, please describe:

_____

_____

_____

_____

26. Are you allergic to any medications?

- Yes
- No

27. If yes, please list medication name, specific allergic reaction and severity of reaction (very mild, mild, moderate, severe)

	Medication Name	Allergic Reaction	Severity
1			
2			
3			

28. Are you currently taking any non-psychiatric prescription medications for your general medical conditions?

- Yes
- No

29. If yes, please do your best to list current non-psychiatric medications along with dosages, frequency taken, and any side effects experienced:

	Medication Name	Dosage	Frequency	Side effects
1				
2				
3				

30. Are you currently taking any over-the-counter medications, vitamins, and/or supplements?

- Yes
- No

31. If yes, please do your best to list current over-the-counter medications, vitamins, and/or supplements below along with dosages, frequency taken, and any side effects experienced:

	Name	Dosage	Frequency	Side effects
1				
2				
3				

32. Have you undergone any surgical procedures?

- ○ Yes
- ○ No

33. If yes, please list all procedures along with dates performed:

	Procedure	Date
1		
2		
3		

34. Have you ever suffered a severe concussion or head injury with loss of consciousness?

- ○ Yes
- ○ No

35. If yes, please describe, including age when event occurred:

_____

Alcohol, Drug, and Tobacco Use

36. Do you drink alcohol?

- ○ Yes
- ○ No

37. If yes, how many drinks do you consume, on average, during the week?

- ☐ 0 (only drink on rare occasion)
- ☐ 2-4 drinks per week
- ☐ 7-10 drinks per week
- ☐ 11+ drinks per week

38. Do you use marijuana and/or CBD products?

- ○ Yes
- ○ No

39. If yes, please do your best to specify the types of marijuana and/or CBD products used along with quantity consumed, frequency taken, and any comments you would like to include:

	Type	Quantity Consumed	Frequency Taken	Notes/Comments
1				
2				

40. Do you use illicit drugs and/or misuse prescription drugs?

- ○ Yes
- ○ No

41. If yes, please do your best to specify the substances used along with quantity consumed, frequency taken, and any comments you would like to include:

	Substance	Quantity Consumed	Frequency Taken	Notes/Comments
1				
2				
3				

42. Do you use tobacco products?

- ○ Yes
- ○ No

43. If yes, please do your best to specify the types of tobacco products used along with quantity consumed, and total length of time used:

Type of Tobacco _____ Quantity Consumed _____ Length of Time Used _____

44. Have you experienced any personal problems in your life as a result of your drinking/drug/tobacco use?

- ○ Yes
- ○ No

45. If yes, please describe problems that have affected you (legal, financial, health, relationship issues, etc.):

_____

46. Have you ever been admitted to an in-patient rehab, gone through a partial hospitalization program (PHP), and/or entered an intensive outpatient program (IOP) due to substance use?

- ○ Yes
- ○ No

47. If yes, please do your best to specify the type/name of programs, date ranges, and any notes/comments you would like to include:

	Program Type/Name	Date Range	Notes/Comments
1			
2			
3			

Social History

48. Where were you born and where did your spend the majority of your youth?

_____

49. Did your parents stay together while you were growing up?

- ○ Yes
- ○ No

50. If not, how old were you when your parents separated?

_____

51. Do you have any siblings?

☐ Yes ☐ No

52. If yes, how many siblings do you have?

Sisters: _____ Brothers: _____ Other Siblings: _____

53. Did you suffer from any major illnesses or injuries while you were growing up?

- ○ Yes
- ○ No

54. If yes, please describe:

_____

55. Are/were a victim of any form of abuse?

- Yes
- No

56. If yes, please describe, revealing as much or as little as you feel comfortable with sharing:

_____

_____

_____

_____

57. What is the highest educational degree that you have obtained?

_____

58. Are you currently employed?

- Yes
- No

59. If yes, please describe where you work and what do you do:

_____

60. Are you currently involved in a romantic relationship?

- Yes
- No

61. If yes, please describe, sharing as much or as little as you would like:

_____

_____

_____

_____

62. Have you been involved in any previous significant intimate/romantic relationships?

- Yes
- No

63. If yes, please describe, sharing as much or as little as you would like:

_____

64. Do you have any children?

- Yes
- No

65. If yes, what are their names and ages?

	Name	Age
1		
2		
3		

66. What are some things you enjoy doing in your spare time (hobbies, interests, physical activities, etc.)?

_____

67. Have you ever been convicted of any crimes, incarcerated in jail/prison, and/or placed on probation?

- ○ Yes
- ○ No

68. If yes, please describe:

_____

Family History

69. Is there any family history of mental illness and/or substance abuse among your blood relatives?

- ○ Yes
- ○ No

70. If yes, please describe, sharing as much information as you can recall:

_____

_____

_____

_____

Patient/Guardian Signature

_____ _____

Signature Date