BOUTELLE PSYCHOLOGICAL SERVICES

6060 Center Drive - Floor 10, Suite 38
Los Angeles, CA 90045
OFFICE: (310) 439-1131
FAX: (424) 369-9244
CELL: (310) 600-8111

NEW PATIENT INFORMATION

PATIENT NAME (Last, First, Middle)		DATE OF BIRTH	GENDER
ADDRESS	APT. #	CITY	ZIP
CELL PHONE	WORK PHONE	EMAIL ADDRESS	
( )	( )		

WHO REFERRED YOU?

☐ Insurance Website ☐ Internet Website ☐ Friend/Family ☐ Psychology Today ☐ Other _____

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ DOMESTIC PARTNERSHIP ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

INSURED INFORMATION

INSURED (Last, First, Middle)			INSURED BIRTHDATE
ADDRESS	APT. #	CITY	ZIP
PHONE			
INSURED MEMBER ID #	INSURED GROUP #		INSURED PLAN/PROGRAM NAME

AUTHORIZATION AND RELEASE

I authorize the release of any medical or other information necessary to process this medical claim to a third-party payer and/or health practitioner. I authorize and request my insurance company to pay directly to the provider's insurance benefits otherwise payable to me.

_____ _____

Signature of Patient (or parent if minor) **Date**

HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ No ☐ Yes, previous therapist/practitioner:

How long were you in therapy?

Are you currently taking any prescription medication? ☐ Yes ☐ No
If yes, please list:

If yes, please list and provide dates:

General and Mental Health Information

1. How would you rate your current physical health? (Please check one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (Please check one)
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise?

What types of exercise do you participate in?

4. Please list any difficulties you are experiencing with your appetite or eating problems:

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes
If yes, for approximately how long?

6. Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes
If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain? ☐ No ☐ Yes
If yes, please describe:

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. Do you engage in recreational drug use? ☐ No ☐ Yes
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

10. Are you currently in a romantic relationship? ☐ No ☐ Yes
If yes, for how long?

11. On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

12. What significant life changes or stressful events have you experienced recently?

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	YES or NO	FAMILY MEMBER
Alcohol/Substance Abuse Anxiety	☐ YES ☐ NO	
Depression	☐ YES ☐ NO	
Domestic Violence	☐ YES ☐ NO	
Eating Disorders	☐ YES ☐ NO	
Obesity	☐ YES ☐ NO	
Obsessive Compulsive Behavior	☐ YES ☐ NO	
Schizophrenia	☐ YES ☐ NO	
Suicide Attempts	☐ YES ☐ NO	

1. Are you employed? ☐ No ☐ Yes
If yes, what is your current employment situation?

2. Do you enjoy your work? ☐ No ☐ Yes

3. Would you describe your current work as stressful?

4. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
If yes, describe your faith or belief:

5. What do you consider to be some of your strengths?

6. What do you consider to be some of your weaknesses?

7. What would you like to accomplish out of your time in therapy?