

MICHAEL E. LARA, MD
DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

Patient Questionnaire

Name: _____	Today's Date: _____		
Date of birth: _____	Age: _____		
Social Security Number: _____	Driver's License No: _____		
Marital Status: _____			
Home Address: _____			
City: _____	State: _____ Zip Code: _____		
Work Address: _____			
City: _____	State: _____ Zip Code: _____		
Email Address: _____			
Responsibility Party for Payment: _____			
<i>Telephone Numbers</i>			
Home: _____	Cell/Mobile: _____		
Work: _____			
Emergency Contact: _____			
Primary Care Physician and office number: _____			
Preferred pharmacy and phone, if known: _____			
Preferred method of contact for appt reminders and other related correspondence:			
<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Email	<input type="checkbox"/> Work Phone

To My Prospective Clients:

Thank you for taking the time to answer these questions before our initial evaluation. Please take the time to complete this questionnaire as honestly and completely as you can so that we may focus on your current symptoms and potential treatments during our initial consult. I assure you that this information will be kept confidential and will not be shared with anyone without your written consent.

Please fax the completed form at least **48 hours BEFORE** your first visit it to my confidential fax line at 650-594-9299. Also, please bring to your initial visit copies of any prior medical records, discharge summaries, medication charts, lab results, neuropsychological evaluations, or other relevant medical records.

1301 RALSTON AVENUE, BUILDING E, SUITE C, BELMONT, CA
PHONE: 650-592-1229 FAX: 650-594-9299

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What is the main symptom that led you to consult me? (e.g., anxiety, depression, memory problems, concentration difficulties, fatigue, insomnia, agitation)

When specifically did this problem begin? Were there any life stressors associated with the onset of these psychological symptoms?

Do you have any biases against or for the use of psychiatric medications? Do you have any concerns regarding the use of medications?

Who referred you to Dr. Lara's practice? _____

Psychiatric History

Have you ever had outpatient treatment for a psychological problem?

When and where did you receive treatment?

What type of treatment was it (e.g. psychotherapy, medication, behavior therapy)?

Which of the following medications have you taken or are currently taking?

- | | | | | |
|---------------------------------------|------------------------------------|---|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Celexa | <input type="checkbox"/> Zyprexa | <input type="checkbox"/> Depakote | <input type="checkbox"/> Xanax | <input type="checkbox"/> AdderallXR |
| <input type="checkbox"/> Paxil | <input type="checkbox"/> Seroquel | <input type="checkbox"/> Lamictal | <input type="checkbox"/> Klonopin | <input type="checkbox"/> Ritalin |
| <input type="checkbox"/> Zoloft | <input type="checkbox"/> Risperdal | <input type="checkbox"/> Lithium | <input type="checkbox"/> Ativan | <input type="checkbox"/> Dexedrine |
| <input type="checkbox"/> Prozac | <input type="checkbox"/> Geodon | <input type="checkbox"/> Tegretol/Equetro | <input type="checkbox"/> Valium | <input type="checkbox"/> Concerta |
| <input type="checkbox"/> Lexapro | <input type="checkbox"/> Abilify | <input type="checkbox"/> Neurontin | <input type="checkbox"/> Ambien | <input type="checkbox"/> Provigil |
| <input type="checkbox"/> Cymbalta | <input type="checkbox"/> Haldol | <input type="checkbox"/> Topamax | <input type="checkbox"/> Restoril | <input type="checkbox"/> Strattera |
| <input type="checkbox"/> EffexorXR | <input type="checkbox"/> Symbyax | | | |
| <input type="checkbox"/> WellbutrinXL | | | | |

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Have you ever been hospitalized for a psychological problem? When and where?

Have you ever thought about suicide? When was the last time? _____

Have you ever engaged in any self-harming behaviors such as cutting? _____

In the last **two weeks** have you experienced any of the following symptoms/conditions?

Please **circle** the items that you have experienced in the last two weeks:

- Excessive worrying/anxiety
- Low, down or depressed mood
- Loss of interest in activities/people
- Uncharacteristic irritability or grouchiness
- Changes in energy
- Concentration problems
- Difficulty falling asleep
- Appetite changes
- Rapid heartbeat
- Shortness of breath
- Dizziness
- Panic or anxiety attacks
- Flashbacks or nightmares about past traumatic events
- Compulsive behaviors such as counting, cleaning, hair pulling or other rituals
- Excessive fear of dirt or germs or contamination
- Sexual thoughts or obsessions
- Muscle tension
- Fatigue
- Feeling as if something bad is about to happen
- Suicidal thoughts
- Restlessness
- Memory problems
- Strange thoughts
- Unexplained perceptual disturbances or hallucinations
- Paranoia
- Feeling that people are gossiping or talking about you
- Uncharacteristic pursuit of goal-directed activities
- Talking fast
- Mood swings
- Decreased need for sleep
- Engaged in uncharacteristic risky behaviors such as gambling, spending money excessively, sexual indiscretions, or stealing
- Bingeing, purging, restricting or any other unusual eating behaviors

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Please list the names and contact numbers for each of your past treatment providers, if known:

Treatment Provider	Title (MD, PhD, LCSW)	Dates Seen	Contact Phone

Medication History

What medications are you taking now (medical or psychiatric)?

Drug	Dose	Frequency	Prescribing Physician

What psychiatric medications have you taken in the past?

Drug	Date	Reason for discontinuing	Prescribing Physician

Do you use nonprescription medications? If yes, which ones?

Do you use herbal medication, supplements, vitamins or other forms of alternative, integrative, or complementary medicine? (Acupuncture, chiropractic, homeopathy)

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Do you or have you used recreational or illegal drugs? (marijuana, cocaine, LSD, methamphetamines, ecstasy, mushrooms, PCP, heroin, tranquilizers, or others).

Amount and date last used: _____

Have you ever participated in an outpatient or inpatient drug rehabilitation program? If yes, state when and where: _____

When was the last time you actually used any recreational or illegal drugs? _____

Do you drink alcohol? If yes, how much _____

Have you ever participated in AA or a similar 12-step program? When? _____

Do you use tobacco? How much? _____

Medical History

Current Primary Care Physician/Internist _____

Office Phone: _____ Address: _____

Date of last physical exam: _____

What illnesses or surgeries have you had in the past?

Do you have any medical illnesses at the present? (e.g., high blood pressure, diabetes, asthma, high cholesterol, thyroid problems, chronic pain)

Have you ever had a head injury? When? _____

Have you ever had a seizure? When? _____

Have you ever had or received treatment for tuberculosis? _____

Have you ever been exposed or tested positive for HIV? _____

Have you ever been exposed or tested for hepatitis? _____

Educational History

Grammar School _____

High School _____

College _____

Postgraduate/Professional _____

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Occupational History

Current employment/position: _____

Previous Employment	Dates	Reason job ended
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Place of birth _____

Any complications at the time of your birth? _____

Any developmental delays such as in walking, talking, or speaking? _____

Any unusual experiences or traumas in your grammar school years? _____

Did you ever receive special education services as a result of a learning disorder? _____

Are you currently involved in a committed relationship? _____

Are relationships a frequent source of stress for you? _____

Have you ever been the victim or witnessed domestic abuse or violence?

Children, if any:

Name	Age	Medical/Psychiatric Illnesses
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legal History

Have you ever been convicted of a felony or misdemeanor? _____

Do you currently have any outstanding warrants or restraining orders? _____

Have you ever been placed on a 72-hour involuntary hold such as a 5150 or on a conservatorship or guardianship?

Are you currently involved in litigation or are you awaiting a legal settlement for any reason?

Have you ever received disability benefits? _____

Are you currently seeking disability for any condition? _____

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Family Medical History

Mother's name: _____ Deceased? _____
Does (or did) she have any medical or psychiatric illnesses?

Father's name: _____ Deceased? _____
Does (or did) he have any medical or psychiatric illnesses?

Brother and sisters:

Name	Age	Medical/Psychiatric Illnesses
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Psychiatric History

Has anyone in your extended family (aunts, uncles, cousins) ever had a psychiatric problem (e.g. depression, mood swings, strange thinking, drug or alcohol abuse, anxiety problems, or suicide attempts?) _____

If yes, please indicate the nature of problems and the type of treatment received (medications, psychotherapy, counseling, electroconvulsive therapy)

Please list below any other additional questions or concerns that you would like me to address by the end of our FIRST visit:

I hereby agree that the above personal information is accurate and complete, to the best of my ability. I also understand that this information will remain confidential and will not be released to any individual or organization without my prior written consent.

Name Date signed

Treatment Agreement Contract

Payment for services is required at the time they are rendered. Payment may be made by cash or personal check. We do not accept credit cards. As patients are expected to maintain a zero balance, our office does not send patients statements on a regular basis. Accounts need to stay current in order to maintain ongoing treatment. Unpaid accounts over 90 days are routinely reviewed for submission to collections. *Initials:* _____

Insurance Billing: We do not bill insurance. We will provide patients with receipts that may be submitted to insurance carriers for reimbursement. Parties are responsible for all charges whether or not they are covered by your insurance. Payment to our office cannot be delayed for the purposes of receiving reimbursement from insurance companies. *Initials:* _____

Fees Charged: The fees charged are based on the amount of time scheduled for dealing with patient issues. The minimum amount of time scheduled is for a half-session (20-25 minutes). If additional time beyond the scheduled time is taken to assist patients, there will be a charge for the amount of time used. In addition, patients are charged for time spent on the telephone for conversations longer than 5 minutes, and for time taken to write reports or correspondence on patient's behalf. *Initials:* _____

Appointment Cancellation Policy: Cancellations for scheduled appointments must be received 48 hours in advance during regular office hours (Monday through Thursday 10:00 am to 5:00 pm; Friday 9:00 am until Noon). Not kept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee. This fee can equal but will not exceed the fee for the time originally scheduled. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge. *Initial:* _____

On-Call and Refill Policy: We offer 24/7 phone coverage for non-medical urgent care or questions. For medical emergencies or life-threatening emergencies, please go to the nearest Emergency Room as we are not equipped to handle medical emergencies. For refills on existing prescriptions, please call your pharmacy directly and ask the pharmacist to fax to our office a refill authorization request form. Calling the pharmacy directly will assure timely receipt of your prescriptions. *Initials:* _____

I have read and understand the above stated policies.

Signature of Client or Responsible Party:

_____ Date: _____