BEHAVIORAL ASSOCIATES | LA
462 North Linden Drive, Suite 430 | Beverly Hills, CA 90212 | Phone: 310-205-0523

New Client Packet

Please read through the following information provided within and complete the attached forms. This information will assist us in the initial assessment and in making the best treatment recommendations for you. Please answer each question with as much detail as possible.

Your first meeting/ several meetings will serve as an initial assessment and is not a commitment to treatment. Following the completion of the assessment, your therapist will present you with his/her treatment recommendations. If it is determined that Behavioral Associates is not a good match for your needs, your therapist will recommend referrals to other providers in the area who may better serve you.

PLEASE NOTE:

Behavioral Associates does not accept insurance of any kind. Please discuss payment options with your therapist.

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Patient Information Sheet

Name: _____

Date: _____

Referred By: _____

Date of Birth: _____ Ethnicity: _____

Sexual Orientation: _____ Marital Status: _____

Religion: _____ Occupation: _____

Home Address: _____

_____

Home Phone: _____ OK to leave message here? YES NO

Cell Phone: _____ OK to leave message here? YES NO

Emergency Contact: Name: _____

Relationship: _____ Phone: _____

Address: _____

_____

Other current treatment providers:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Primary Reason for Seeking Treatment or Evaluation:

_____

_____

_____

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Self-Report Questionnaire

Symptom Checklist: Please check all of symptoms you have experienced in the past **two weeks.**

- Hyperactivity ◯
- Loss of interest in activities ◯
- Feeling sad or depressed ◯
- Tearful ◯
- *Thoughts of ending your life* ◯
- *Making plans to end life* ◯
- Low Energy, fatigue ◯
- Trouble concentrating ◯
- Feeling worthless ◯
- Feeling guilty ◯
- Change in weight ◯
- Change in appetite ◯
- Sleep difficulties ◯
- Racing heart ◯
- Chest pain ◯
- Lightheaded/dizzy ◯
- Sweating ◯
- Short of breath ◯
- Hot/cold flashes ◯
- Racing thoughts ◯
- Feeling like "I'm going crazy" ◯
- Excessive worry, fear, dread, or feeling out of control ◯
- Distortions in vision, hearing, etc ◯
- Frightening flashbacks to an earlier traumatic event ◯
- Nightmares ◯
- Having to do or say something to prevent a bad thing from happening ◯
- Decreased need for sleep ◯
- Rapid Speech ◯
- Feeling overjoyed with life/on top of the world/ I can do anything ◯
- Spending or giving away too much money for my financial situation ◯
- Hearing things or voices others don't hear ◯
- Seeing things others don't see ◯
- Smelling/tasting odd things others don't; things crawling on me ◯
- Feeling that other people are controlling my thoughts ◯
- History of physical abuse ◯
- History of sexual abuse ◯
- History of verbal/emotional abuse ◯
- Getting into verbal of physical fights ◯
- *Thoughts of harming others* ◯
- *Plans to harm others* ◯

Other Current Symptoms (please list):

_____

_____

Family Mental Health History

Have any of your family members ever been diagnosed with:

Depression ◯
Bipolar Disorder ◯
Suicide/Suicide Attempt ◯
Schizophrenia ◯
Eating Disorder ◯
Anxiety Disorder ◯
Substance Abuse ◯
ADHD ◯
Thyroid problems ◯
Other (Please List): _____

Medical Diagnoses

Please list:

_____

_____

Current Medications

Please list:

_____

_____

Current Substance Use

Type of Substance	Times used per week	Amount consumed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____