Pasadena Neuropsychiatry & TMS Center
595 E Colorado Blvd, Suite 602
Pasadena, Ca 91101
Phone: (626) 636-4020 Fax (626) 765-6675

New Patient Intake Form

Please fill in all the information as accurately as possible. **Date:**

First Name_____ Last Name_____ Preferred name (i.e. nickname) _____ Date of Birth_____

Cell Phone (____)_____ Home Phone (____)_____ email_____

Address _____ City _____ State _____Zip _____

SSN # _____ Preferred Method of communication: Cell Phone ( ) Home Phone ( ) email ( )

Emergency Contact:

Name _____ Relationship _____ Phone number _____

Mother's maiden name (required by HIPPA for verification purpose): _____

Which gender you identify with _____how should we refer to you to reflect this appropriately_____

Primary Care Physician Name _____Contact Information_____

Do you give permission for your treating physician at Pasadena Neuropsychiatry to communicate with your PCP? Yes ( ) No ( )

Preferred pharmacy name _____ City _____ Phone _____

REFERRED BY

Physician ___ Name _____ Insurance ____ Carrier Name _____ Other___Specify _____

What are the concerns that bring you to Pasadena Neuropsychiatry?

1. _____
2. _____

What are your treatment goals?

_____

Current Symptoms checklist ***(****check for any symptoms present, twice for major symptoms****)***

1. Depressed mood ( ) ( )	2. Sleep pattern disturbance ( ) ( )	3. Unable to enjoy activities ( ) ( )
4. Loss of interest ( ) ( )	5. Concentration / forgetfulness ( ) ( )	6. Decreased Libido ( ) ( )
7. Change in appetite ( ) ( )	8. Excessive guilt ( ) ( )	9. Impulsivity ( ) ( )
10 Fatigue ( ) ( )	11. Increased risky behavior ( ) ( )	12. Increased irritability ( ) ( )
13. Crying spells ( ) ( )	14. Excessive worry ( ) ( )	15. Anxiety attack ( ) ( )

16. Avoidance ( ) ( ) 17. Decreased need for sleep marked by fatigue ( ) ( )

18. Decreased need for sleep at least four consecutive days without fatigue, marked by excessive energy, racing thoughts ( ) ( )

Auditory Hallucination *(If yes, start date: _____)*

1. Only when using illicit substances or during withdrawal from including alcohol and benzodiazepines. Yes ( ) No ( )
2. Experience them regardless of substance use Yes ( ) No ( )
3. Inaudible sounds, whispers, mumbling Yes ( ) No ( )
4. Hearing your name called Yes ( ) No ( )
5. Hearing a distance voice Yes ( ) No ( )
6. Hearing a distance voice making disparaging comments about you (mood congruent, auditory hallucinations. Yes ( ) No ( )
7. Hearing two voices or more Yes ( ) No ( )
8. Hearing two voices conversing Yes ( ) No ( )

Visual Hallucination *(If yes, start date: _____)*

1. Only when using illicit substances or during withdrawal from including alcohol and benzodiazepines. Yes ( ) No ( )
2. Experience them regardless of substance use Yes ( ) No ( )
3. Suspiciousness paranoia Yes ( ) No ( )

a. If yes, what are some examples 1._____ 2. _____ 3. _____

Firearms

1. Do you own firearms? If yes, please explain Yes ( ) No ( )

a. Number: _____

b. Type: _____

c. Purpose _____

d. How they are stored _____

Medical History

1. Do you have any allergies? If yes, please explain _____

List current and past Psychiatric Medication taken

Trial #	***Medication***	***Total daily dosage***	***Start date***	***End date***
1				
2				

3				
4				
5				
6				
7				
8				
9				
10				

a. Name _____ Total Daily Dosage _____ Estimated start date _____

b. Name _____ Total Daily Dosage _____ Estimated start date _____

c. Name _____ Total Daily Dosage _____ Estimated start date _____

d. Name _____ Total Daily Dosage _____ Estimated start date _____

e. Name _____ Total Daily Dosage _____ Estimated start date _____

2. List all current prescription medications (if none, write N/A)

a. Name _____ Total Daily Dosage _____ Estimated start date _____

b. Name _____ Total Daily Dosage _____ Estimated start date _____

c. Name _____ Total Daily Dosage _____ Estimated start date _____

d. Name _____ Total Daily Dosage _____ Estimated start date _____

e. Name _____ Total Daily Dosage _____ Estimated start date _____

3. List all current over-the counter medications or supplements (if none, write N/A)

a. Name _____ Total Daily Dosage _____ Estimated start date _____

b. Name _____ Total Daily Dosage _____ Estimated start date _____

c. Name _____ Total Daily Dosage _____ Estimated start date _____

4. Explain current medical problems: _____

_____

_____

5. Explain past medical problems, non-psychiatric, hospitalization, or surgeries : _____

_____

_____

6. When was the last time you were seen in the ER or urgent care and why: _____

_____

7. Have you ever had EKG? Yes ( ) No ( )
   a. If yes; Date _____ Why _____
8. Last physical exam. Date _____ Location _____
9. To your knowledge, are you up to date with the recommended preventative health screening guidelines for your age group (Cervical Cancer screening, mammogram, etc) Yes ( ) No ( ) Not sure ( )

For CIS Females only

Date of last menstrual period _____

1. Are you currently pregnant or do you think you might be pregnant Yes ( ) No ( ) Not sure ( )
   a. If no, are you planning to get pregnant in the future Yes ( ) No ( ) Not sure ( )
   b. If no, what for of birth control do you use/ have you most consistently used _____
2. Do you experience worsening of the symptoms you are here to have evaluated during the two weeks preceding your menstrual cycle Yes ( ) No ( )
3. If you have been pregnant in the past, how many times _____, how many live births _____
4. If you have had live births, how many were born preterm and/or required transfer to the NICU post delivery _____
5. If you have been pregnant, have you experienced depression, anxiety, paranoia, or other symptoms during pregnancy, in the post partum period, or following an unexpected loss of a pregnancy Yes ( ) No ( )
   a. If yes, please provide the date _____
   b. Did you received treatment Yes ( ) No ( )
      i. If yes, what form (talk therapy, group therapy, pharmacotherapy, brexanalone, etc) _____

If you are currently pregnant, experienced a recent loss of pregnancy, or are within a 12 month post partum period, please let the staff know

Personal and Family Medical History *(You and First Degree Family Member, parents, siblings and children)*

1.	Thyroid Disease	You ( )	Mother ( )	Father ( )	Brother ( )	Sister ( )	Children ( )
2.	Gastrointestinal problems	You ( )	Mother ( )	Father ( )	Brother ( )	Sister ( )	Children ( )
3.	Anemia	You ( )	Mother ( )	Father ( )	Brother ( )	Sister ( )	Children ( )
4.	Cancer	You ( )	Mother ( )	Father ( )	Brother ( )	Sister ( )	Children ( )

5. Headaches, Migraines You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
6. Headaches, cluster type You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
7. Fibromyalgia You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
8. Heart Disease You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
9. Chronic Fatigue You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
10. Chronic Pain You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
11. Kidney Disease You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
12. High Cholesterol You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
13. Diabetes (I or II) You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
14. High blood pressure You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
15. Rheumatologic disorder You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
16. Asthma/Respiratory problems You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
17. Serious rash called Steven Johnson You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
18. Huntington's Chorea You ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
19. Parkinson's disease or Alzheimer's dementia Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
20. Sudden cardiac death Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
21. Schizophrenia – at what age _____ Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
22. Suicide (completed) Mother ( ) Father ( ) Brother ( ) Sister ( ) Children ( )
23. Have you been diagnosed with:
    a. Hepatitis (alcohol induced, viral or autoimmune) Yes ( ) No ( )
    b. HIV Yes ( ) No ( )
    c. Head Trauma, secondary to repetitive concussive injury Yes ( ) No ( )
    d. Head Trauma, secondary to single traumatic event Yes ( ) No ( )
    e. Anoxic brain injury Yes ( ) No ( )
24. Do you ever restrict your caloric intake to less than 1000 calories per day Yes ( ) No ( )
25. Do you or have you in the past engaged in binge eating and purging behavior Yes ( ) No ( )
26. Have you ever attempted to end your life Yes ( ) No ( )
    a. If yes, what was the method _____ Date _____
    b. If you hospitalized, number of days _____ Hospital and location _____
    c. Was a medical intervention such as gastric lavage, sutures, or other treatment Yes ( ) No ( )
    d. Have you engaged in or do you engaged in cutting or other forms of self injurious behavior Yes ( ) No ( )

27. When your mother was pregnant with you, were there any complications during the pregnancy Yes ( ) No ( ) Not sure ( )

Psychiatric History

1. Were you ever diagnosed with a pervasive developmental disorder as a child or adolescent Yes ( ) No ( )
2. Did you / do you currently receive services through the Regional Center Yes ( ) No ( )
3. Have you ever been treated by a psychiatrist in the past Yes ( ) No ( )
    a. If yes, at what age _____
    b. Who was the most recent psychiatrist involved in your care _____
4. What characteristics would your ideal psychiatrist have _____

    _____
5. Have been hospitalized for psychiatric reasons Yes ( ) No ( )
    a. If yes, describe the reason _____
    b. When _____ Where _____
6. List past Psychiatric Medication taken – If you can't remember all the details, just write in what you do remember)

    _____

    _____

Substance Use

1. Have you ever been in treatment for substance use Yes ( ) No ( )
    a. If yes, where _____ When _____
    b. Treatment; Inpatient _____ Outpatient _____Residential _____ Voluntary _____ Mandated _____
2. Do you drink alcohol or use cannabis Yes ( ) No ( )
    a. If yes, how many days a week; Alcohol _____ Cannabis _____
    b. If cannabis, what age did you start using _____
    c. Do you use other substances Yes ( ) No ( )
3. Have you ever abused prescription medication Yes ( ) No ( )
    a. If yes, which ones and for how long _____
4. Do you have any DUIs Yes ( ) No ( )
    a. If yes, how many _____ dates: _____
5. Have you ever been resuscitated from near overdose with the use of naloxone Yes ( ) No ( )
6. Have you ever been hospitalized for alcohol or benzodiazepine withdrawals Yes ( ) No ( )
7. Have you experienced delirium tremens from alcohol or benzodiazepine withdrawal Yes ( ) No ( )
8. Have you ever bee in a MAT Program (Medication Assisted Treatment) Yes ( ) No ( )

a. If yes, which medication are you taking _____

9. Are you interested in discussing substance use treatment options Yes ( ) No ( )

Tobacco Use

1. Have you ever smoked cigarettes or used tobacco products Yes ( ) No ( )
2. Are you currently using cigarettes or used tobacco products Yes ( ) No ( )
   a. If yes, how many packs per day _____ How many years _____
   b. If yes, are you interested in discussing tobacco cessation option Yes ( ) No ( )

Family Background and Childhood History

1. Were you adopted Yes ( ) No ( )
   a. If yes, do you know your biological family's medical history Yes ( ) No ( )
2. Your primary caregivers
   a. Early childhood (0-6 yrs) Mother ( ) Father ( ) Grandparents ( ) Foster parents ( ) Other ( )
   b. Middle childhood (7-12 yrs) Mother ( ) Father ( ) Grandparents ( ) Foster parents ( ) Other ( )
   c. Adolescence (13-18 yrs) Mother ( ) Father ( ) Grandparents ( ) Foster parents ( ) Other ( )
3. Did you experience a significant event during your childhood Yes ( ) No ( )
   a. If yes, explain briefly _____
4. Overall, how would you describe your childhood, please check the appropriate adjective
   a. Stable, overall happy ( )
   b. Stable, overall neutral ( )
   c. Stable, but overall unhappy ( )
   d. Unstable, overall happy ( )
   e. Unstable, overall neutral ( )
   f. Unstable, overall difficult ( )
5. Have you experienced a traumatic event or ongoing trauma in your life Yes ( ) No ( ) Prefer not to answer ( )
6. What is the highest grade you completed in school _____
7. Did you achieve the highest degree you wanted Yes ( ) No ( )
   a. If no, what was/is an obstacle _____

Employment and marital History

1. Are you employed Yes ( ) No ( )
   b. Employed 32+ hrs/week ( )
   c. Employed 20-32 hrs/week ( )

d. Employed less than 20 hrs/week ( )
e. Unemployed looking for employment ( )
f. Student ( )
g. Disabled permanent ( )
h. Disabled temporary ( )
i. Retired ( )

2. If employed, how long in present position _____
3. What is your occupation _____
4. Have you ever served in the military Yes ( ) No ( )
   a. If yes, what branch _____
5. Are you currently married, if no, please select below Yes ( ) No ( )
   a. Partnered (not legally married, same household) ( )
   b. Divorced ( )
   c. Widowed ( )
   d. Never married ( )
6. If not married, are you in a relationship Yes ( ) No ( )
   a. If yes, how long _____
7. Married or in relationship, is the relationship (to your knowledge) Monogamous ( ) Polygamous ( )
8. If you are sexually active, is it with Men ( ) Woman ( ) Both ( ) Prefer not to answer ( )

As recommended by the CDC, all patients seen for their first appointment will be offered an HIV test, a screening test for syphilis as well screening testing for viral hepatitis. These tests are offered as part of the CDC's general recommendations for all patients. As such, they are recommended, but not required. This will be discussed during your appointment

9. Do you have children Yes ( ) No ( )
   a. If yes, how many _____ Ages _____, _____, _____, _____, _____
   b. Do any of your children reside with you Yes ( ) No ( )
10. Housing situation, live with
   a. Spouse/partner ( )
   b. Children ( )
   c. Parents ( )
   d. Extended family ( )
   e. Roommate ( )
   f. Alone ( )
   g. Is your housing currently secure Yes ( ) No ( )

Legal History

1. Have you ever been incarcerated Yes ( ) No ( )
   a. If yes, please indicate the length of time _____ and location : County ( ) State ( ) Federal ( )
2. Are you currently on probation or parole Yes ( ) No ( )
3. Have you ever been declared Incompetent to Stand Trial or a Mentally Disordered Offender Yes ( ) No ( )
4. Have you been the subject of an involuntary order for medication/treatment Yes ( ) No ( )
   a. If yes, are you currently conserved Yes ( ) No ( )
      i. If yes, who is your conservator _____ which county _____
5. Have you ever been a patient at a state hospital (Patton, Metropolitan, etc) Yes ( ) No ( )

Signature _____ Print name _____ Date _____

Guardian – If under age 18

Signature _____ Print name _____ Date _____

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Insurance Information and Financial Responsibility

Insurance Company Name _____ Insured's ID # _____ Policy Group ID # _____

Policy Holder's Name _____ Date of birth _____ Social Security # _____

Policy holder's Address _____ City _____ State ____ Zip _____

Policy Holder's Relationship _____

Financial Agreement

We may participate in different insurance plans. You will be responsible for any co-payments or deductibles at the time services are rendered. For some insurances we accept assignment of benefits but in all cases, we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services under some medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays are expected at the time of service. If this fee is not covered by insurance it will be your responsibility. We allow your insurance company 30 days to pay your claim. If we do not receive payment in 30 days, you will be given a bill at that time. Missed appointments are not covered by your insurance and the charges associated with them are your responsibility. **Initials** _____

Assignment of Insurance Benefits:

I hereby authorize direct payment to **Pasadena Neuropsychiatry Center, Torie Sepah MD** of any insurance or health benefits otherwise payable to or on behalf of the patient for examination or treatment. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits. **Initials** _____

Release of Information:

I hereby authorize **Pasadena Neuropsychiatry Center, Torie Sepah MD** to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination and treatment received by the patient. I also authorize **Pasadena Neuropsychiatry Center, Torie Sepah MD** to release the medical records of the patient to the patient's referring physician or family physician indicated on the first page of this form (when necessary).
Initials _____

HIPAA Acknowledgement:

By signing below, I acknowledge that I received a copy of **Pasadena Neuropsychiatry Center, Torie Sepah MD** Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we

maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available. **Initials** _____

I have read and agree to the terms above:

Signature of Patient_____ Print Name _____ Date _____

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"No Show" and "Cancellation" Policy & Procedure For Office Visits

At Pasadena Neuropsychiatry Center, our goal is to provide quality care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of care. The following policy is with regard to patients who fail to keep their scheduled office visit appointment. Please be courteous and call the Pasadena Neuropsychiatry Center if you are unable to attend an appointment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care.

- Patients who fail to show for their scheduled appointment or do not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee. This fee is 50% of the initial or follow up appointment fee. In the event of an emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- These fees are not covered by insurance and is therefore the sole responsibility of the patient and a credit card will be kept on file.

How to Cancel Your Appointment

To cancel or reschedule an appointment please call our office (626) 636-4020. If you call after hours please leave a message with your name, appointment date and cancellation reason or request for rescheduling. Thank you for choosing Pasadena Neuropsychiatry Center.

Credit Card Information

Name on the card _____ Card Number _____

Exp _____ CVV _____Zip code_____

Patient/Parent Signature _____ Date_____

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General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Parent Signature _____ Date_____

Printed Name _____

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Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A physician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the physician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your health problems evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different physician.

You are responsible for:

- Knowing your health care staff name and title.
- Giving the staff correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your physician so we can reach you in the event of a schedule change or to give medical instructions.

- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your physician.
- Signing a “Release of Information” form when asked so your physician can get medical records from other physicians involved in your care.
- Telling your physician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, **bring the bottles to your appointment.**
- Telling your physician about any changes in your condition or reactions to medications or treatment.
- Asking your physician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your physicians advice. If you refuse treatment or refuse to follow instructions given by your health care provider, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the office at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office’s rules about patient conduct.
- Respecting the rights and property of our staff and other persons in the office.

I have read and understand the statements above

Patients Signature_____ Printed Name _____ Date _____

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Patient Consent to Medical Scribe

Please note that Torang Sepah, MD uses a medical scribe to help her better document your visit into our Electronic Medical Records system. A medical scribe is a part of our team and he/she will listen and transcribe your visit into our Electronic Medical Records (EHR) charting system. This service provides a more accurate record quickly and helps your doctor focus on your well-being.

I understand that my visit will be transcribed into my electronic chart by a medical scribe.

Patient or Patient Representative Signature _____ Date _____