<u>**Susan Chakmakian, M.A., M.F.T.**</u>

PATIENT INFORMATION SHEET

Today's Date: ______/____/______

Name(s): ____

Home Phone: ____________________________ Work Phone: ________________

Mobile Phone: ___________________________ Text messages? Y or N

Best number to contact you? ____

Email : _____________________________ OK to contact by email ? Y or N

Address: ____

______________________________OK to send mail to this address? Y or N

Alternate address (if applicable): ______________________________________

Age: ______________ Date of Birth: ____/____/______ Male / Female

Marital Status_____________________________SSN#:________-________-________

Employer/School ___________________________Educational Level_____________

Children (Name, Ages) ____

____

Person or organization who referred you: _________________________________

IN CASE OF EMERGENCY, NOTIFY:

Name____________________________________ Relationship________________

Telephone ____

PATIENT HISTORY

Areas of Concern

What issues/concerns caused you to seek treatment?________________________

____

Do you have any specific goals with regard to your treatment?_________________

____

Do you have any particular concerns/fears with regard to treatment?____________

____

Family of Origin History

Describe your family history (relationship with parents, siblings, family stressors):

____

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____

Psychological History

Have you ever received mental health treatment before? _____________________

When? ______________________ For how long?______________________________

Name(s) of therapist(s)____

____

Have you taken any medication for a mental/emotional condition? ______________

Medications:____

When:_________________________________How long?_________________________

Have you ever attempted suicide? When? Describes circumstances____________

____

Are you currently having any suicidal thoughts?______________________________

Medical History

Have you ever been diagnosed with a serious illness?________________________

____

Do you have any conditions that may affect your mental health treatment?_______

____

Please describe your overall health today.____________________________________

When was your last medical checkup? ______________________________________

Are you currently taking any prescription medications?_______________________

Medications: ____

Prescribed by whom?____

Have you ever been in a 12 step program?___________________________________

Do you smoke / how much / how long?_______________________________________

Do you drink alcohol? __________On average, how much do you consume in a week?____

Do you currently use illegal drugs? ___________ Have you ever used?___________

Please describe:____

Other Information

Have you ever been a victim of a crime? ________________________________

Spiritual Orientation: ____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested.

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Other Info

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____

____

Susan Chakmakian, M.A., M.F.T.
License # MFC 41817

OFFICE POLICIES/CONSENT FOR TREATMENT

Confidentiality: Information disclosed by you during the course of your therapy is generally confidential. However, there are exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse, expressed threats of violence towards an ascertainable victim, and where you tender your mental and emotional state in a legal proceeding.

Payment: My fee for a 50-minute session is 160.00 unless otherwise arranged. _______________
Extended sessions can be arranged at an additional fee.
Blue Shield/Optum co-payment, if applicable. _______________
Payment is to be made at each therapy session by cash, check or debit/credit card. Please make checks payable to Susan Chakmakian. If you request a statement for insurance reimbursement, it can be provided monthly. Your fee will remain consistent except for possible periodic adjustments.

Appointments and Cancellations: Sessions are 50 minutes and ordinarily take place one time per week. Since your specific time is held for you weekly, please note that you will be responsible for payment if you are unable to cancel with at least 24 hours advance notice. In the case of excessive absences, the cancellation policy may be reviewed in order to ensure that therapy is progressing regularly. Blue Shield clients: Insurance cannot be billed for cancelled appointments; therefore you would be responsible for total fee.

Communications/Emergencies: If you need to communicate with me between sessions, please leave a message for me on my voicemail or text me and I will respond as soon as possible. I do check my voicemail/texts periodically throughout the day. Messages left for me in the late evening will generally be returned the following day. In an emergency, you may need to call 911 or go to an Emergency Room.

Patient's Rights and Responsibilities: You have the right to end your therapy at any time, for whatever reason without any obligation except for fees already incurred. You have the right to question any aspect of your treatment. You also have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, which would greatly compromise the therapeutic relationship.

Therapy involves a partnership between therapist and patient. I will contribute knowledge, skills, and a willingness to do my best. The determination of success, however, will ultimately depend on your commitment to your own personal growth and care.

Your signature below indicates your understanding of and agreement to the above policies.

_______________________________	_______________________________
Patient's Printed Name	Patient's Signature
_______________________________	_______________________________
Patient's Representative	Date
_______________________________	_______________________________
Therapist's Signature	Date

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