



Sayeh Beheshti, M.D., M.A.
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PATIENT INFORMATION FORM

LAST	FIRST	MI	YYYY	MM	DD	<input type="checkbox"/> M <input type="checkbox"/> F
NAME			BIRTHDATE		GENDER	

STREET
CITY, STATE
COUNTRY, ZIP CODE

ADDRESS

EMAIL	<input type="checkbox"/>
HOME PHONE	<input type="checkbox"/>
WORK	<input type="checkbox"/>
CELL	<input type="checkbox"/>

CONTACT INFORMATION. PLEASE INDICATE PREFERRED METHOD OF CONTACT

NAMES AND AGES

CHILDREN (IF APPLICABLE)

NAME
PHONE
STREET ADDRESS
CITY, STATE
COUNTRY, ZIP CODE

PRIMARY CARE PHYSICIAN

SOCIAL SECURITY NUMBER
<input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED

RELATIONSHIP STATUS

RELIGIOUS/SPIRITUAL BACKGROUND
HIGHEST LEVEL OF EDUCATION / DEGREE / SPECIALIZATION

OCCUPATION
NAME
OCCUPATION

SIGNIFICANT OTHER'S NAME & OCCUPATION (IF APPLICABLE)

1. NAME
PHONE
RELATIONSHIP
2. NAME
PHONE
RELATIONSHIP

EMERGENCY CONTACTS

SIGNATURE: _____ DATE: _____



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HOW DID YOU HEAR ABOUT DR. BEHESHTI?

PLEASE DESCRIBE THE REASON FOR SEEKING TREATMENT (INCLUDE DATE/MONTH THE PROBLEM BEGAN)

PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS WITHIN THE LAST MONTH:

<input type="checkbox"/> DIFFICULTY FALLING ASLEEP <input type="checkbox"/> DIFFICULTY STAYING ASLEEP <input type="checkbox"/> EARLY MORNING WAKENING <input type="checkbox"/> DECREASED ENERGY/FATIGUE <input type="checkbox"/> APPETITE CHANGE- INCREASED OR DECREASED <input type="checkbox"/> WEIGHT- LOSS OR GAIN <input type="checkbox"/> HOPELESSNESS/HELPLESSNESS <input type="checkbox"/> LOSS OF INTEREST <input type="checkbox"/> SEXUAL DYSFUNCTION <input type="checkbox"/> TEARFULNESS <input type="checkbox"/> DEPRESSED MOOD <input type="checkbox"/> POOR CONCENTRATION <input type="checkbox"/> MEMORY DIFFICULTIES- SHORT TERM <input type="checkbox"/> MEMORY DIFFICULTIES- LONG TERM <input type="checkbox"/> TROUBLE ORGANIZING THOUGHTS <input type="checkbox"/> FEELINGS OF GUILT <input type="checkbox"/> THOUGHTS OF HARMING YOURSELF <input type="checkbox"/> IRRITABILITY <input type="checkbox"/> IMPULSE CONTROL PROBLEMS <input type="checkbox"/> ANGER OUTBURSTS <input type="checkbox"/> DECREASED NEED FOR SLEEP <input type="checkbox"/> RECKLESS BEHAVIOR <input type="checkbox"/> PROMISCUITY <input type="checkbox"/> RACING THOUGHTS <input type="checkbox"/> HYPERACTIVITY <input type="checkbox"/> TALKING TOO FAST OR TOO MUCH	<input type="checkbox"/> NOT FINISHING PROJECTS <input type="checkbox"/> EASILY DISTRACTED <input type="checkbox"/> HEARING VOICES <input type="checkbox"/> SEEING THINGS THAT ARE NOT THERE <input type="checkbox"/> FEELING PARANOID <input type="checkbox"/> OBSESSIVE THOUGHTS <input type="checkbox"/> COMPULSIVE BEHAVIORS <input type="checkbox"/> PERFECTIONISM <input type="checkbox"/> SOCIAL ANXIETY <input type="checkbox"/> PERFORMANCE ANXIETY <input type="checkbox"/> SPECIFIC PHOBIA <input type="checkbox"/> AGORAPHOBIA <input type="checkbox"/> NERVOUSNESS/ANXIETY <input type="checkbox"/> EXCESSIVE WORRY/FEAR <input type="checkbox"/> PANIC ATTACKS <input type="checkbox"/> HYPERVIGILANCE <input type="checkbox"/> FLASHBACKS OF TRAUMATIC EVENT <input type="checkbox"/> NIGHTMARES <input type="checkbox"/> EATING DISORDER <input type="checkbox"/> PREGNANCY RELATED MOOD DISORDER <input type="checkbox"/> POSTPARTUM DEPRESSION <input type="checkbox"/> POSTPARTUM PSYCHOSIS <input type="checkbox"/> RELATIONSHIP DIFFICULTIES <input type="checkbox"/> LEGAL TROUBLES <input type="checkbox"/> THOUGHTS OF BRINGING HARM TO ANOTHER PERSON
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LIST OF MEDICAL CONDITIONS

LIST OF SURGICAL PROCEDURES

YYYY	MM	DD
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DATE OF LAST PHYSICAL EXAM

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____



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ALLERGIES

CURRENT MEDICATIONS (DOSE, FREQUENCY, PRESCRIBING MD)

VITAMINS/HERBS/SUPPLEMENTS

ALCOHOL

CIGARETTES

CAFFEINE

OTHER DRUGS (PLEASE LIST)

HOW MUCH OF THE FOLLOWING DO YOU CONSUME OR HAVE COMSUMED IN THE PAST

PREVIOUS PSYCHIATRIC DIAGNOSES/TREATMENT/MEDICATIONS

LIST OF PSYCHIATRIC ILLNESS IN ANY OF YOUR FAMILY MEMBERS

HAVE YOU EXPERIENCED ANY TRAUMA OR ABUSE (PHYSICAL, EMOTIONAL, SEXUAL, NEGLECT)

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____