Sayeh Beheshti, M.D., M.A.
18141 Beach Blvd., Suite 220
Huntington Beach, CA 92648

Phone: (714) 274-9848
Fax: (714) 274-9855
Email: DrB@DoctorBeheshti.com
Website: DoctorBeheshti.com

# PATIENT INFORMATION FORM

LAST FIRST MI — NAME

YYYY MM DD — BIRTHDATE

☐ M ☐ F — GENDER

STREET

CITY, STATE

COUNTRY, ZIP CODE

ADDRESS

SOCIAL SECURITY NUMBER

☐ SINGLE ☐ DIVORCED ☐ WIDOWED
☐ MARRIED ☐ SEPARATED

RELATIONSHIP STATUS

EMAIL ☐
HOME PHONE ☐
WORK ☐
CELL ☐

CONTACT INFORMATION. PLEASE INDICATE PREFERRED METHOD OF CONTACT

RELIGIOUS/SPIRITUAL BACKGROUND

HIGHEST LEVEL OF EDUCATION / DEGREE / SPECIALIZATION

NAMES AND AGES

CHILDREN (IF APPLICABLE)

OCCUPATION

NAME

OCCUPATION

SIGNIFICANT OTHER'S NAME & OCCUPATION (IF APPLICABLE)

NAME

PHONE

STREET ADDRESS

CITY, STATE

COUNTRY, ZIP CODE

PRIMARY CARE PHYSICIAN

1. NAME

PHONE

RELATIONSHIP

2. NAME

PHONE

RELATIONSHIP

EMERGENCY CONTACTS

SIGNATURE: _____ DATE: _____

Sayeh Beheshti, M.D., M.A.
18141 Beach Blvd., Suite 220
Huntington Beach, CA 92648

Phone: (714) 274-9848
Fax: (714) 274-9855
Email: DrB@DoctorBeheshti.com
Website: DoctorBeheshti.com

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:

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

LIST OF MEDICAL CONDITIONS

LIST OF SURGICAL PROCEDURES

YYYY MM DD
DATE OF LAST PHYSICAL EXAM

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

Sayeh Beheshti, M.D., M.A.
18141 Beach Blvd., Suite 220
Huntington Beach, CA 92648

Phone: (714) 274-9848
Fax: (714) 274-9855
Email: DrB@DoctorBeheshti.com
Website: DoctorBeheshti.com

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: _____