Alisa Ruby, M.A. MFTI

9171 Wilshire Blvd. #600
Beverly Hills, CA 90210
(310) 806-3049
www.alisaruby.com

PATIENT INTAKE FORM

(Family)

Parent's Name: Home Phone: _____

Address: _____ Cell Phone: _____

City & Zip: Work Phone: _____

Soc. Sec. #: _____ Birth Date: _____

Marital Status: _____ E-mail: _____

Parent's Name: Home Phone: _____

Address: _____ Cell Phone: _____

City & Zip: Work Phone: _____

Soc. Sec. #: _____ Birth Date: _____

Marital Status: _____ E-mail: _____

Child's Name: _____ Birth Date: _____

Soc. Sec. #: _____ Grade: _____

Pediatrician: _____ Phone #: _____

School: _____ Phone #: _____

Child lives with: _____ Teacher: _____

Child's Name: _____ Birth Date: _____

Soc. Sec. #: _____ Grade: _____

Pediatrician: _____ Phone #: _____

School: _____ Phone #: _____

Child lives with: _____ Teacher: _____

Child's Name: _____ Birth Date: _____

Soc. Sec. #: _____ Grade: _____

Pediatrician: _____ Phone #: _____

School: _____ Phone #: _____

Child lives with: _____ Teacher: _____

In Case of Emergency Notify: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Psychiatrist: Phone #:

Medical Problems: _____

_____

List all accidents or surgeries any family member has ever had (include date & why): _____

_____

_____

List all medications that are currently being prescribed, the dosage, the reason why, and for how long: _____

_____

_____

By Whom? _____ Phone #:_____

How did you hear about Alisa Ruby? _____

For parents who are divorced, please state custody arraignments (you may be required to provide legal documentation of custody arraignments): _____

_____

Is ex-spouse (biological parent) aware that you are bringing their children to therapy? _____

If not, please explain: _____

_____

Are any of the children adopted? _____

Have there been any significant losses, deaths, or hospitalizations in the last several years? _____

_____

Are you currently involved in any litigation? If yes, please explain: _____

_____

_____

Have you ever been arrested (include date and why)? _____

_____

Family history of mental illness: _____

Special considerations: _____

_____

Reason for seeking therapy (what brings you here): _____

_____

_____

_____

_____

Please circle the symptoms <u>you</u> are currently experiencing: (if any)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Sadness/Depression	1	2	3	Memory Problems	1	2	3
Suicidal Thoughts	1	2	3	Compulsive Behavior	1	2	3
Sleep Problems	1	2	3	Feelings of Hostility	1	2	3
Change in Appetite	1	2	3	Acts of Violence	1	2	3

Weight Change	1	2	3	Social Isolation	1	2	3
Inability to Concentrate	1	2	3	Strange Thoughts	1	2	3
Obsessive Thoughts	1	2	3	Sexual Problems	1	2	3
Tension/Anxiety	1	2	3	Phobias	1	2	3
Panic Attacks	1	2	3	Other:	_______________		

Please circle the symptoms <u>your child</u> is currently experiencing: Child's Name: ____________________

	Mild	Moderate	Severe		Mild	Moderate	Severe
Sadness/Depression	1	2	3	Memory Problems	1	2	3
Suicidal Thoughts	1	2	3	Compulsive Behavior	1	2	3
Sleep Problems	1	2	3	Feelings of Hostility	1	2	3
Change in Appetite	1	2	3	Acts of Violence	1	2	3
Weight Change	1	2	3	Social Isolation	1	2	3
Inability to Concentrate	1	2	3	Strange Thoughts	1	2	3
Obsessive Thoughts	1	2	3	Stomach Aches	1	2	3
Tension/Anxiety	1	2	3	Headaches	1	2	3
Panic Attacks	1	2	3	Phobias	1	2	3
Bedwetting	1	2	3	Other:	_______________		

Please circle the symptoms <u>your child</u> is currently experiencing: Child's Name: ____________________

	Mild	Moderate	Severe		Mild	Moderate	Severe
Sadness/Depression	1	2	3	Memory Problems	1	2	3
Suicidal Thoughts	1	2	3	Compulsive Behavior	1	2	3
Sleep Problems	1	2	3	Feelings of Hostility	1	2	3
Change in Appetite	1	2	3	Acts of Violence	1	2	3
Weight Change	1	2	3	Social Isolation	1	2	3
Inability to Concentrate	1	2	3	Strange Thoughts	1	2	3
Obsessive Thoughts	1	2	3	Stomach Aches	1	2	3
Tension/Anxiety	1	2	3	Headaches	1	2	3
Panic Attacks	1	2	3	Phobias	1	2	3
Bedwetting	1	2	3	Other:	_______________		

Please circle the symptoms <u>your child</u> is currently experiencing: Child's Name: ____________________

	Mild	Moderate	Severe		Mild	Moderate	Severe
Sadness/Depression	1	2	3	Memory Problems	1	2	3
Suicidal Thoughts	1	2	3	Compulsive Behavior	1	2	3
Sleep Problems	1	2	3	Feelings of Hostility	1	2	3
Change in Appetite	1	2	3	Acts of Violence	1	2	3
Weight Change	1	2	3	Social Isolation	1	2	3
Inability to Concentrate	1	2	3	Strange Thoughts	1	2	3
Obsessive Thoughts	1	2	3	Stomach Aches	1	2	3
Tension/Anxiety	1	2	3	Headaches	1	2	3
Panic Attacks	1	2	3	Phobias	1	2	3
Bedwetting	1	2	3	Other:	_______________		

1. Please circle the number that best describes how well you are doing on your job:

1	2	3	4	5
No Problems	Mild Problems	Moderate Problems	Serious Problems	Cannot Function

2. Please circle the number that best describes how well you are doing in your marital/sig. other relationship:

1	2	3	4	5
No Problems	Mild Problems	Moderate Problems	Serious Problems	Cannot Function

3. Please circle the number that best describes how well you are doing in your family (of origin) relationships:

1	2	3	4	5
No Problems	Mild Problems	Moderate Problems	Serious Problems	Cannot Function

4. Please circle the number that best describes how well you are doing in relationships with people outside your family:

1	2	3	4	5
No Problems	Mild Problems	Moderate Problems	Serious Problems	Cannot Function

5. Please circle the number that best describes your current physical health:

1	2	3	4	5
No Problems	Mild Problems	Moderate Problems	Serious Problems	Very Poor

6. Please circle the number that best describes your general happiness and well-being:

1	2	3	4	5
No Problems	Mild Problems	Moderate Problems	Serious Problems	Very Poor

Please Circle:

Alcohol Use:	Never	1-4 times per year	1-4 times per month	2-3 times per week	Daily
Level of Consumption:		1-2 drinks per sitting	3-4 drinks per sitting	5+ drinks per sitting	
Intoxication Frequency:	Never	1-4 times per year	1-4 times per month	2-3 times per week	Daily

Circle All Used: None Marijuana Sedatives Stimulants Cocaine/Opiates Hallucinogenic

Frequency:	Never	1-4 times per year	1-4 times per month	2-3 times per week	Daily

Do you or does anyone in your family have a history of alcohol or chemical abuse? _____

_____

Additional Comments: _____

_____

_____

Rami M. Sadeghi, Ph.D.

9171 Wilshire Blvd. #610
Beverly Hills, CA 90210
(310) 273-7000
www.drsadeghi.com

INFORMATION AND CONSENT FOR TREATMENT FORM

The therapeutic relationship is unique in that it is highly personal and, at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work and what each of us can expect. Please feel free to discuss any of this with me.

Therapy involves a partnership between therapist and client. There are no miracle cures. Or, at least, I haven't been able to find any. I cannot promise that your behavior or circumstance will change. I can promise to contribute knowledge, skills, and a willingness to work very hard with you and to do my best to understand and support you, as well as help you clarify what it is you want for yourself. The determination of success, however, will ultimately depend upon your commitment to your own personal growth and care.

Confidentiality: As your therapist, I am legally prohibited from revealing to another person that you are in therapy with me, nor can I reveal what you have said to me in any way that identifies you without your written permission. However, in the following instances, your right to confidentiality must be set aside as required by law and/or professional guidelines:

A. Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services.
B. If I have a reason to believe that a client poses an unavoidable and imminent danger of violence to another person (or to another's property), I must warn whoever may be in danger, and I must notify the appropriate authorities.
C. If a court has ordered your treatment with me, or if I am served with a subpoena. For example, in the context of a legal proceeding in which you raise your own psychological state as an issue, I am required to release information to the court, or may have to appear in court.
D. Finally, if you as a client reveal a serious intent to harm yourself, I am ethically bound to do what I can to help you keep safe, which may involve notifying others who may be of help.

In all of the above cases, it is incumbent upon me to release only that information necessary to appropriately carry out my responsibilities – your confidentiality still remains an ethical priority. While it is my legal responsibility to report any of the above incidents, it is my ethical responsibility to help you through these stressful times.

Professional consultation is an important component of a healthy psychotherapy practice. As such, and in order to provide the best possible service, from time to time I will participate in clinical, ethical, and legal consultation with appropriate professionals. During these consultations, I will not reveal any personally identifying information.

Sessions: Your weekly appointment time is reserved for you. Therapy sessions are normally 50 minutes. Appointment cancellations must be made 24 hours in advance, otherwise, you are responsible for the fee for such sessions.

Payment for Services: You are expected to pay for services at the time of our session, unless we have agreed on other arrangements. If you request it, I will give you a monthly statement, which you can use to bill your insurance for reimbursement. We will agree upon a fee at the outset of treatment. My fees may change over the course of treatment, typically fees will be raised once yearly.

Past due payments – Payment for services which are past due over 120 days may be subject to collection through the use of a collection agency. However, efforts will be made to make other arrangements with you as needed.

Telephone Accessibility: I will attempt to return calls during business hours, and I do not carry a pager. Should you have a clinical emergency, you may need to call a suicide prevention line or go to an emergency room for evaluation. I do not charge fees for telephone consultations that are less than 10 minutes. Consultations of greater length will be pro-rated based on your hourly fee.

Patient's Rights: In addition to confidentiality, as spelled out above, you have the right to end your therapy at any time, for whatever reason, without any moral, legal, or financial obligations, except for fees already incurred. When it is time for you to end, I would appreciate your giving me at least two weeks notice. This way, we can help bring about better closure.

You have the right to question any aspect of your treatment with me, and to expect that I will work with you to meet your needs. You also have the right to expect that I will maintain professional relational and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which would greatly compromise our work together.

By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this agreement, that you provide your consent to your participation in psychotherapy with me, and that I have answered any questions you might have to your satisfaction.

Sign: _____ Date: _____ Home #: _____

Print: _____ Cell #: _____

Address: _____ Work #: _____

List all minors attending therapy: _____

Emergency contact information: _____