

Paul B. Bohn, M.D., Psy.D.

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Welcome to our office!

Enclosed is an important questionnaire for you to fill out and bring with you to the appointment. Please be sure to fill out all pages. Also enclosed is an appointment card and a map indicating the location of the office.

We want you to understand our psychiatric-medical specialty and to feel comfortable in our office. Please feel free to ask Dr. Bohn or ourselves any questions that may remain unanswered.

Dr. Bohn received his psychiatric residency training at UCLA-Neuropsychiatric Institute. After residency, he went on to complete a fellowship in anxiety disorders and behavior therapy at the University of Southern California, and a psychoanalytic training program at the Institute for Contemporary Psychoanalysis. Dr. Bohn is a general psychiatrist for adults specializing in psychopharmacology (medication) and psychotherapy (cognitive-behavioral and psychoanalytic). He is also involved in teaching and research and is currently a Clinical Professor of psychiatry at UCLA.

We look forward to meeting you.

Sincerely,

Latasha
Administrative Coordinator

Paul Bohn, M.D., Psy.D.

Consent for Evaluation or Treatment

Please take a moment to review some information to which you are entitled before receiving psychiatric services.

Any information you disclose will be maintained in the strictest confidence, unless you specifically authorize its release, or unless law or professional standards of practice require its release. In particular, your right to confidentiality may not be maintained if you are in immediate danger to yourself or to someone else, and steps must be taken to assure your own or another's safety. Also, any clinician hearing that a child or elder is being or has been physically or psychologically abused is required by law to report this information to a designated agency. If it is necessary to disclose information to anyone else pertaining to you, this will be discussed with you.

All outpatient visits must be paid for at the time of the visit. At the time of your outpatient visit, you will be provided with an insurance statement to submit to your insurance company. We cannot accept responsibility for negotiating claims with insurance companies or other persons. You are responsible for payment of your medical care regardless of the status of your claim. Any other financial arrangement must be made with us prior to service.

Any outstanding bills will be billed again monthly. If payment is not received after two successive billings, your account may be sent to a collection service. **Should you need to cancel a session, please do so at least 24 hours in advance. Otherwise, the time will be held open, and you will be charged at your regular rate for the canceled session.** Under circumstances where a party other than the patient is responsible for payment, that party must sign a separate agreement guaranteeing payment of the bill.

I agree in the event of non-payment to bear the cost of collection and/or court costs and legal fees should this be required.

I have read and understood the foregoing, and I consent to this evaluation or treatment.

Signature

Date

Paul B. Bohn, M.D., Psy.D.

NEW PATIENT INFORMATION

Referred by: _____

Address: _____

Phone: _____

PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT):				DATE:	
PATIENT:					
Mr. Mrs. Miss	LAST NAME	FIRST NAME	MIDDLE		
PATIENT STREET ADDRESS		CITY	STATE	ZIP	HOME PHONE
SOCIAL SECURITY NUMBER		DATE OF BIRTH	AGE	DRIVERS LICENSE NUMBER	
PATIENT'S EMPLOYER			OCCUPATION		
EMPLOYER'S ADDRESS: STREET		CITY	STATE	ZIP	BUSINESS PHONE
SPOUSE'S NAME		MARITAL STATUS		REFERRED BY	
SPOUSE'S EMPLOYER: STREET ADDRESS		CITY	STATE	ZIP	BUSINESS PHONE
IN CASE OF AN EMERGENCY CONTACT: NAME		ADDRESS	CITY, STATE		ZIP PHONE
MEDICAL INSURANCE INFORMATION:					
COMPANY		POLICY NUMBER			
COMPANY		POLICY NUMBER			
IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT PLEASE COMPLETE THE FOLLOWING SECTION:					
RESPONSIBLE PARTY:					
MR. MRS. MISS	LAST NAME	FIRST NAME	MIDDLE	RELATIONSHIP	
STREET ADDRESS		CITY	STATE	ZIP	HOME PHONE
OCCUPATION		EMPLOYED BY		BUSINESS PHONE	
EMPLOYER'S STREET ADDRESS		CITY	STATE	ZIP	

I hereby authorize Dr. Bohn to release any and all medical information to the above-named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I agree in the event of non-payment to bear the cost of collection and/or court costs and legal fees should this be required. I have read this authorization and understand it.

Insured or Guardian's Signature _____ Patient's Signature _____

PAUL BOHN, M.D.
MEDICAL EVALUATION

Patient's Name: _____

I. TO BE COMPLETED BY PATIENT

Please complete the following questions to the best of your ability

A. Identifying Data:

Name: _____ Home Phone: () _____

Address: _____ Marital Status _____

_____ Date of Birth ____/____/____
Zip Code MO DY YR

Occupation: _____ Work Phone: () _____

Educational Level: _____

B. What brings you in to see the doctor?

C. Personal Medical History:

1. Do you receive regular medical care from a physician or clinic? No Yes

If yes, please provide the following information:

Name of Physician or Clinic: _____ Phone () _____

Address: _____
(Zip Code)

2. Have you ever had any of the following illnesses?

Yes No

Yes No

High Blood Pressure			Migraine Headaches		
Diabetes			Peptic Ulcers (stomach ulcers)		
Cancer			Colitis		
Thyroid Disease			Irritable Bowel Syndrome		
Other Hormone Problem			Tuberculosis		
Alcoholism			Stroke		
Heart Disease			Rheumatic Fever		
Glaucoma			Asthma		
Epilepsy			Birth Defects		

(a) Have you had any other disease? No Yes If yes, explain: _____

(b) What is your current weight (estimate if you do not know exactly)? _____ lbs.

C. Personal Medical History: (continued)

(c) What is the most you have ever weighed? _____ lbs. When? _____

(d) Can you explain any recent weight loss or weight gain? _____

(e) What is your height? _____ ft. _____ in.

3. Have you ever had to be hospitalized? No Yes If yes, complete the following:

Year	Doctor's Name	Name of Hospital	Reason
_____	_____	_____	_____
_____	_____	_____	_____

4. Have you ever had surgery or been advised to have surgery? No Yes If yes, complete the following:

Year	Doctor's Name	Name of Hospital	Name of Operation or Procedure
_____	_____	_____	_____
_____	_____	_____	_____

5. Have you ever had any injuries?

	Yes	No	When	How did it happen?
Head Injury				
Concussion (ever been knocked unconscious)				
<input type="checkbox"/> Food <input type="checkbox"/> Chemical <input type="checkbox"/> Drug Poisoning				
Broken Bone				
Severe Cuts or Lacerations				
Other _____				

6. Do you have any allergies?

	Yes	No	How are you affected?
Penicillin			
Other Medication Allergies			

7. Have you recently had any of the following tests?

	Yes	No	When	Where	Results
Physical Exam					
Thyroid Blood Test					
Blood Tests					
Chest X-Ray					
TB Skin Test (PPD)					
Electrocardiogram (EKG)					
Brain Scan or MRI					
EEG					

8. Are you in the habit of using any of the following items?

Amount Currently Using

Most Ever Used

Coffee (cups/day)		
Cigarettes (packs/day)		
Alcohol (amounts and types of alcohol used daily)		
Marijuana (joints/day)		
Vitamins		
Sleeping Pills		
Herbs		
Aspirin		
Laxatives or Diuretics		

D. Family History:

	Father	Mother	Brother			Sister			Spouse	Children					
			1	2	3	1	2	3		1	2	3	4	5	6
Age (if deceased give date and age at Death)															
Anxiety Disorder or Phobia															
Psychosis or Schizophrenia															
Shyness															
Obsessive Compulsive Disorder															
Manic Depression															
Heart Attack or Heart Trouble															
Epilepsy or Convulsions															
Nervous Breakdown or Depression															
Alcoholism															
Suicide or Suicide Attempt															
Drug Abuse															
Hospitalization for Psychiatric Problem															
Thyroid Problem															
Attention Deficit Disorder															
Alzheimer's Disease															
Migraine Headaches															

E. Review of your current health:

1. Do you have?

Yes

No

Yes

No

Lumps anywhere			Unusual excessive thirst		
Double vision or poor vision			Urine problems, blood in urine		
Difficulty hearing			Indigestion, gas, heartburn		
Fainting spells, blackout spells			Stomach pain or stomach ulcer		
Convulsion			Diarrhea		
Paralysis			Constipation		
Dizziness			Vomiting, vomiting blood		
Headaches			Blood in stool		
Thyroid problem, goiter			Change in appetite or eating habits		
Skin problem			Trouble sleeping		
Cough or wheeze			Sexual problems		
Spitting up blood			Depression		
Palpitation or heart fluttering			Suicidal thoughts		
Chest pain			Weight loss or weight gain		

F. Review of your current health: (continued)

1. Do you have?

Yes

No

Yes

No

Shortness of breath at night or with mild exercise	<input type="checkbox"/>	<input type="checkbox"/>	Problems with memory, thinking or concentration	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	Weakness or tiredness	<input type="checkbox"/>	<input type="checkbox"/>
Visual hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>

Please describe or explain any of the positive answers above

2. For females only:

Date your last menstruation began: _____ Number of pregnancies _____

Number of children born alive: _____ Number of therapeutic abortions _____

Number of miscarriages or stillbirths: _____ Have you had a Pap smear within the last year? No Yes

Do you use any contraceptive method? No Yes If yes, what? _____

Do you examine your breasts for lumps? No Yes

Patient's Signature _____ Date _____

1) Have you ever taken any of the following Medication?

	<u>YES</u>	<u>NO</u>
a) Prozac (fluoxetine)	_____	_____
b) Wellbutrin (bupropion)	_____	_____
c) Anafranil (clomipramine)	_____	_____
d) Norpramin/Pertofrane (desipramine)	_____	_____
e) Pamelor (nortriptyline)	_____	_____
f) Buspar (buspirone)	_____	_____
g) Tegretol (carbamazepine)	_____	_____
h) Depakote/Depakane (valproic acid)	_____	_____
i) Desyrel (trazodone)	_____	_____
j) Asendin (amoxapine)	_____	_____
k) Xanax (alprazolam)	_____	_____
l) Klonopin (clonazepam)	_____	_____
m) Zoloft (sertraline)	_____	_____
n) Paxil (paroxetine)	_____	_____
o) Parnate	_____	_____
p) Marplan	_____	_____
q) Nardil	_____	_____
r) Effexor	_____	_____
s) Ambien	_____	_____
t) Risperdal	_____	_____
u) Serzone	_____	_____
v) Luvox	_____	_____
w) Lithium	_____	_____
x) Remeron	_____	_____
y) Lamictal	_____	_____
z) Neurontin	_____	_____
aa) Zyprexa	_____	_____
bb) Seroquel	_____	_____
cc) Clozapine	_____	_____
dd) Zeldox	_____	_____

- | | | |
|---|------------|-----------|
| 2) Do you now or in the past: | <u>YES</u> | <u>NO</u> |
| a) snore | _____ | _____ |
| b) jerk your arms/legs while asleep | _____ | _____ |
| c) gasp for breath during sleep | _____ | _____ |
| d) have creeping or crawling leg sensations | _____ | _____ |
| e) fall asleep suddenly during the day | _____ | _____ |
| f) wet the bed | _____ | _____ |
| g) walk or talk in your sleep | _____ | _____ |
|
 | | |
| 3) Have you ever: | <u>YES</u> | <u>NO</u> |
| a) binged on food uncontrollably | _____ | _____ |
| b) forced yourself to vomit food | _____ | _____ |
| c) used laxatives, water pills, diet pills,
enemas or ipecac to lose weight | _____ | _____ |
| d) lost so much weight you stopped
having your menstrual period | _____ | _____ |
| e) been told you are bulimic or anorexic | _____ | _____ |
|
 | | |
| 4) Do you ever have: | <u>YES</u> | <u>NO</u> |
| a) repetitive, unwanted thoughts | _____ | _____ |
| b) irresistible urges to check, count
clean, touch or say things repeatedly | _____ | _____ |
| c) spasms, twitches or tics | _____ | _____ |
|
 | | |
| 5) While in school, did you: | <u>YES</u> | <u>NO</u> |
| a) have trouble sitting still in class | _____ | _____ |
| b) have trouble concentrating on school
work | _____ | _____ |
| c) have trouble getting along with
schoolmates | _____ | _____ |
| d) have anxiety about going to school | _____ | _____ |
| e) get left back or expelled | _____ | _____ |
| f) attend special education classes | _____ | _____ |
| g) have stutter, lisp | _____ | _____ |
| h) run away from home | _____ | _____ |
|
 | | |
| 6) Have you ever experience | <u>YES</u> | <u>NO</u> |
| a) hearing voices when no one is around | _____ | _____ |
| b) watching things disappear, or change
shape, color or position when this should
not have occurred | _____ | _____ |
| c) unusual (rotten or fragrant) smells
without anything to account for it | _____ | _____ |
| d) feelings of being touched without
anyone or anything actually touching
you | _____ | _____ |
| e) a sense of detachment from your
surroundings | _____ | _____ |

g) periods of excessive energy, racing thoughts, diminished need for sleep, euphoria, spending sprees, increased sex drive, feelings of power _____

7) Have you ever had: YES NO
a) Hepatitis _____
b) Kidney disease/stones _____
c) Blood transfusions _____
d) Lyme disease _____

8) Have any of your family (parents, brothers/sisters, aunts/uncles, grandparents) had the following: YES NO
a) Panic attacks _____
b) Autism _____
c) Epilepsy _____
d) Tourette's disease _____
e) Huntington's disease _____
f) Wilson's disease _____
g) Parkinson's disease _____
h) Porphyria _____
i) Anorexia or Bulimia _____

9) Have you ever been: YES NO
a) in the military _____
if yes, dishonorably discharged _____
b) arrested for any reason _____
c) injured in an accident or war _____
d) subject to physical, sexual or verbal abuse _____
e) involved in a personal injury, workman's compensation or medical malpractice lawsuit _____
f) to your knowledge, have you been exposed to any toxic chemicals _____

10) Have you ever had the experience of: YES NO
a) finding yourself in a place and having no idea how you got there _____
b) minutes, hours or days having gone by without any memory of what has happened during that time _____
c) having no memory for some important event in your life (for example, a graduation, wedding, death) _____

- | 11) Do you ever have irresistible urges to: | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| a) hurt, attack or kill someone | _____ | _____ |
| b) throw, break, destroy property | _____ | _____ |
| c) steal objects you don't need for personal use or monetary value | _____ | _____ |
| d) gamble, whether you can afford to or not | _____ | _____ |
| e) deliberately set fires | _____ | _____ |
| f) deliberately pull your hair out | _____ | _____ |

- | 12) Recent stressful life events (in last 2 years): | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| a) marriage or engagement | _____ | _____ |
| b) separation or divorce | _____ | _____ |
| c) breakup of important relationship | _____ | _____ |
| d) death of close family, friend | _____ | _____ |
| e) child left home | _____ | _____ |
| f) bad health of family, friend | _____ | _____ |
| g) personal injury or illness | _____ | _____ |
| h) sexual difficulties | _____ | _____ |
| i) changes in school, work | _____ | _____ |
| j) changes in residence | _____ | _____ |
| k) financial difficulties | _____ | _____ |
| l) legal difficulties | _____ | _____ |