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Diplomate, American Board of Psychiatry and Neurology
Specializing in Women's Issues: Psychiatric Evaluations, Psychotherapy, & Psychopharmacology
Licensed In N.Y., N.J., S.C. and Florida. 561-504-0490

Today's Date _____Referred By _____
Patient's Full Name _____
Title _____Occupation _____FT____PT____
Date of Birth _____ M__S__D__W__ Residing with:_____
Mailing Address

Home Phone _____Cell Phone_____
Your preferred/ confidential : Email (do not use a business email)-please write clearly

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Please provide a copy of your driver's license or another picture ID card as proof of your identity, prior to the first appointment. If you are on Medicare, submit a copy of your Medicare card, also. These may be emailed with all the paperwork to the encrypted email of drcarolparas@protonmail.com or faxed to 561-961-0082.

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CONSENT FOR EMERGENCY CONTACTS : *This is required to be seen by Dr. Paras. You must have 2 reliable and informed contacts… persons who agree to be willing to be your contacts, and one of them must witness your signature below.*

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In the case of an emergency, I, _____, hereby give Dr. Paras the right and authorization to contact and inform, as is needed to protect me or others, the following persons.

1- Name_____ Relationship _____
Phone Numbers: _____
2- Name_____ Relationship _____
Phone Numbers: _____

As per HIPPA, many other people and agencies may be contacted without written consent about you and your PHI, if necessary. Treating doctors, hospitals, 911 dispatch, emergency rooms, police and other officials can *legally be contacted to protect your welfare or the welfare of others, without written authorization. Florida is a Baker Act State. NY is a Safe Act State. The duty to warn ruling applies in all States.*

Signature _____ Date_____
Printed name _____

Witness/emergency contact # 1 _____Date _____
Printed Name _____

Ideally, paperwork must be received 36 hrs. before your initial appointment.
Generally, the first three appointments are evaluative in nature. Completing this paperwork in a thoughtful manner allows us to have more time to speak meaningfully, rather than just collect data.

What led to you making this appointment?

What feelings, experiences or behavioral changes are you experiencing?

In your own words, tell me the relevant history, as you see it, in chronological order that led to this situation:

What are your goals/questions as you seek an evaluation or treatment at this time?

<u>Symptom/Behavior Checklist</u> Check all that have applied in the past 12 months.

Anxiety ___	Panic ___	Palpitations ___
Breathing Problems ___	Chest Pains ___	Sweating ___
Shakiness ___	Dizziness ___	Fainting ___
Phobias ___	Avoidance___	Fearfulness___
Depressed Mood ___	Irritability ___	Lethargy ___
Daytime Sleepiness ___	Suicidal thoughts ___	Crying ___
Lack of enjoyment ___	Increased sleep ___	Eating Problems ___
Decreased sleep	Decreased Energy ___	Excess Energy ___
Suicidal thoughts____	Irritability___	Unusual behaviors ___
Confusion_____	Rage___	Excess Energy ___
Food Restricting ___	Binging on Food ___	Vomiting ___
Distractibility_____	Forgetfulness_____	Memory Problems ___
Sexual Problems ___	Gambling Problems_____	Suicidal Plans____
Memory Problems ___	Nightmares_____	Headaches_____
Suicidal Acts_____	Learning Issues_____	Emotional Eating_____
Obsessive thoughts_____	Hair pulling_____	Skin Picking_____
Compulsions _____	Hand washing_____	Intrusive thoughts_____

<u>Past History of Psychological or Psychiatric Treatment--When, where, reason, and with who and outcome</u>? Give dates – use extra sheets, if necessary ..
Outpatient Treatment:

_____
_____
_____
_____

Past Inpatient Psychiatric Or Drug Treatment/Rehab/residential/AA /NA?

_____
_____
_____

Psychotropic Medications taken – at anytime- list name, dose, reasons, side effects and dates. Reasons for starting and stopping:
Sleep meds, antidepressants, stimulants, antianxiety meds, antipsychotic, lithium, mood stabilizers A full list is available on request or we can discuss it during your appointment:

_____
_____
_____
_____

Family history of psychiatric illness – include -adhd, autism, suspected illnesses

Substance Use History:

Do you have a past or current history of substance use?_____Please Explain :

Do you currently use marijuana? How much? When? Effects? Adverse Reactions?

Do you currently use alcohol ? How much?_____

Do you currently use tobacco? Vape? Cigars? Chewing tobacco? Amount/Frequency

***Other substances**: cocaine, meth, stimulants, opiates, hallucinogens, heroin, inhalants, ecstasy, fentanyl, others:_____*

Have you been arrested or fired due to such a problem?

DUI's_____ DWAI's_____

Health Complications from any substances?_____

***Family History of Substance Abuse**:_____*

NA_____ AA _____ Detox_____ Other Treatment?_____

Have you taken any recreational drugs in the past month? Yes No

Explain, if yes-_____

***Your Social History**:*

Describe current living situation:_____

Current partner/spouse Y_____ N____; Length of relationship_____

Children Y_____ N _____

Prior Marriages or Significant Relationships Y_____ N_____

Other Important people in your life _____

Pets _____

Social Support System_____

Do you feel adequately supported? _____

*****Do you have access to guns ? Home or elsewhere?***

Early Development:
*Birth- any complications*_____
Were you adopted Yes_____ No _____. Siblings. # _____
Parents occupations Mom_____. Dad _____
Were your parents divorced? _____ How old were you?_____
When did you leave home if at all? Age _____ Reasons_____
Early Social Experiences:
Play groups_____ Pre-school_____
Group Activities_____ Best Friends_____
Shy Isolated Bullied What ages
Camp Sports
Social Organizations
Age of first romantic relationship
*Childhood Illnesses*_____
*Learning disabilities*_____
*Special ed*_____
Educational History*:*
Highest grade completed_____ Where?_____
Current Employment

_____
Unemployed_____ Student_____Disabled _____ Retired _____
*Business owner*_____
*Health care professional*_____
Government Official _____
*Volunteer Job*_____
Military Service-- past or current

_____
_____
*Deployment*_____
*First responder*_____
*Are you satisfied with your current employment?*_____
_____

Spiritual Life *(religion or otherwise)*_____
_____
_____

Trauma History: *Have you been sexually, physically or emotionally abused, sexually assaulted, or neglected as a child or an adult? Yes_____ No_____*
Have you ever felt you would rather not be alive? Yes_____ No_____
Currently_____ How often? _____Last Time you had thoughts _____

Consent for Psychiatric Evaluation

The first few visits we have are an evaluation. At the end of those visits *I may recommend further work together,* ***OR a*** *medical intervention,* ***OR*** *a different type of care* ***OR*** *a different type of treatment setting,* ***OR*** *whatever is deemed to be more appropriate for you.*

You are free to follow, or not follow, the recommendations offered to you.

The evaluation itself is not treatment*. It is an assessment that answers your questions about why you are in distress now, to the best of my ability and offers you a plan of action.*
The evaluation is not for: *court/forensic purposes, disability assessment, workmen's comp, or for a divorce hearing or a fitness for duty or anything else except the questions just mentioned. No report will be written.*
The purpose of this evaluation is for the benefit and knowledge OF YOU alone, *regarding problems that you may be having, and that you feel are psychological/psychiatric in nature.*
If I feel that you need crisis care, medical care or a different type of care, I will tell you asap. *I will not continue the evaluation, nor charge for the full evaluation, but rather just charge for the time utilized to assess the issues that were found to require a different type of or emergency care. Generally, this can be ascertained in the first visit.*
If we continue working together you will need to sign a consent for treatment.

I , _____, agree to be evaluated by Dr. Paras for

(the nature of your current problems)

I attest that the information I provided in this registration form and evaluation consent has been answered truthfully, and fully, to the best of my ability.
I understand that withholding of information can result in termination of this evaluation. I agree to release all necessary records and test results so that Dr. Paras can perform my evaluation and accurately assess my needs.

Signature _____ Date _____

Print Name_____

AFFIX HERE : A copy of your legal picture id.

Affix Medicare Card-- front and back if relevant.....