YUJUAN CHOY, M.D.
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Tel: 949.288.3098; Fax: 949.272.0072

PATIENT CONTACT INFORMATION *(Please fill in blanks)*

Name _____ Today's Date _____

Employment _____ Date of Birth _____
(list profession)

Work Address Home Address

_____ _____

_____ _____

_____ _____

Telephone _____ Telephone _____

Cellphone _____ Preferred contact: □ work □ home □ cell

EMERGENCY CONTACT

Name _____ Telephone _____
(day)

Relationship _____ Telephone _____
(evening)

BACKGROUND INFORMATION *(Please mark "X" in appropriate boxes)*

Relationship Status
- □ Single
  - □ Not in relationship
  - □ In commited relationship
- □ Domestic Partner
- □ Married
- □ Separated
- □ Divorce
- □ Widowed

Sexual Orientation
- □ Heterosexual
- □ Gay or Lesbian
- □ Bi-sexual

Religious Affiliation
- □ None
- □ Christianity
- □ Judaism
- □ Muslin
- □ Buddism
- □ Other: _____

Level of education
- □ HS or techical school
- □ Undergraduate
- □ Graduate school
  - □ Masters
  - □ Ph.D.
- □ Medical or Law school

Country of Birth
- □ United States
- □ Other: _____

Ethnicity
- □ Caucasian, European-American
- □ African-American
- □ Asian-American
- □ Pacific Islander
- □ Chicano, Latino, Hispanic
- □ Native-American, Alaskan Native
- □ Multi-racial:_____
- □ Other: _____

SOURCE OF REFERRAL

- □ Doctor: _____
- □ Therapist:_____
- □ Friend/family
- □ Colleague
- □ Psychology Today
- □ Academy of Cognitive Therapy (ACT)
- □ Anxiety Disorders Association of America (ADAA)
- □ American Psychiatric Association (APA)
- □ Orange County Psychiatric Association (OCPA)
- □ www.121psychiatry.com website

REASON FOR VISIT *(Please write reason below)*

_____

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PHYSICAL HEALTH INFORMATION *(Please mark "X" in appropriate boxes, or circle YES or NO)*

How would you describe your physical health? □ Excellent □ Good □ Fair □ Poor

Have you ever been hospitalized at least overnight for any medical reasons? YES NO

Have you ever had any major surgeries in the past? YES NO

Do you take any medications? YES NO

If yes, list current medications →

Are you allergic to any medications? YES NO

If yes, please list allergy →

CURRENT/PAST MEDICAL CONDITIONS *(Please circle YES or NO)*

Have you ever had or currently have any of the following medical conditions?

Cardiovascular Problems

High cholesterol	YES	NO
High blood pressure	YES	NO
Heart attacks	YES	NO
Chest pains	YES	NO
Heart murmurs	YES	NO
Palpitations	YES	NO
Fainting episodes	YES	NO
Irregular heart rhythm	YES	NO
Heart failure	YES	NO

Neurologic

Recurrent headaches	YES	NO
Head injury	YES	NO
Seizures	YES	NO
Loss of consciousness	YES	NO
Strokes	YES	NO
Brain infections (e.g. meningitis)	YES	NO
Muscular/sensory loss (e.g.multiple sclerosis	YES	NO

Cancer YES NO

Respiratory

Asthma	YES	NO
Emphysema	YES	NO

Gastrointestinal

Colitis	YES	NO
Internal bleeding	YES	NO
Ulcers	YES	NO
Reflux disease	YES	NO
Irritable bowel syndorme	YES	NO

Hormonal Problems

Thyroid disease	YES	NO
Diabetes	YES	NO

Infectious

Tuberculosis	YES	NO
HIV	YES	NO
Hepatitis	YES	NO
Chronic UTI	YES	NO
STDs (chlamydia, herpes, gonorrhea)	YES	NO

Dermatologic

Psoriasis	YES	NO
Eczema.	YES	NO

Musculo-skeletal

Arthritis	YES	NO
Fibromalygia	YES	NO
Back pain	YES	NO
Chronic fatigue syndrome	YES	NO

Hematologic

Anemia	YES	NO
Blood clots	YES	NO
Bleeding d/o	YES	NO

Major Traumas

Gun shots	YES	NO
Car accidents	YES	NO
Stab wounds	YES	NO
Work-related injuries	YES	NO

Other medical problems: _____

OTHER HEALTH INFORMATION

Are you sexually active? YES NO

When you are active, what type of contraception do you and your partner use?

□ Condoms □ Oral contraceptives □ IUD □ None

□ Diaphragm □ Depopovera (injection) □ Other: _____

(Women) Are you currently pregnant or have reason to believe you may be pregnant? YES NO

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MENTAL HEALTH INFORMATION

Please circle YES or NO

Mental Health Screen

Have you ever had a panic attack out of the blue, when you suddenly felt frightened or developed a lot of physical symptoms?	YES	NO
In the last six months, have you been persistently nervous, tense or jittery?	YES	NO
Do you often avoid certain social situations because they make you anxious?	YES	NO
Have you ever been bothered by intrusive, unwanted thoughts or impulses (obsessions)? These are generally embarrassing, don't make any sense, and wouldn't go away. (*e.g. fears of germs, disturbing images*)	YES	NO
Are there any rituals or actions that you engage in repeatedly and cannot resist doing? (*e.g. counting, checking, washing*)	YES	NO
Have you ever had a period of time when you were clinically depressed? *(feeling sad/hopeless/worthless or losing pleasure in things you usually enjoyed)*	YES	NO
Have you ever had a hypomanic or manic episode, which is when your mood was unusually elevated or high for a period of time?	YES	NO
Have you ever had a fear of gaining weight, and as a result would diet rigorously, restrict your diet, or compensate by vomitting, exercising excessively, taking	YES	NO
Have you ever had problems controlling your appetite and would frequently binge on a lot of food in one sitting?	YES	NO
Have you ever made a suicide attempt in the past?	YES	NO
Have you ever attempted self-injurious behavior in the past (e.g. cutting)?	YES	NO

Treatment History

Have you ever received counseling or therapy for emotional problems?	YES	NO
Have you ever been hospitalized for any mental health or psychiatric reasons?	YES	NO
Have you ever taken medication for any emotional or psychiatric problems?	YES	NO

Family History

Do any of your biological family members have a history of mental illness?	YES	NO
Do any of your family members have an alcohol or substance use problem?	YES	NO

Legal/Violence History

Have you ever been cited, arrested or convicted of a legal violation?	YES	NO
Have you ever caused serious bodily injury to the another person?	YES	NO

Trauma History

Have you ever experienced any of the following traumatic events? (circle all that apply) Victim of a violent crime Physical abuse/assault Sexual abuse/assault Major natural disaster Serious accident or fire Witness someone killed or badly hurt Others (specify):_____	YES	NO
Have you had recurrent nightmares, flashbacks, or intrusive thoughts of these events?	YES	NO

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Substance Use history

Have you ever had a problem with alcohol or recreational drugs?	YES NO
Have you ever felt that you should cut down on your drinking or use of recreational drugs?	YES NO
Have people annoyed you by criticizing your drinking or recreational drug use?	YES NO
Have you ever felt bad or guilty about your drinking or recreational drug use?	YES NO
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (i.e. as an eye-opener)?	YES NO
Have you ever been in treatment for alcohol or substance related problems?	YES NO

Please indicate your use

(Circle 1-7)	Current Use (past 4 weeks) Frequency # of days of week	Amount per day	Past Use (> 4 wks ago) Frequency # of days of week	Amount per day
Caffeine	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Alcohol	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Marijuana	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Other recreational drugs	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Cocaine	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Amphetamines	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Opioids/heroin	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Hallucinogens	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
LSD/PCP	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Rx drug use (not authorized by your doctor): Please list _____				
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Recreational use of Over-the-Counter drugs. Please list: _____				
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Any other recreational drugs. Please list: _____				
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

I acknowledge that I have answered the above questions to the best of my ability.

Patient Signature _____