Neal Mazer, MD, MPH
110 1/2 E. De La Guerra Street
Santa Barbara, CA 93101

New Patient Intake Form

Patient Name:________________________________ **Date:**________________

If under 18 responsible party's name:__________________________________

Relationship to patient:____

Mailing Address: **Physical Address (if different):**

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

May I send mail to the above address? **Y / N**

Telephone Numbers (please provide only numbers at which you give me permission to call)

Home: _______________________ May I leave a detailed message? ____yes ____*no

Work: _______________________ May I leave a detailed message? ____yes ____*no

Cell: _______________________ May I leave a detailed message? ____yes ____*no

Date of Birth/Age: _____________ **Relationship Status:** ________________

Occupation/Employer: ____

Contact Person in case of emergency: _________________________________

Relationship: _______________________ **Telephone #:** __________________

Primary Care Physician: ____________________ **Telephone #:** ____________

Therapist: _________________________________ **Telephone #:** ____________

MEDICAL HISTORY

List any medical problems:

____

____

____

List any medical hospitalizations:

____

____

____

Please list all medications you are prescribed for medical reasons:

Name of medicine	Dose	Reason Prescribed	Prescribed by	Date began

List all known Allergies:

____

PSYCHIATRIC HISTORY

Have you ever been given a psychiatric diagnosis?

No ________ Yes (describe) ______________________________________

____

Have you ever had psychotherapy or counseling in the past?

No ________ Yes (describe) ______________________________________

____

Have you ever seen a psychiatrist before?

No ________ Yes (describe) ______________________________________

____

Have you ever attempted suicide or had serious suicidal thoughts?

No ________ Yes (describe) ______________________________________

____

Please list all medications you are prescribed for psychiatric reasons:

Name of medicine Dose Reason Prescribed Prescribed by Date began

____
____
____
____

Hospitalizations (Psychiatric or Substance abuse – give place and year):

____
____
____
____

Have you ever been the victim of mental, physical, or sexual abuse?

No ________ Yes _______

FAMILY HISTORY

Mental illness? No________ Yes (who, describe) ____________________
____

Substance abuse? No________ Yes (who, describe) ____________________
____

Suicide? No________ Yes (who, describe) ____________________
____

SUBSTANCE USE

Have you ever had a problem with alcohol or drugs? No_______ Yes_______

(describe) ____

How often do you?

Smoke _______never _______monthly _______weekly _______daily

Drink alcohol _______never _______monthly _______weekly _______daily

Use drugs _______never _______monthly _______weekly _______daily

WHAT ARE YOUR GOALS FOR TREATMENT?

____

____

____

____

____

____

CONSENT FOR TREATMENT:

Your signature below indicates that you have read the practice policies and procedures and agree to its terms and also serves as an acknowledgement that you have access to the Notice of Privacy Practices, which is located on our website www.drnealmazer.com or via fax or email upon your request.

____ ___________________________

Signature of Patient (or Guardian if under 18) Date

____ ___________________________

Printed Name Dr. Mazer's Signature

RECORD RELEASE AUTHORIZATION:

I hereby authorize Dr. Mazer to furnish information to insurance carriers concerning my illness/ treatment.

____ ___________________________

Signature of Patient (or Guardian if under 18) Date