

Susan Chakmakian, M.A., M.F.T.

PATIENT INFORMATION SHEET

Name(s): _____

Address: _____

_____ Zip: _____

OK to send mail to this address? _____

Alternate mailing address if applicable: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Email : _____

OK to contact you and leave messages at the above #'s ? _____

Age: _____ Date of Birth: _____ SSN#: _____

Insurance: _____

Referred by: _____

IN CASE OF EMERGENCY, NOTIFY:

Name _____ Relationship _____

Telephone _____

620 North Brand Blvd., Suite 401
Glendale, CA 91203

315 South Beverly Drive., Suite 307
Beverly Hills, CA 90212

(818) 754-4455

Susan Chakmakian, M.A., M.F.T.

License # MFC 41817

OFFICE POLICIES/CONSENT FOR TREATMENT

Confidentiality: Information disclosed by you during the course of your therapy is generally confidential. However, there are exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse, expressed threats of violence towards an ascertainable victim, and where you tender your mental and emotional state in a legal proceeding.

Payment: My fee for each 50 minute session is \$130.00 unless otherwise arranged. Payment is made at each therapy session. Please make checks payable to Susan Chakmakian. If you request an insurance statement it will be provided monthly. Your fee will remain consistent except for possible periodic adjustments.

Appointments and Cancellations: Sessions are 50 minutes and ordinarily take place one time per week. Since your specific time is held for you weekly, please note that you will be responsible for payment if you are unable to cancel with at least 24 hours advance notice. In the case of excessive absences, the cancellation policy may be reviewed in order to ensure that therapy is progressing regularly.

Telephone Communications/Emergencies: If you need to communicate with me between sessions, please leave a message for me on my voicemail and I will return your call as soon as possible. I do check my voicemail periodically throughout the day. Please note that calls may not be returned immediately. Messages left for me in the late evening will generally be returned the following day. In an emergency, you may need to call 911 or go to an Emergency Room.

Patient's Rights and Responsibilities: You have the right to end your therapy at any time, for whatever reason without any obligation except for fees already incurred. You have the right to question any aspect of your treatment. You also have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, which would greatly compromise the therapeutic relationship.

Therapy involves a partnership between therapist and patient. I will contribute knowledge, skills, and a willingness to do my best. The determination of success, however, will ultimately depend on your commitment to your own personal growth and care.

Your signature below indicates your understanding of and agreement to the above policies.

_____	_____
Patient's Printed Name	Patient's Signature
_____	_____
Patient's Representative	Date
_____	_____
Therapist's Signature	Date

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PATIENT HISTORY

Name _____ Date of Birth _____

Referred by _____ Marital Status _____

Educational Level _____ Occupation _____

Names and Ages of Children _____

Areas of Concern

What issues/concerns caused you to seek treatment? _____

Do you have any specific goals with regard to your treatment? _____

Do you have any particular concerns/fears with regard to treatment? _____

Family of Origin History

Please describe your child hood _____

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Psychological History

Have you ever received mental health treatment before? When? For how long?_____

Name(s) of therapist(s)_____

Have you taken any medication for a mental/emotional condition? When? How long?_____

Have you ever attempted suicide? When? Describes circumstances_____

Medical History

Have you ever been diagnosed with a serious illness?_____

Do you have any conditions that may affect your mental health treatment?_____

Please describe your overall health today._____

Are you taking any prescription medications_____ prescribed by whom?_____

Have you ever been in a 12 step program?_____

Do you smoke/ how much how long?_____

Do you drink alcohol? How much do you consume in a week?_____

Do you currently use illegal drugs? Have you ever used?_____

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Other Info
