

**Neal Mazer, MD, MPH**  
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## 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:

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List any medical hospitalizations:

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Please list all medications you are prescribed for medical reasons:

Name of medicine	Dose	Reason Prescribed	Prescribed by	Date began
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**List all known Allergies:**

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**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
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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?**

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**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 received the HIPAA information.

\_\_\_\_\_  
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

**PLEASE FAX TO AMY, OFFICE MANAGER AT 805.919.5261 OR  
SCAN AND E-MAIL TO [AMY@DRNEALMAZER.COM](mailto:AMY@DRNEALMAZER.COM)  
\*\* PRIOR TO YOUR FIRST SESSION.**