JOANN NG, M.D.
Psychiatrist
Diplomate American Board of
Psychiatry & Neurology

PATIENT NAME _____ AGE_____ BIRTHDATE_____

ADDRESS _____CITY_____ZIP_____

PHONE (HOME) _____(CELL)_____
RESPONSIBLE PARTY _____
MEDICARE PATIENTS: MEDICARE # OR SOCIAL SECURITY # _____

FAMILY MEMBERS & AGES _____
_____

MARITAL STATUS _____ (IF MARRIED, # OF YEARS) _____
OCCUPATION _____ AND/OR SPOUSE/ PARENT _____
SCHOOLING COMPLETED _____
SCHOOL (IF STUDENT) _____ GRADE _____
REFERRED BY _____

REASON FOR VISIT (PLEASE DESCRIBE PROBLEM(S)/ COMPLAINT(S)
_____
_____
_____
_____
_____

FAMILY PHYSICIAN _____PHONE_____
ALLERGIES: _____
CURRENT MEDICAL PROBLEMS _____
_____
_____
SIGNIFICANT PAST MEDICAL HISTORY _____
_____
_____
HISTORY OF HEAD TRAUMA, SEIZURES, LOSS OF CONSCIOUSNESS
_____
_____

PREVIOUS PSYCHOTHERAPY (TYPE, DATES)_____
_____
_____

I understand, that unless otherwise arranged, I will be responsible for payment at the end of each session. I may choose to submit my receipts along with claim forms to my insurance company for direct reimbursement to me for services rendered.
I understand that all appointments that are cancelled within 24 hours notice will be charged for time reserved, except in the case of an emergency.

PATIENT SIGNATURE _____ DATE _____

629 State Street, Suite 203, Santa Barbara, CA 93101
~ tel 805 618 8853

540 Alisal Road, Suite 3, Solvang, CA 93463
~ fax 805 688 4058

Have you ever been hospitalized (Non-psychiatric Addmissions)? ☐ Yes ☐ No If yes, please complete the following:

Month / Year	Doctor's Name	Name of Hospital	Reason
____ / ____			
____ / ____			
____ / ____			

Have you had surgery or been advised to undergo surgery? ☐ Yes ☐ No If yes, please complete the following:

Month / Year	Doctor's Name	Name of Hospital	Operation or Procedure
____ / ____			
____ / ____			
____ / ____			

Have you had any of the following injuries? (Please check all that apply and provide details in blanks)

- ☐ Head Injury _____
- ☐ Concussion (Knocked Unconscious) _____
- ☐ Broken Bones _____
- ☐ Severe Cuts or Lacerations _____
- ☐ Severe Burns (2nd or 3rd Degree) _____
- ☐ Food Poisoning _____
- ☐ Chemical or Drug Poisioning _____
- ☐ Other _____

Do you have any of the following allergies? (Please check all that apply and describe how you are affected in blanks)

- ☐ Penicillin _____
- ☐ Other _____

Have you recently had any of the following tests? (Please check all that apply)

	Month / Year	Where	Results
☐ Physical Exam	____ / ____		
☐ Blood Test	____ / ____		
☐ Chest X-Ray	____ / ____		
☐ Tuberculosis Skin Test (PPD)	____ / ____		
☐ Electrocardiogram (EKG)	____ / ____		
☐ Brain Scan or EMI	____ / ____		
☐ EEG	____ / ____		

Do you use or have you ever used any of the following? (Please check all that apply)

	Amount of Current Usage	Most Ever Used
☐ Laxatives		
☐ Cigarettes/Tobacco		
☐ Alcohol		
☐ Sleeping Pills		
☐ Marijuana		
☐ Cocaine		
☐ Methamphetamine (Speed)		
☐ Opiates (Heroin, Prescription)		

Do you currently take any medications? ☐ Yes ☐ No If yes, please complete the following:

Name of Medication:	Dosage (Example: 150 mg twice daily)

Do you use or have you ever used any of the following? (Please check all that apply)

	When	Amount
☐ Dilantin, Tegretol, L-Dopa, Cogentin or Artane		
☐ Valium, Librium, Serax, Dalmane, Tranxene or Ativan		
☐ Sinequan, Tofranil, Elavil or Meprobamate		
☐ Lithium		
☐ Thorazine, Mellatill, Stelazine, Moban or Serentil		
☐ Phenobarbital, Seconal, Tuinal or other barbiturates		

	When	Amount
☐ Amphetamines, Methamphetamine, Ritalin, Adderall or other stimulants		
☐ Heroin, Codeine, Methadone, Percodan, Dilaudid, Talwin, Darvon or Demerol		
☐ Quaaludes, Placidyl or other sedatives		
☐ Cocaine or crack cocaine		
☐ LSD, Mushrooms, Psilocybin or other hallucinogens		
☐ Other:		

PSYCHIATRIC HISTORY

Have you ever received psychiatric or psychological treatment? ☐ Yes ☐ No If yes, please complete the following:

Year	Doctor's Name	Hospital or Clinic	Reason	Medication(s) Used (if any)

Have you attempted suicide in the past? ☐ Yes ☐ No If yes, please complete the following:

Year	Method of Attempt	What happened afterwards?

FAMILY HISTORY

If any members of your immediate family are deceased, please check the box and provide the age and cause of death.
If the person is still alive, simply write in his or her current age.

	Age	Cause of Death (if applicable)		Age	Cause of Death (if applicable)
☐ Mother			☐ Spouse 1		
☐ Father			☐ Spouse 2		
☐ Brother 1			☐ Child 1		
☐ Brother 2			☐ Child 2		
☐ Brother 3			☐ Child 3		
☐ Sister 1			☐ Child 4		
☐ Sister 2			☐ Child 5		
☐ Sister 3			☐ Child 6		

Do any of your immediate family members suffer with any of the following, now or in the past? (Check all that apply)

	Moth.	Fath.	Bro 1	Bro 2	Bro 3	Sis 1	Sis 2	Sis 3	Spo 1	Spo 2	Chi 1	Chi 2	Chi 3	Chi 4	Chi 5	Chi 6
Cancer																
Tuberculosis																
Diabetes																
High Blood Pressure																
Stroke																
Heart Attack or Cardiac Disease																
Epilespy or Convulsions																
Nervous Breakdown																
Severe Depression or Manic-Depression																
Alcoholism																
Suicide or Suicide Attempt																
Drug Abuse																
Birth Defect or Genetic Disorder																
Thyroid Disease																
Other Hormone Problem																
Migraine Headaches																
Other:																

Are you currently experiencing any of the following medical symptoms? (Please check all that apply)

- ☐ Lumps Anywhere
- ☐ Double Vision or Poor Vision
- ☐ Difficulty Hearing
- ☐ Fainting or Blackouts
- ☐ Convulsions
- ☐ Paralysis
- ☐ Dizziness
- ☐ Thyroid Problem (Goiter)
- ☐ Skin Problem
- ☐ Constipation
- ☐ Diarrhea
- ☐ Cough or Wheeze
- ☐ Chest Pain
- ☐ Spitting up or Vomiting Blood
- ☐ Shortness of Breath
- ☐ Heart Flutter or Palpitation
- ☐ Swollen Hands or Feet
- ☐ Visual Hallucinations
- ☐ Fever, Sweat or Chills
- ☐ Unusually Excessive Thirst
- ☐ Urine Problems or Blood in Urine
- ☐ Stomach Pain or Stomach Ulcer
- ☐ Blood in Stool
- ☐ Indigestion, Gas or Heartburn
- ☐ Change in Appetite or Eating Habits
- ☐ Trouble Sleeping
- ☐ Sexual Problems
- ☐ Weight Loss or Gain
- ☐ Depression
- ☐ Thoughts of Suicide
- ☐ Problems with Memory
- ☐ Problems Thinking or Concentrating
- ☐ Weakness or Tiredness
- ☐ Joint Pain
- ☐ Audio Hallucinations
- ☐ Other: _____

FEMALES ONLY:

What was the date of your last menstrual period? _____ (MONTH) /_____ (DAY) /_____ (YEAR) Number of Pregnancies: _____

Number of children born alive: _____ Number of miscarriages and stillbirths: _____ Number of abortions: _____

Do you use any contraceptive method? ☐ Yes ☐ No If yes, which one? _____

Have you had a Pap smear in the past year? ☐ Yes ☐ No

Do you regularly examine your breasts for lumps? ☐ Yes ☐ No

Patient Signature _____ Patient Name Printed _____ Date _____

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of private health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home address.

I wish to be contacted in the following manner:

1. Please print the telephone number(s) where you prefer to receive calls regarding your (or your child's) appointments, lab results, medications, etc.:
   _____
   _____

2. Can messages regarding your appointments and follow-up visits be left on your telephone answering machine or voicemail? Yes _____ No (leave message with call-back number only) _____

3. Please print the address (or fax number) of where you would like follow-up correspondence from our office to be sent:
   _____

4. Please list the family members or other persons, if any, with whom we may speak to regarding your care and treatment:
   _____
   _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. For purposes of collaboration between health care providers to improve my treatment, I hereby authorize for release of my medical information.

FROM:
Name of Physician_____

Address/ Phone:_____
_____
_____
_____

TO:
Joann Ng, M.D.
540 Alisal Road, Suite 3
Solvang, CA 93463
OR
P.O. Box 90910
Santa Barbara, CA 93190
Tel. (805) 618-8853
Fax (805) 456-0272

_____
_____
_____

Patient Signature (guardian if under 18): _____Date:_____
Patient Name: _____

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Dear Patient:
The doctor-patient relationship requires both cooperation and mutual trust. I will strive to provide you with the best possible psychiatric care, and ask that you participate in this effort to the best of your ability. This information sheet was prepared to help you better understand the nature of my medical practice. I welcome any questions you may have about our professional relationship.

ABOUT ME:
I am a California-licensed psychiatrist, board-certified in adult psychiatry by the American Board of Psychiatry and Neurology since 2006. I graduated from Mount Sinai Medical School in NYC and completed my internship and residency training at Harbor-UCLA Medical Center. From 2006-7, I was the Director of the Adult Attention-Deficit/ Hyperactivity Disorder Clinic at North Shore- Long Island Jewish Medical Center in New York City. From 2007-9, I was the Founding Medical Director of the Harbor- UCLA Wellness Center in Carson, CA. From 2009-2013, I maintained a private practice in an outpatient setting in Los Angeles. I also have served as consulting psychiatrist for Torrance Memorial Hospital, and currently serve as consultant for The Dunn School in Los Olivos, where I perform psychiatric evaluations and medication assessments for students on campus. In addition, I believe in the power of mind-body interventions and have extra training and experience with utilizing medical hypnosis & guided imagery for improving quality of life issues such as: psychosomatic concerns, pain management, pre/post surgery, stress reduction, TMJ, relaxation training, and ego strengthening.

My office hours are generally from 8:30 to 5pm every weekday. My office phone is generally off when I am in session with patients. I check my phone messages several times each day and you may expect a return call as soon as I can within 24 hours.

EMERGENCIES: If you are in crisis and need emergency assistance, **please contact me at 805-618-8853. If you are unable to reach me then call 911 or go to the nearest emergency room.**

CONFIDENTIALITY: All communications between adult patients and the psychiatrist are kept strictly confidential and I would require written and signed consent from patients to release information, unless in the case of a court ordered subpoena. Communications between child patients and the psychiatrist are kept relatively confidential as I explain to minors that I will have some contact with their parents and teachers. There are, however, two exceptions to confidentiality:

If I am convinced that the patient will be of harm to him/herself , or to someone else, I am required by law to take appropriate measures to assure the safety of the patient or the safety of anyone else who is threatened.

If a patient reveals child abuse (sexual, physical, or emotional), I am required by law to report such matters to the Child Protective Services or the appropriate authorities.

FEES: There are no monthly bills or statements. Payments are expected at the time of each session by cash, check or credit card (banks will add 2% processing fees for credit cards). The fees for sessions vary based on duration, context and location of the meeting. The rates will be released upon initial inquiry.

Initial psychiatric evaluation and medication assessment, review of medical/ psychiatric records and testing results, gathering of collateral information, and/ or medication evaluation (60-90 min including interviews/ discussions with other health care providers, teachers, and parents):

Future sessions for psychotherapy and/ or medication management (50 min.+ 10 min documentation):

Medication management visits (25 min+ 5 min documentation.):

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If you do not have health insurance and are under financial distress, I will be open to discuss fees and offer a discount.

CANCELLATIONS: Appointments are time reserved for you. All appointments that are cancelled less than 48 hours of notice are charged full price, except in cases of emergencies.

INSURANCE: Currently, I am not on any insurance panels except for Cottage Health. This allows for minimal extraneous paperwork, maximal patient care and maximal patient confidentiality. In some cases, health insurance plans will reimburse patients for a specified portion of the billed amount. I require that the patient pays the entire bill to me at time of visit and then be reimbursed by the insurance company. I can provide receipts after each session that contain both diagnostic and therapy codes. You may submit the receipt to your insurance company along with their claim form to file for direct reimbursement to you. The amount of reimbursement depends on individual plans, insurance companies, annual deductibles, etc, and ranges from 40 to 80%. You may contact your insurance company for the specifics. I, of course, will be happy to help you. If you choose, my office can submit electronic claims on your behalf to your insurance.

ABOUT YOU:
Because I believe it is important for you and your family to have confidence in the medical and psychiatric treatment you receive, and because it is both necessary and desirable that you participate in maintaining good health habits, I hope you will assist me by doing the following:
1. You agree to keep all scheduled appointments. If you must cancel or re-schedule an appointment, please let us know as early as you can, so that other patients can be scheduled.
2. You follow medical advice which is always given for your benefit, and your cooperation is essential.
3. You understand that the main treatment goal is to improve your ability to function better by reducing symptoms. In addition to medication management and psychotherapy, you agree to help yourself by following good health habits: exercising, eating nutritious diet, and avoiding the use of alcohol, tobacco and illegal substances. By adopting healthy lifestyle, you can hope to have the most successful outcome from my treatment.
4. Ask questions whenever you do not understand your treatment or my medical advice. For your protection and mine, California laws give patients the right to know about the treatment they receive. Sometimes, good practice requires that I tell you about the risks associated with treatment or the use of medication, as well as the limitations of both. You are always welcome to ask for more details if you wish.
5. Always report any problems you have with the medications or treatment. Different people react differently to the same treatment or drugs. It is possible for me to properly manage your care only if you tell me about difficulties you are having, or if medications are not effective or causing you discomfort.

With your written authorization, I will be happy to collaborate with your other doctors as a team for your treatment purposes. Always feel free to bring in copies of recent medication changes by other doctors/ laboratory blood work/ and/or psychological testing results.

Sincerely,
Joann Ng, M.D.

Please sign the following: I have read the above statement and all questions have been answered to my satisfaction. I agree to these terms and agree to be responsible for payment of services.

X_____Print Name:_____Date:_____
Signature of patient/ parent (if patient is less than 18 years old)

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~ fax 805 688 4058

BDI II
Name:
Date:

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you **do not choose more than one statement for any group**, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. **Sadness**
   - 0 I do not feel sad.
   - 1 I feel sad much of the time.
   - 2 I am sad all of the time.
   - 3 I am so sad or unhappy that I can't stand it.

2. **Pessimism**
   - 0 I am not discouraged about my future.
   - 1 I feel more discouraged about my future than I used to be.
   - 2 I do not expect things to work out for me.
   - 3 I feel my future is hopeless and will only get worse.

3. **Past Failures**
   - 0 I do not feel like a failure.
   - 1 I have failed more than I should have.
   - 2 As I look back, I see a lot of failures.
   - 3 I feel I am a total failure as a person.

4. **Loss of Pleasure**
   - 0 I get as much pleasure as I ever did from the things I enjoy.
   - 1 I don't enjoy things as much as I used to.
   - 2 I get very little pleasure from the things I used to enjoy.
   - 3 I can't get any pleasure from the things I used to enjoy.

5. **Guilty Feelings**
   - 0 I don't feel particularly guilty.
   - 1 I feel guilty over many things I have done or should have done.
   - 2 I feel quite guilty most of the time.
   - 3 I feel guilty all of the time.

6. **Punishment Feelings**
   - 0 I don't feel I am being punished
   - 1 I feel I may be punished.
   - 2 I expect to be punished.
   - 3 I feel I am being punished.

7. **Self-Dislike**
   - 0 I feel the same about myself as ever.
   - 1 I have lost confidence in myself.
   - 2 I am disappointed in myself.
   - 3 I dislike myself

8. **Self-Criticalness**
   - 0 I don't criticize or blame myself more than usual.
   - 1 I am more critical of myself than I used to be.
   - 2 I criticize myself for all of my faults.
   - 3 I blame myself for everything bad that happens.

9. **Suicidal Thoughts or Wishes**
   - 0 I don't have any thoughts of killing myself.
   - 1 I have thoughts of killing myself, but I would not carry them out.
   - 2 I would like to kill myself.
   - 3 I would kill myself if I had the chance.

10. **Crying**
    - 0 I don't cry anymore than I used to.
    - 1 I cry more than I used to.
    - 2 I cry over every little thing.
    - 3 I feel like crying, but I can't.

11. **Agitation**
    - 0 I am no more restless or wound up than usual.
    - 1 I feel more restless or wound up than usual.
    - 2 I am so restless or agitated that it's hard to stay still.
    - 3 I am so restless or agitated that I have to keep moving or doing something.

Subtotal Page 1

12. **Loss of Interest**

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. **Indecisiveness**

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. **Worthlessness**

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. **Loss of Energy**

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. **Changes in Sleeping Pattern**

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. **Irritability**

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. **Changes in Appetite**

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. **Concentration Difficulty**

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. **Tiredness or Fatigue**

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. **Loss of Interest in Sex**

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Subtotal Page 1 _____

Subtotal Page 2 _____

Total _____

1. Has there ever been a period of time when you were not your usual self and...

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐ **Yes**	☐ **No**
...you were so irritable that you shouted at people or started fights or arguments?	☐ **Yes**	☐ **No**
...you felt much more self-confident than usual?	☐ **Yes**	☐ **No**
...you got much less sleep than usual and found you didn't really miss it?	☐ **Yes**	☐ **No**
...you were much more talkative or spoke much faster than usual?	☐ **Yes**	☐ **No**
...thoughts raced through your head or you couldn't slow your mind down?	☐ **Yes**	☐ **No**
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐ **Yes**	☐ **No**
...you had much more energy than usual?	☐ **Yes**	☐ **No**
...you were much more active or did many more things than usual?	☐ **Yes**	☐ **No**
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐ **Yes**	☐ **No**
...you were much more interested in sex than usual?	☐ **Yes**	☐ **No**
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐ **Yes**	☐ **No**
...spending money got you or your family into trouble?	☐ **Yes**	☐ **No**

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ **Yes** ☐ **No**

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please select one response only.

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem