New Patient Information

Patient Name (Last)_____(First)_____(M.I.)_____

Address_____City_____State_____Zip_____

Sex: **M** **F** Patient's Employer_____

Birth Date _____ Age_____ Social Security Number _____

Home Phone (___) _____Work (___) _____Cell (___)_____

Marital Status: _____ Driver License #: _____

Spouse/Partner Name _____ Spouse Soc Sec #:_____

Spouse place of Employment _____ Spouse Phone #: _____

Other Emergency Contact _____ Relationship to Patient _____

Emergency Contact Phone (___)_____

Insurance Information

1) Name of **Primary** Insurance: _____

Contract #_____ Group #_____Effective Date_____

Policy Holder's Name: _____ DOB_____ Soc Sec Number _____

Relationship_____ Employer_____ Phone #'s: _____

2) Name of **Secondary** Insurance: _____

Contract #_____ Group #_____Effective Date_____

Policy Holder's Name: _____ DOB_____ Soc Sec Number _____

Relationship_____ Employer_____ Phone #'s: _____

Request for Confidential Handling of Health Information

Complete only if you want communications regarding your health care information sent to an alternate address or telephone other than listed above. I request that my provider handle my confidential health information as described below. All reasonable requests to receive communication of your health information by alternative means and/or locations will be granted. Please describe the alternative means below (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Alternate Address_____

Alternate Telephone_____ Alternate Telephone_____

Agreement

If your insurance company OR health plan requires pre-approval OR referral for your visit, it is your responsibility to obtain this referral or YOU will be personally responsible for the bill. I, the undersigned (patient or legal guardian), authorize medical treatment to be rendered by the provider and assume financial responsibility. In the event the account is not paid in full within 90 days*, the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waives all rights of exemption under the constitution and laws of the State of Alabama. I also authorize the release of my medical records to my physicians and insurance carriers. If the provider has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay. I understand that all of the providers in the offices at 2018 Brookwood Medical Center Drive, POB Suite 311 and POB Suite 310 are independent practitioners (not partners) although they are sharing office and staff. Your signature below also indicates you have received the Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of your Health Information and agree to its terms and serves as an acknowledgement that you have been given a copy of the HIPAA Notice Form.

Signature of Patient or Responsible Party: _____ Date_____

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ADULT INFORMATION FORM

Name_____ Date of 1st Appointment_____ Therapist _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:

1)_____ Dosage/Freq_____ Start Date_____Purpose_____

2)_____ Dosage/Freq _____ Start Date_____Purpose_____

3)_____ Dosage/Freq _____ Start Date_____Purpose_____

4)_____ Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience:_____

_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

_____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

_____

_____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain: _____

_____

What was the last year of school you completed? _____ If you did not complete high school, please explain:

_____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)_____ Year(s)_____

(2) School(s)_____ Year(s)_____

(3) School(s)_____ Year(s)_____

How would you describe your current support network? (friends, relatives, etc.): _____

_____

Please check all information which applies to your biological parents:

MOTHER	FATHER
____ living	____ living
____ deceased	____ deceased
____ married	____ married
____ divorced	____ divorced
____ remarried ____# of times	____ remarried ____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____

Where do your parents live? Mother _____

Father _____

Describe your relationship with your mother while growing up: _____

_____

Currently: _____

_____

Describe your relationship with your father while growing up: _____

_____

Currently: _____

_____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse: _____

_____

_____

Sexual/physical/emotional abuse: _____

_____

_____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ____resentful
____worthless ____tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless

Describe any other feelings you have had: _____

_____

What activities or hobbies do you participate in? _____

_____

Do you participate in regular exercise? (Circle One) YES NO Describe: _____

Describe your current working environment: _____

_____

Have you had any change in sleeping habits? (Circle One) YES NO Describe: _____

_____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): _____

_____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior. Please explain:_____

_____

_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

_____

Please list your therapy goals:

_____

_____

_____

_____

_____

THANK YOU!