

New Patient Information

Patient Name (Last) _____ (First) _____ (M.I.) _____
Address _____ City _____ State _____ Zip _____
Marital Status _____ Sex: M F Employer _____
Birth Date _____ Age _____ Social Security Number _____
Home Phone (____) _____ Work (____) _____ Cell (____) _____
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 _____

If signed by a responsible party, describe that representative's authority to act for the patient _____

Policy for Canceling and Rescheduling Appointments

It is the policy of Jeannie Briscoe's office to charge a fee of \$80.00 for any appointment that is missed or broken without at least one business day notice. The payment is due prior to rescheduling your next appointment.

We make every effort to remind you of scheduled appointments. When an appointment is scheduled in our office, we provide you with the doctor's business card with the appointment time and date indicated. We also attempt to make courtesy reminder calls one business day before your appointment. Please be advised, however, that it is ultimately your responsibility to keep track of your appointments.

We appreciate your understanding of this policy. Please feel free to speak to our office staff if you have any questions.

I have read the above policy and agree to abide by the terms indicated when scheduling appointments.

Patient Signature: _____ Date: _____

PARENT QUESTIONNAIRE

Child's full name _____ Date: _____

Male; Female Birthdate _____ Age _____ Race _____

Address _____

This child is in legal custody of _____

Child is:

Natural child of parents Adopted child of parents Foster child

Parents are:

Married and together Father remarried Father deceased
 Married and separated Mother remarried Mother deceased
 Divorced Never married

Mother's full name _____

Age _____ Education _____ Occupation _____

Address: _____ Same

Home phone _____ Work phone _____ Facsimile number _____

General relationship between mother and child _____

Father's full name _____

Age _____ Education _____ Occupation _____

Address: _____ Same

Home phone _____ Work phone _____ Facsimile number _____

General relationship between father and child _____

Other significant contact _____ Phone _____

CURRENT PERSONAL AND FAMILY CIRCUMSTANCES

Describe your child's problems:

Length of time

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |

What do you think may have caused your child's problem(s) ? _____

What have you tried so far to correct the problem(s) ? _____

List the good things about your child. What can he/she do well ? Any special talents ?

What specific event(s) caused you to seek help at this time ? _____

Please check all events that may have occurred within the family in the past 12 months:

- | | |
|--|---|
| <input type="checkbox"/> Death of spouse | <input type="checkbox"/> Death of close friend |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Personal injury or illness |
| <input type="checkbox"/> Parent's separation | <input type="checkbox"/> Change in financial status |
| <input type="checkbox"/> Significant marital conflicts | <input type="checkbox"/> Change in residence |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Change in schools |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Birth of sibling | <input type="checkbox"/> Parent losing job |
| <input type="checkbox"/> Gain of new family member | <input type="checkbox"/> Parent with emotional difficulties |
| <input type="checkbox"/> Child leaving home | <input type="checkbox"/> Violence in neighborhood |
| <input type="checkbox"/> Death of close family member | <input type="checkbox"/> Other stress _____ |

List all persons living in the household with this child:

Name	Age	Relationship	Education	Occupation
1.				
2.				
3.				
4.				
5.				

Check if any natural parent, brother, sister, uncle, aunt, cousin or grandparent has:

- | | |
|---|---|
| <input type="checkbox"/> Attention deficit/hyperactivity disorder | <input type="checkbox"/> Problems with anxiety or panic attacks |
| <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Problems with alcohol or drugs |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> "Blues", depressions | <input type="checkbox"/> Other psychiatric problem |
| <input type="checkbox"/> Attempted suicide | <input type="checkbox"/> Tics, seizures or neurologic problem |
| <input type="checkbox"/> Bipolar/Manic depressive illness | <input type="checkbox"/> Legal problems |

Please describe _____

DEVELOPMENTAL HISTORY

Mother's age when child was born _____ Planned pregnancy Yes No
 Was the pregnancy free of problems? Yes No. Explain _____

During pregnancy mother: Drank alcohol Smoked tobacco Used drugs
 Took medication Was depressed None

Was child born full term? Yes No. Explain _____

Was labor and delivery normal? Yes No. Explain _____

Child's condition at birth was Normal Blue baby
 Jaundice Other. Explain _____

Child's weight at birth was _____ APGAR score if known _____

What was your child like in early infancy ?

- Affectionate
- Content
- Fearful
- Sleepy
- Cried a lot
- Cuddly
- Playful
- Quiet
- Irritable
- Overly active
- Fussy
- Under active
- Moody
- Aggressive
- Colicky
- Physically sick

What was mother like in the first year of child's life ?

- Nervous
- Depressed
- Other problem. Explain _____
- Sick
- Working out of home
- Tired and uninvolved
- Doing well

What was father like in the first year of child's life ?

- Nervous
- Unemployed
- Other problem. Explain _____
- Uninvolved
- Sick
- Depressed
- Supportive/helpful

Approximate age at which your child

Sat alone _____ Walked alone _____ Pedaled tricycle _____
Said "dada/mama" _____ Used short sentences _____ Was toilet trained _____

Where there any difficulties in toilet training ? No Yes. Explain _____

Has your child had any traumatic experiences? No Yes. Explain _____

MEDICAL HISTORY

Child's physician or clinic _____ Phone _____

Is your child allergic to medication or anything ? No Yes. Explain _____

Does your child have or had any of the following ?

- Eye problems
- Hearing problems
- Speech problems
- Severe headaches
- Other medical problem. Explain _____
- Staring spells
- Seizures
- Motor/vocal tics
- Heart trouble
- Head trauma
- Asthma
- Liver disease
- Kidney problems

Has your child ever been hospitalized? No Yes. Explain _____

Please describe any concerns you may have about your child's physical health: _____
 None

List all clinicians that have evaluated or treated your child for behavioral or emotional problems:

Clinician	Reason	Type of treatment	Year and length
1.			
2.			
3.			
4.			

List all medications your child has received over the past 12 months: None

Medication	Reason	Dosage	Length of treatment
1.			
2.			
3.			
4.			

Do you have any concerns about this youngster using drugs/alcohol? No Yes
Explain _____

Is this youngster sexually active? No Do not know Yes. Explain _____

Only for females:

Date of first menstrual period _____ Date of last menstrual period _____

Are the menstrual periods regular? Yes No. Explain _____

Is this youth on birth control? Yes No. Explain _____

SCHOOL HISTORY

Name of current school _____

Grade level _____ Homeroom teacher _____

List all pre-schools and schools attended:

School name	Year / Grade level	Academic grades	Conduct
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Has your child passed each grade ? Yes No. Explain _____

Has your child ever been enrolled in special services for

Reading problems

Speech and language disorder

Mathematics problems

Emotional/Behavioral problems

Compared to children of the same age, how would you rate your child's intellectual ability ?

Average

Below

Above

What were the date and results of the last IQ/educational testing done at school ? _____

How is your child getting along with peers and teachers ? _____

MOTHER'S CHECKLIST

Please complete this form by yourself. Do not take into account what anyone else thinks.

	Not at all	Just a little	Quite a bit	Very much
1. Sits fiddling with small objects				
2. Hums and makes other odd noises				
3. Falls apart under stress				
4. Poor coordination				
5. Restless or overactive				
6. Excitable				
7. Inattentive				
8. Difficulty in concentrating				
9. Oversensitive				
10. Overly serious or sad				
11. Daydreams				
12. Sullen or sulky				
13. Selfish				
14. Disturbs other children				
15. Quarrelsome				
16. "Tattles"				
17. Acts "smart"				
18. Destructive				
19. Steals				
20. Lies				
21. Temper outbursts				
22. Isolates self from children				
23. Unaccepted by peer group				
24. Appears to be easily led				
25. No sense of fair play				
26. Appears to lack leadership				
27. Does not get along with other sex				
28. Compassionate				
29. Teases other children				
30. Obedient				
31. Antagonistic or defiant				
32. Shameless				
33. Shy				
34. Fearful				
35. Excessive demands for attention				
36. Stubborn				
37. Overly anxious to please				
38. Uncooperative				
39. Impulsive/Acts without thinking				

FATHER'S CHECKLIST

Please complete this form by yourself. Do not take into account what anyone else thinks.

	Not at all	Just a little	Quite a bit	Very much
1. Sits fiddling with small objects				
2. Hums and makes other odd noises				
3. Falls apart under stress				
4. Poor coordination				
5. Restless or overactive				
6. Excitable				
7. Inattentive				
8. Difficulty in concentrating				
9. Oversensitive				
10. Overly serious or sad				
11. Daydreams				
12. Sullen or sulky				
13. Selfish				
14. Disturbs other children				
15. Quarrelsome				
16. "Tattles"				
17. Acts "smart"				
18. Destructive				
19. Steals				
20. Lies				
21. Temper outbursts				
22. Isolates self from children				
23. Unaccepted by peer group				
24. Appears to be easily led				
25. No sense of fair play				
26. Appears to lack leadership				
27. Does not get along with other sex				
28. Compassionate				
29. Teases other children				
30. Obedient				
31. Antagonistic or defiant				
32. Shameless				
33. Shy				
34. Fearful				
35. Excessive demands for attention				
36. Stubborn				
37. Overly anxious to please				
38. Uncooperative				
39. Impulsive/Acts without thinking				