

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: _____

PATIENT QUESTIONNAIRE

Full name _____ Date: _____
 Male; Female Birthdate _____ Marital status _____ Age _____ Race _____
 Address _____ Phone _____
 Occupation _____ Phone _____
 Other significant contact _____ Phone _____
 Referred by _____

CLINICAL HISTORY

List problems for which evaluation is sought:

	Length of time
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Impairment associated with current problems:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Work					
Social life					
Daily activities					

What have you tried so far to correct these problems (changes in life, psychotherapy, drugs) ?

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

List all clinicians that have evaluated or treated you.

None

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

List prescribed and non-prescribed medications you are presently taking:

None

Medication	Reason	Dosage	Length of treatment
1.			
2.			
3.			
4.			
5.			

CURRENT PERSONAL CIRCUMSTANCES

Spouse's name _____
 Age _____ Education _____ Years together _____
 Occupation _____
 General relationship with spouse _____
 Physical or emotional problems _____

List all persons living in the household with you:

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

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

- Significant marital conflicts
- Separation
- Divorce
- Spouse with emotional difficulties
- Death of spouse
- Marriage
- Pregnancy
- Birth of child
- Gain of new family member
- Child leaving home

- Death of close family member
- Death of close friend
- Personal injury or illness
- Change in financial status
- Change in residence

- Significant conflicts at work
- Losing job
- Change in job
- Legal problems
- Other stress _____

Leisure and recreational activities _____
 Religious affiliation and practice _____
 Any legal problems? No Yes. Explain _____

FAMILY HISTORY

Mother's full name _____
 Age _____ Education _____ Occupation _____
 General relationship with mother _____
 Health problems or cause of death _____

Father's full name _____
 Age _____ Education _____ Occupation _____
 General relationship with father _____
 Health problems or cause of death _____

Brothers and sisters:

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

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

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

Please describe and indicate relation _____

DEVELOPMENTAL AND SOCIAL HISTORY

Were there any problems with your mother's pregnancy or delivery of you? No Yes
 Explain _____

Were you born full term? Yes No. Mother's age when you were born _____

Did you experience any separations from your parents as a child? No Yes. Explain _____

What were you like as a child?

- | | | | |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Very sensitive | <input type="checkbox"/> Irritable | <input type="checkbox"/> Moody |
| <input type="checkbox"/> Content | <input type="checkbox"/> Distractible | <input type="checkbox"/> Overly active | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Playful | <input type="checkbox"/> Fussy / cranky | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Physically sick | <input type="checkbox"/> Quiet | <input type="checkbox"/> Nervous | <input type="checkbox"/> Obedient |

Did you ever experienced verbal / physical abuse? No Yes. Explain _____

Did you ever experienced sexual abuse? No Yes. Explain _____

What were you like during adolescence?

- | | | | |
|-------------------------------------|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Confident | <input type="checkbox"/> Shy | <input type="checkbox"/> Overly active | <input type="checkbox"/> Happy |
| <input type="checkbox"/> Sociable | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Defiant |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Peaceful | <input type="checkbox"/> Explosive | <input type="checkbox"/> Responsible |
| <input type="checkbox"/> Rebellious | <input type="checkbox"/> Depressed | <input type="checkbox"/> Unconventional | <input type="checkbox"/> Moody |

List some good things about you. What can you do well? Any special talents? _____

Have you been married more than once? No Yes. Explain _____

List all children residing away from home or deceased:

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

MEDICAL HISTORY AND HABITS

Your physician or family doctor _____ Phone _____

Are you allergic to medication or anything? No Yes. Explain _____

List all physical problems presently under treatment or observation: _____ Length of time _____

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have or had any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Staring spells | <input type="checkbox"/> Head trauma |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Motor/vocal tics | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Other medical problem. Explain _____ | | |

Have you ever been hospitalized? No Yes. Explain _____

List surgical operations or injuries:	Date occurred	Any complications?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Do you have or had any difficulty with drugs/alcohol? No Yes. Explain _____

How much alcohol do you drink on average per week? _____
 How much coffee or tea do you drink on average per day? _____
 How many cigarettes do you smoke per day? _____ How many years? _____

Only for females:
 Date of first menstrual period _____ Date of last menstrual period _____
 Are the menstrual periods regular? Yes No. Explain _____
 Are you on birth control? Yes No. Explain _____
 List of pregnancies and age _____
 List of miscarriages/ abortions and age _____
 Problems with pregnancies or deliveries? Yes No. Explain _____

EDUCATIONAL AND WORK HISTORY

Educational degree and year completed _____
 Describe your school performance: _____

Grade level	Academics	Conduct
Elementary School		
Middle School		
High School		
College		

Did you pass each grade/year? Yes No. Explain _____
 Were you ever enrolled in special services for
 Reading problems Speech and language disorder
 Mathematics problems Emotional/Behavioral problems
 How did you get along with peers and teachers? _____

Past occupational and military history:

Employer	Type of job / position	Years of service