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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ADOLESCENT 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:____

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:____

Date of last medical evaluation:__________________ Date of next appointment:____________________

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

Hospital	Mo/Yr	Reason
____________________	________	______________________________
____________________	________	______________________________
____________________	________	______________________________

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

Do you experience any academic problems while in school? (Circle One) YES NO

If yes, please explain:____

What was the last year of school you completed? _______What school are you currently attending? ____________________

Who is in your current support network? (friends, relatives, other adults):______________________________

____

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

With whom do you live? Mother____ Father____ Stepmother____ Stepfather____ Guardian ____ Grandparent____

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

____

List first names and ages of your brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
____________	____	____________	____________
____________	____	____________	____________
____________	____	____________	____________
____________	____	____________	____________

Others living in the home with you:

Name	Age	Relationship	Grade/Occupation
____________	____	____________	____________
____________	____	____________	____________
____________	____	____________	____________

Describe your relationship with your mother:

Currently:____

____

In the past:____

____

Describe your relationship with your father:

Currently:____

____

In the past:____

Describe your relationship with your stepmother:____________________________________

____

Describe your relationship with your stepfather:____________________________________

____

Describe any problems that have occurred in your family relating to:

Alcohol/drug abuse:____

____

Sexual/physical/emotional abuse:____

MENTAL STATUS

Please check any of the following that describe how you believe you feel:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful ____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless ___annoyed

Describe any other feelings you have had:____

____

Please check any of the following risk-taking behaviors you have engaged in:

___street racing ___gang involvement ___skip school ___dropped out ___dangerous dieting ___cutting ___stealing

___unprotected sex ___running away ___bullying others ___fire starting ___hurt animals ___restrict or restricted food intake

___over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

____beer ____wine ____hard liquor ____pot ____cocaine ____heroin ____Ecstasy ____speed ___over the counter drugs

____prescription drugs ____ Other:________________________________

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 any current problems you are having in daily psychological, social or school functioning (i.e. isolation from friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members):____

____

What activities or hobbies do you participate in?____________________ ____________________

____

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

Describe:____

How much time do you spend online or gaming?____

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!