Comprehensive Memory Center

Voice: (205) 329-7815, fax: 329-7816

Richard Azrin, Ph.D.
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PATIENT INFORMATION FORM

CONFIDENTIAL

Instructions: Please complete this form as accurately and completely as you can. A doctor will discuss your responses with you.

Patient's Name Mr/Ms/Mrs ____________________ **Evaluation Date:**___/___/___ **Date of Birth:**___/___/___

Soc Sec Num:______________ Date form was completed:___/___/___ Who completed this form?______________

Address ______________________ Home Phone__________ Work/other Phone__________

Insurance Company__________________ Policy #____________________ Insured's Name:________________

Who referred you to this clinic? **(Full Name and Phone):**____

When is your **next appointment** to see that referring doctor/ counselor? __________________________________

Besides referral source, who else should get a copy of your report:____

Patient's Age_____ **Gender (circle): Male Female** **Race:**____________ Are you right/left Handed? ________

Presenting or Current Problems

What difficulties, symptoms, or complaints do you have that led to your referral here?________________________

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Significant Symptoms

Please indicate whether you have ever experienced any of the symptoms below, when, and briefly describe:

Symptom	Circle Yes or No		When it began	Please briefly describe Problem(s) and Treatments, if any
Loss of Consciousness	No	Yes		
Changes in ability to Smell	No	Yes		
Seizures	No	Yes		
Dizziness	No	Yes		
Allergies	No	Yes		
Asthma	No	Yes		
High Fever	No	Yes		
Bowel or Bladder Problems	No	Yes		
Changes in ability to walk	No	Yes		
Blurred/Double Vision	No	Yes		
Chronic Ringing in Ears	No	Yes		
Muscle Jerks or Twitches	No	Yes		
Chronic Pain	No	Yes		
Mental Confusion	No	Yes		
Speech Difficulties	No	Yes		
Memory Difficulties	No	Yes		
Weight Changes	No	Yes		
Sleep Difficulties	No	Yes		
Decreased Energy	No	Yes		
Decreased Motivation	No	Yes		
Decreased Happiness	No	Yes		
Social Isolation	No	Yes		
Persistently Depressed Mood	No	Yes		
Frequent Headaches	No	Yes		
Feeling Shaky	No	Yes		
Frequent Anxiety	No	Yes		
Excessive Worry	No	Yes		
Nightmares	No	Yes		
Angry Outbursts	No	Yes		
Feelings of Paranoia	No	Yes		
Unusual/Frightening Thoughts	No	Yes		

Diagnostic Examinations

Please describe results of any neurological tests/examinations of your brain:

	MRI	**CT**	**Brain Scan or SPECT**	**EEG**	**Neurological Examination /Other**
Approximate Date					
Describe results					

Other
(describe):____

Medical History

Please describe briefly your **history of past and present serious illnesses** and treatment.

Past and present illnesses, diseases, syndromes	Dates (From - To)	Treatment (Surgery/Medication)	CurrentStatus

Do you suffer from:	High Blood Pressure	Diabetes	High Cholesterol	Other:________
Treatment controlling it? (Yes No)				

Describe past **Accidents/Falls** leading to injury	Dates (From - To)	Surgery/Medications/Treatment

Describe any Other **Hospitalizations/Surgeries**	Dates (From - To)	Treatment (Surgery/Medication)	Current status

Current Medications

List names of Current Medications	Date medication prescribed	Dose (mg) (total per day)	Name of doctor who prescribed	What illness is medication for?	How well is this medication working

Alcohol Use

What type of alcohol (beer, vodka, wine) do you usually drink?_________ Are you currently drinking alcohol? **No** **Yes**

Total Number of Years drinking on a fairly regular basis___________ Have you ever had a drinking problem? **No** **Yes**

Average Amount you regularly drink (for example: 1 drink/week, 5 drinks/day, etc.) ____________________________

Have you been involved in any treatment for: (circle) Drinking **Alcohol** (including A.A.) / Using **Drugs**: **No** **Yes**

Please list any current, recent or past drug use and any treatment for drug use:

Type of **Alcohol** or **Drug**	Average Amount Used per week	Describe any treatment?

Smoking

If you smoked previously, when did you stop?_____________ Are you currently smoking? **No** **Yes**

Briefly describe attempts to quit smoking: ____

Approximately how many years smoked in lifetime: ______ Average number of packs/day ________

Psychological/Psychiatric

Have you ever had any treatment for psychiatric/psychological difficulties (relationship counseling psychological counseling, medicines for depression or anxiety, etc.): If yes, please describe below: **No** **Yes**

Problem	Date (From - To)	Describe Treatment received

Family Medical History

Please describe any family history of medical/neurological illness (Stroke, Alzheimer's, Dementia, High Blood Pressure) (include medical problems in all of your blood relatives, including psychiatric or psychological problems)

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Activities of Daily Living

Do you currently hold a driver's license? **Yes** **No** (If No, how do you get around?)____________

If yes, are you currently driving? **Yes** **No** (if No, who drives you?)____________

Have your **driving** abilities worsened or become bad? (describe problems)____________ **No** **Yes**

Do you have trouble showering/dressing, cooking, cleaning, or remembering to take medicines or eat? **No** **Yes**

Have you left items on the stovetop or in the oven and forgotten them? **No** **Yes**

Does someone, other than yourself, manage your finances? (If yes, then who):____________ **No** **Yes**

Have thinking problems made you unable to pay bills, balance checkbook, invest, shop, make change? **No** **Yes**

What chores do you perform around the house?____________

What sorts of things do you do for fun? ____________

Describe what you do and how often you spend time with family or friends relaxing or enjoying an entertaining or recreational activity?:____________

Describe how you get along with other people?____________

Education

Last grade completed?____________ At what age?_____ Usual grades (A,B,C,D,F) in school?_______

Did you get a GED? **No** **Yes** Or did you get a high school diploma? **No** **Yes**

Did you ever repeat a grade? If yes, which grade(s)?____________ **No** **Yes**

Have you ever been enrolled in special education or learning disability classes? **No** **Yes**

If Yes, please describe:____________

List degrees beyond high school (medical, associate, bachelors, masters, doctorate, etc.)?__________ in __________

From what colleges ____________

Please list any technical training or college education you have received since high school:

____

Have you taken intelligence, cognitive, achievement, or neuropsychological tests in the past? **No** **Yes**

If Yes, please describe:____________

Occupational History Are you currently working? **Yes** **No** (please list past jobs, even if not presently working)

Please outline your recent vocational history **beginning with your most recent (or current) employment**:

Dates (began -- ended)	Company Name	Job Title	Describe your duties	Why did you leave?
Start here with most recent job 1. --				
2. --				
3. --				
4. --				

Are you currently **receiving** any type of **disability** income? If Yes, please explain:__________________ **No** **Yes**

Are you currently in the process of **applying for disability** income?(SSI or others) explain?____________ **No** **Yes**

Have you ever been arrested for anything (if yes, describe) ____ **No** **Yes**

Have you ever served in the military? If yes, please complete the following: **No** **Yes**

Dates	Branch	Highest rank	Type of discharge	Combat duty (Y/N)

Marital Status (circle)? **Widowed Single Separated Divorced Married**

Spouse's name	Age when you married?	How long did you remain married?	Describe how you get along with that person now: (Good, Bad, No Contact, etc.)
1st:			
2nd:			
3rd:			
4th:			
Current spouse:			

Who currently lives with you? ____

Family

For the following family members please list their **age, education, occupation, and how well you get along:**

Relation	Name	Age	lives with you? **Yes/No**	Highest Grade Completed	Occupation	How well do you get along (good, bad, etc.)	List Health Problems
Spouse							
Children							
Mother							
Father							
Brothers and Sisters							
Other family members							

STOP, Please do not write below this line!

Who was present for this interview: Patient Who else: ______________________

New Patient Information

Name (Last)_______________________(First)___________________________(M.I.)_____

Address______________________________City______________State______Zip_________

Marital Status_________ Sex: **M** **F** Employer_____________________________________

Birth Date______________ Age_______ Social Security#_____________________________

Home Phone (____)______-_____________ Work Phone (____)________-_______________

Closet Relative not living with you________________ Home Phone (_____)______-_________

Address______________________ City______________ State_______ Zip_____________

Person Responsible for Payment (only complete if different from above)

Name_____________________ Relationship_____________ Employer_______________________

Home Phone (____)_____-________ Work Phone (____)_____-________________

Insurance Information

Name of Primary Insurance____

Contract #_________________ Group #_______________ Effective Date________________

Request for Confidential Handling of Health Information

I request that my provider handle my confidential health information in the following way:

A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe the alternative means (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

B. All reasonable requests to receive communication of your health information at alternative locations will be granted. Please complete the following section only if you want communications regarding your health care information sent to an alternate address (other than your residence).

____

(Alternate Address) (City) (State) (Zip)

______________________ ______________________

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 doctor 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 doctor has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay.

I understand that Dr. Tieszen, Dr. Xavier, Dr. Melvin, Dr. Herndon, Dr. Azrin, Dr. Millsaps, and Margaret Smith, LCSW are independent practitioners (not partners) although they are sharing office and staff.

Patient Signature_______________________________________ Date_____________

Comprehensive Memory Center
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Professional Office Building, Suite # 310 Birmingham AL, 35209
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Patient Name: ______________________ Date of Birth: ______________

Social Sec. #____________________ Date(s) of requested records: ____________

I hereby authorize the above providers to obtain and release the protected information specified below.
Please list any restrictions on this release of information______________________________

Name______________________ Phone______________ Fax____________
Address____
City State Zip

Name______________________ Phone______________ Fax____________
Address____
City State Zip

Name______________________ Phone______________ Fax____________
Address____
City State Zip

Name______________________ Phone______________ Fax____________
Address____
City State Zip

Name______________________ Phone______________ Fax____________
Address____
City State Zip

Records to be Obtained: Please send copies of all EEG, MRI, CT, History and Physical, and the doctors last progress notes.
Release: This form when completed and signed by you, authorizes me to release, as well as obtain, protected information from your clinical record to and from the person(s) you designate. I hereby authorize Dr. Richard Azrin, Dr. Cheryl Millsaps, Margaret Smith, LCSW, and/or his or her administrative and clinical staff to release any and all contents of my chart (including at least billing information, psychotherapy/progress notes, test results/data, reports, visit information, prescriptions, medical information, documents provided by patient, insurance/third party forms/reports, records received by others). This information should only be released to and/or obtained from the above individuals.
I am requesting my psychologist, psychiatrist, or social worker release this information to aid in treatment and/or assessment and/or provide information about me to others. This authorization shall remain in effect indefinitely. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my psychologist, psychiatrist, or social worker generally may not condition psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.
I hereby release the above treatment/assessment providers and their respective medical staff and office from any and all liability and claims arising out of or relating to the disclosure and/or release of confidential and/or privileged information.

____________________ ____________________ ____________
Name of patient and/or responsible party Signature of patient or responsible party Date

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If signed by patient's representative, a description of representative's authority to act for the patient is provided above.

***** Please fax records to Fax# (205) 877-2878 OR call Voice # (205) 877-2956**