



Wiregrass Behavioral Group LLC

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TODAY'S DATE: _____

NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED PH # TO RECEIVE APPOINTMENT REMINDER: _____

CELL PHONE: _____

HOME PHONE: _____

EMAIL: _____

POLICY HOLDER/INSURANCE/ INFORMATION

PRIMARY INSURED CARRIER: _____

INSURANCE POLICY/IDENTIFICATION NUMBER: _____

GROUP NUMBER: _____

POLICY HOLDER NAME: _____ **POLICY HOLDER DOB:** _____

INSURED EMPLOYER: _____

SECONDARY INSURANCE (If Applicable):

PRIMARY INSURED CARRIER: _____

INSURANCE POLICY/IDENTIFICATION NUMBER: _____

GROUP NUMBER: _____

POLICY HOLDER NAME: _____ **POLICY HOLDER DOB:** _____

EMERGENCY CONTACT: _____

PARENT / GUARDIAN NAME: _____

(If Patient is a minor)

*Please list anyone you would like to be able to receive information about your care such as appointments, medications (refills), etc. below.

Name	Relationship	Telephone Number
_____	_____	_____
_____	_____	_____

Patient Signature/Consent

Date

CURRENT SYMPTOMS – PLEASE CHECK ALL THAT APPLY

<input type="checkbox"/> Depression	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Loss of interest	<input type="checkbox"/> Anger
<input type="checkbox"/> Crying spells	<input type="checkbox"/> Irritability
<input type="checkbox"/> Appetite or weight increase	<input type="checkbox"/> Easily frustrated
<input type="checkbox"/> Appetite or weight decrease	<input type="checkbox"/> Racing thoughts
<input type="checkbox"/> Appetite or weight unchanged	<input type="checkbox"/> Restlessness or pacing
<input type="checkbox"/> Decreased concentration	<input type="checkbox"/> Inflated or high self esteem
<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Euphoria or happiness
<input type="checkbox"/> Helplessness	<input type="checkbox"/> Increased energy
<input type="checkbox"/> Guilty thoughts	<input type="checkbox"/> Don't need as much sleep
<input type="checkbox"/> Low self esteem	<input type="checkbox"/> Spending sprees
<input type="checkbox"/> Lowered hygiene	<input type="checkbox"/> Sexual promiscuity
<input type="checkbox"/> Isolating yourself	<input type="checkbox"/> Socializing too much
<input type="checkbox"/> Thoughts of death or dying	<input type="checkbox"/> Legal problems
<input type="checkbox"/> Thoughts of suicide or self-harm	<input type="checkbox"/> Traffic problems
<input type="checkbox"/> Symptoms worse during the day	<input type="checkbox"/> Impulsive behaviors
<input type="checkbox"/> Symptoms are worse at night	<input type="checkbox"/> Easily distracted
<input type="checkbox"/> Problems falling asleep	<input type="checkbox"/> Disorganized thinking
<input type="checkbox"/> Problems staying asleep	<input type="checkbox"/> Procrastination
<input type="checkbox"/> Problems waking up too early	<input type="checkbox"/> ADHD
<input type="checkbox"/> Problems sleeping too much	<input type="checkbox"/> Interrupting others
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Rude behavior
<input type="checkbox"/> Sleep talking or other behaviors	<input type="checkbox"/> Road rage
<input type="checkbox"/> Fatigue or easily becoming tired	<input type="checkbox"/> Violence toward others
<input type="checkbox"/> Loss of energy	<input type="checkbox"/> Being a victim of violence
<input type="checkbox"/> Excess worry	<input type="checkbox"/> Bulimia or Anorexia
<input type="checkbox"/> Difficulty relaxing, feeling tense	<input type="checkbox"/> Exercising too much
<input type="checkbox"/> Easily startled	<input type="checkbox"/> Worried about weight & body
<input type="checkbox"/> Anxiety or panic attacks	<input type="checkbox"/> Hearing hallucinations
<input type="checkbox"/> Obsessive thinking	<input type="checkbox"/> Seeing hallucinations
<input type="checkbox"/> Germophobia	<input type="checkbox"/> Feeling hallucinations
<input type="checkbox"/> Perfectionistic tendencies	<input type="checkbox"/> Smelling hallucinations
<input type="checkbox"/> Social anxiety	<input type="checkbox"/> Feeling scared
<input type="checkbox"/> Performance anxiety	<input type="checkbox"/> Feeling someone is after you
<input type="checkbox"/> Compulsive behaviors	
<input type="checkbox"/> Rechecking what you did	
<input type="checkbox"/> Rituals	
<input type="checkbox"/> Other :	

WHO REFERRED YOU: _____

REASON FOR APPOINTMENT: _____
