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DATE OF APPOINTMENT: _____

NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED PH # TO RECEIVE APPOINTMENT REMINDER BY TEXT OR VOICE MAIL:

CELL PHONE: _____

HOME PHONE: _____

EMAIL: _____

WHO REFERRED YOU: _____

REASON FOR APPOINTMENT: _____

POLICY HOLDER/INSURANCE/ INFORMATION

INSURED NAME: _____ **INSURED DOB:** _____

INSURED EMPLOYER: _____

INSURED CARRIER: _____

INSURANCE POLICY / IDENTIFICATION NUMBER: _____

GROUP NUMBER: _____

PREFERRED PHARMACY: _____

EMERGENCY CONTACT: _____

*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 :	

CURRENT SYMPTOMS: CONTINUED

QUESTION	DETAILS
HOW LONG HAVE THE CURRENT SYMPTOMS BEEN GOING ON	
HAS ANYTHING HELPED IMPROVE YOUR SYMPTOMS	
HAS ANYTHING MADE YOUR SYMPTOMS WORSE	
WHAT ARE YOUR CURRENT STRESSORS	
HAVE THERE BEEN ANY RECENT CHANGES TO YOUR PHYSICAL HEALTH	
DESCRIBE ANY RECENT PHYSICAL HEALTH SYMPTOMS	
HAVE THERE BEEN ANY RECENT CHANGES TO YOUR MEDICATIONS	

PAST MEDICAL HISTORY:

ALLERGY	DETAILS ABOUT ALLERGY
MEDICATION ALLERGIES	
ENVIRONMENTAL ALLERGIES	
FOOD ALLERGIES	
OB/GYN HISTORY	DETAILS
AGE AT 1ST MENSES	
CYCLE LENGTH	
LAST MENSTRUAL PERIOD	
NUMBER OF PREGNANCIES	
NUMBER OF MISCARRIAGES	
NUMBER OF DELIVERIES / DATES / METHOD OF DELIVERY	
PROBLEMS WITH MENSES	PAIN IRREGULAR CYCLE
PROBLEMS WITH UTERUS	FIBROIDS ENDOMETRIOSIS CYSTS PROLAPSE BLEEDING
SEXUAL PROBLEMS	LIBIDO ORGASM PAIN SPASMS
MENOPAUSE	
CURRENT CONTRACEPTION	

CHRONIC MEDICAL CONDITIONS – CHECK ALL THAT APPLY

CARDIOVASCULAR SYSTEM	NEUROLOGICAL SYSTEM
<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> HEAD TRAUMA
<input type="checkbox"/> CORONARY ARTERY DISEASE	<input type="checkbox"/> HEAD TRAUMA WITH LOSS OF CONSCIOUSNESS
<input type="checkbox"/> CARDIOMYOPATHY	<input type="checkbox"/> AUTISM / SPECTRUM DISORDER
<input type="checkbox"/> ENDOCARDITIS / MYOCARDITIS	<input type="checkbox"/> BELL'S PALSY
<input type="checkbox"/> HEART FAILURE	<input type="checkbox"/> BRAIN DAMAGE / HEAD INJURY
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> NEUROPATHY
<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> VASCULITIS
<input type="checkbox"/> ANEURYSM	<input type="checkbox"/> MYOPATHY
<input type="checkbox"/> ARRHYTHMIA / ABNORMAL BEAT	<input type="checkbox"/> STROKE / TIA
<input type="checkbox"/> HEART VALVE DISEASE	<input type="checkbox"/> MULTIPLE SCLEROSIS
<input type="checkbox"/> STROKE	<input type="checkbox"/> MYASTHENIA GRAVIS
<input type="checkbox"/> MINI-STROKE / TIA	<input type="checkbox"/> DEMENTIA
<input type="checkbox"/> CONGENITAL HEART DISEASE	<input type="checkbox"/> SEIZURE DISORDER
<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> TREMOR
<input type="checkbox"/> VASCULITIS	<input type="checkbox"/> MENIERE'S DISEASE
RESPIRATORY SYSTEM	<input type="checkbox"/> MIGRAINE
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> NARCOLEPSY
<input type="checkbox"/> CHRONIC BRONCHITIS	<input type="checkbox"/> TIC DISORDER / TOURETTES
<input type="checkbox"/> COPD	<input type="checkbox"/> PARKINSONS DISEASE
<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> HUNTINGTON'S DISEASE
<input type="checkbox"/> PULMONARY EMBOLISM	<input type="checkbox"/> RESTLESS LEG SYNDROME
GASTROINTESTINAL SYSTEM	<input type="checkbox"/> TRIGEMINAL NEURALGIA
<input type="checkbox"/> MOUTH SORES	<input type="checkbox"/> LUPUS
<input type="checkbox"/> ESOPHAGUS DIFFICULTIES	<input type="checkbox"/> MENINGITIS
<input type="checkbox"/> HEARTBURN / INDIGESTION	<input type="checkbox"/> FAINTING SPELLS / SYNCOPE
<input type="checkbox"/> GERD	<input type="checkbox"/> LYME DISEASE
<input type="checkbox"/> STOMACH ULCER	<input type="checkbox"/> PSEUDOTUMOR CEREBRI
<input type="checkbox"/> GALLSTONES	<input type="checkbox"/> FIBROMYALGIA
<input type="checkbox"/> LIVER DISEASE OR CIRRHOSIS	<input type="checkbox"/> CHRONIC FATIGUE SYNDROME
<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> CHRONIC PAIN DISORDER
<input type="checkbox"/> PANCREATITIS	UROGENITAL SYSTEM
<input type="checkbox"/> MALABSORPTION	<input type="checkbox"/> KIDNEY DISEASE
<input type="checkbox"/> CROHNS DISEASE	<input type="checkbox"/> KIDNEY STONES OR CYSTS
<input type="checkbox"/> CELIAC DISEASE	<input type="checkbox"/> PROLAPSED / FALLEN BLADDER
<input type="checkbox"/> IRRITABLE BOWEL DISEASE	<input type="checkbox"/> URINARY INCONTINENCE
<input type="checkbox"/> CHRONIC CONSTIPATION	<input type="checkbox"/> URINARY TRACT INFECTIONS
<input type="checkbox"/> ANAL FISSURES	<input type="checkbox"/> INTERSTITIAL CYSTITIS
<input type="checkbox"/> HEMORRHOIDS	<input type="checkbox"/> BENIGN PROSTATIC HYPERTROPHY
BLOOD PROBLEMS OR CANCERS	<input type="checkbox"/> PENILE DISEASE
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> TESTICULAR DISEASE
<input type="checkbox"/> LOW IRON	<input type="checkbox"/> ERECTILE DYSFUNCTION
<input type="checkbox"/> LOW VITAMIN B12 OR FOLATE	<input type="checkbox"/> LOW TESTOSTERONE
<input type="checkbox"/> BLEEDING OR CLOTTING PROBLEMS	<input type="checkbox"/> URETHRAL DISCHARGE
<input type="checkbox"/> SICKLE CELL DISEASE	<input type="checkbox"/> INFERTILITY
<input type="checkbox"/> THALASSEMIA	<input type="checkbox"/> SEXUALLY TRANSMITTED DISEASES
<input type="checkbox"/> HODGKINS DISEASE	<input type="checkbox"/> PELVIC INFLAMMATORY DISEASE
<input type="checkbox"/> LYMPHOMA	<input type="checkbox"/> PAIN WITH INTERCOURSE
<input type="checkbox"/> MYELOMA	<input type="checkbox"/> VAGINAL SPASMS
<input type="checkbox"/> HEMOCHROMATOSIS	OTHER MEDICAL PROBLEMS
<input type="checkbox"/> MONONUCLEOSIS	:
<input type="checkbox"/> HIV / AIDS	
MUSCULOSKELETAL	
<input type="checkbox"/> ARTHRITIS	
<input type="checkbox"/> RHEUMATOID ARTHRITIS	
<input type="checkbox"/> BRUXISM / TEETH GRINDING	
ENDOCRINE DISORDERS	
<input type="checkbox"/> HYPOTHYROIDISM	
<input type="checkbox"/> HYPERTHYROIDISM	
<input type="checkbox"/> DIABETES MELLITUS	
<input type="checkbox"/> PARATHYROID PROBLEMS	

PAST PSYCHIATRIC HISTORY: ANSWER YES/NO AND INCLUDE DETAILS PLEASE

QUESTION	DETAILS – DATES, LOCATIONS, TIMELINE
ANY PRIOR INPATIENT PSYCHIATRIC HOSPITALIZATIONS	
ANY PRIOR SUICIDE ATTEMPTS	
ANY PRIOR SELF INJURIOUS BEHAVIOR (LIKE CUTTING/BURNING)	
CURRENT OR PAST PSYCHIATRIST	
CURRENT OR PAST THERAPIST	
ANY PRIOR DIAGNOSES	
PRIOR HISTORY OF DEPRESSION SYMPTOMS	
PRIOR HISTORY OF MANIC-DEPRESSION OR BIPOLAR EPISODES OR SYMPTOMS	
PRIOR HISTORY OF ANXIETY : GENERALIZED WORRY, PANIC ATTACKS, OCD, PHOBIA, PTSD, SOCIAL ANXIETY	
PRIOR HISTORY OF EATING DISORDER	
PRIOR HISTORY OF HALLUCINATIONS	
PRIOR HISTORY OF PARANOIA OR UNUSUAL THOUGHTS	
PRIOR HISTORY OF SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER	
PRIOR HISTORY OF ADHD OR LEARNING PROBLEMS, OR AUTISTIC SPECTRUM	
PRIOR HISTORY OF ELECTROCONVULSIVE THERAPY	
OTHER IMPORTANT INFORMATION ABOUT YOUR PAST HISTORY OF SYMPTOMS OR TREATMENT	

PAST MEDICATIONS YOU HAVE TRIED: CHECK ALL THAT APPLY

MEDICATION NAME (BRAND / GENERIC)		MEDICATION NAME (BRAND / GENERIC)	
	PAXIL	PAROXETINE	STRATTERA
	PROZAC	FLUOXETINE	RITALIN
	LUVOX	FLUVOXAMINE	CONCERTA
	CELEXA	CITALOPRAM	QUILLIVANT
	LEXAPRO	ESCITALOPRAM	METADATE
	ZOLOFT	SERTRALINE	METHYLIN
	BRINTILLIX	VORTIOXETINE	FOCALIN
	EFFEXOR	VENLAFAXINE	DAYTRANA PATCH
	CYMBALTA	DULOXETINE	ADDERALL
	PRISTIQ	DESVENLAFAXINE	DEXEDRINE
	FETZIMA	LEVOMILNACIPRAN	VYVANSE
	WELLBUTRIN	BUPROPRION	CATAPRES
	REMERON	MIRTAZEPINE	TENEX
	SERZONE	NEFAZODONE	CYLERT
	PARNATE	TRANLYCYPROMINE	PROVIGIL
	NARDIL	PHENELZINE	NUVIGIL
	ANAFRANIL	CLOMIPRAMINE	ARICEPT
	ELAVIL	AMITRIPTYLINE	REMINYL
	NORPRAMIN	DESIPRAMINE	EXELON
	PAMELOR	NORTRIPTYLINE	NAMENDA
	SINEQUAN	DOXEPIN	COGENTIN
	SURMONTIL	TRIMIPRAMINE	ARTANE
	BUSPAR	BUSPIRONE	REQUIP
	NEURONTIN	GABAPENTIN	MIRAPEX
	VISTARIL	HYDROXYZINE	NEUPRO
	INDERAL	PROPRANOLOL	SYMMETREL
	XANAX	ALPRAZOLAM	ELDEPRYL
	ATIVAN	LORAZEPAM	COMTAN
	VALIUM	DIAZEPAM	SINEMET
	KLONOPIN	CLONAZEPAM	ABILIFY
	RESTORIL	TEMAZEPAM	FANAPT
	LIBRIUM	CHLORDIAZEPOXIDE	INVEGA
	SERAX	OXAZEPAM	LATUDA
	TOPAMAX	TOPIRAMATE	RISPERDAL
	DEPAKOTE	VALPROIC ACID	SAPHRIS
	LAMICTAL	LAMOTRIGINE	SEROQUEL
	TEGRETOL	CARBAMAZEPINE	ZYPREXA
	TRILEPTAL	OXCARBAZEPINE	CLOZARIL
	ESKALITH	LITHIUM	HALDOL
	GABITRIL	TIAGABINE	PROLIXIN
	KEPPRA	LEVETIRACETAM	TRILAFON
	MELATONIN	MELATONIN	THORAZINE
	ROZEREM	RAMELTEON	MELLARIL
	BENADRYL	DIPHENHYDRAMINE	LOXITANE
	DESYREL	TRAZODONE	STELAZINE
	AMBIEN	ZOLPIDEM	REVIA OR VIVITROL
	LUNESTA	ZOPICLONE	SUBOXONE
	SONATA	ZALEPLON	SUBUTEX
	ANTABUSE	DISULFIRAM	ZUBSOLV
			METHADOSE
			ATOMOXETINE
			METHYLPHENIDATE
			METHYLPHENIDATE
			METHYLPHENIDATE
			METHYLPHENIDATE
			METHYLPHENIDATE
			DEXMETHYLPHENIDATE
			METHYLPHENIDATE
			DEXTROAMPHETAMINE / AMPHETAMINE
			DEXTROAMPHETAMINE
			LISDEXAMFETAMINE
			CLONIDINE
			GUANFACINE
			PEMOLINE
			MODAFINIL
			ARMODAFINIL
			DONEPEZIL
			GALATAMINE
			RIVASTIGMINE
			MEMANTINE
			BENZTROPINE
			TRIHEXYPHENIDYL
			ROPINIROLE
			PRAMIPEXOLE
			ROTIGOTINE
			AMANTADINE
			SELEGILINE
			ENTACAPONE
			LEVODOPA/CARBIDOPA
			ARIPIRAZOLE / ABILIFY MAINTENNA
			ILOPERIDONE
			PALIPERIDONE / INVEGA SUSTENNA
			LURASIDONE
			RISPERIDONE / RISPERDAL CONSTA
			ASENAPINE
			QUETIAPINE
			OLANZAPINE / ZYPREXA RELPREVV
			CLOZAPINE
			HALOPERIDOL / HALDOL DECANOATE
			FLUPHENAZINE / PROLIXIN DECANOATE
			PERPHENAZINE
			CHLORPROMAZINE
			THIORIDAZINE
			LOXAPINE
			TRIFLUOPERAZINE
			NALTREXONE OR NALTREXONE INJECTION
			BUPRENORPHINE/NALOXONE
			BUPRENORPHINE
			BUPRENORPHINE
			METHADONE

DEVELOPMENTAL & SOCIAL HISTORY:

HISTORY	DETAILS
WHERE WERE YOU BORN	
ANY COMPLICATIONS WITH PREGNANCY OR DELIVERY WHEN YOU WERE BORN	
WERE YOUR PARENTS MARRIED AT THE TIME OF YOUR BIRTH	
DID THEY STAY MARRIED, OR GET DIVORCED (HOW OLD WERE YOU AT THAT TIME)	
WHAT WERE YOUR PARENTS OCCUPATION	
DO YOU HAVE ANY SIBLINGS (AND THEIR AGE & OCCUPATION)	
WERE YOU THE VICTIM OF PHYSICAL, SEXUAL, OR EMOTIONAL ABUSE AS A CHILD	
HOW WOULD YOU DESCRIBE YOUR CHILDHOOD OVERALL	
HOW DID YOU DO ACADEMICALLY IN SCHOOL (LEARNING PROBLEMS, GPA, HONOR SOCIETY)	
WHAT EXTRACURRICULAR ACTIVITIES DID YOU PARTICIPATE IN (IF ANY)	
WHAT IS THE LAST GRADE COMPLETED, OR YEAR OF HIGH SCHOOL GRADUATION	
WHAT DID YOU DO AFTER FINISHING HIGH SCHOOL	
DID YOU ATTEND ANY COLLEGE OR OBTAIN FURTHER DEGREES	
WHAT JOBS HAVE YOU HAD, HOW MANY, WHAT KINDS, WHAT IS THE LONGEST TIME AT A JOB	
HAVE YOU EVER HAD ANY PROBLEMS AT WORK, OR BEEN FIRED	
WHAT IS YOUR SEXUAL ORIENTATION	
DESCRIBE YOUR MARRIAGES OR SIGNIFICANT ROMANTIC RELATIONSHIPS, DIVORCES	
WHAT DOES YOUR SPOUSE / SIGNIFICANT OTHER DO FOR A LIVING	
DO YOU HAVE ANY CHILDREN, AGES, WHAT THEY ARE LIKE	
WHO DO YOU TURN TO FOR SUPPORT	
WHO LIVES AT HOME WITH YOU	
ARE YOU RELIGIOUS	
HAVE YOU EVER BEEN IN THE MILITARY	
DO YOU OWN ANY WEAPONS, HOW ARE THEY STORED	
HAVE YOU EVER HAD ANY LEGAL PROBLEMS (SPEEDING, BANKRUPTCY, DV, ASSAULT, ETC)	
HOW WOULD YOU DESCRIBE YOUR PERSONAL STRENGTHS AND PERSONALITY	
IS THERE ANYTHING ABOUT YOURSELF THAT YOU WANT TO IMPROVE	

SUBSTANCE USE HISTORY:

SUBSTANCE	AGE AT 1ST USE	FREQUENCY, AMOUNT USED	ANY PROBLEMS WITH USING THIS SUBSTANCE
CAFFIENE			
NICOTINE			
INHALANTS			
ALCOHOL			
CANNABIS			
LSD / HALLUCINOGENS			
ECSTASY			
PCP			
METHAMPHETAMINE			
HEROIN			
PRESCRIPTION PILLS			
OTHER:			
LEGAL PROBLEMS DUE TO ALCOHOL/DRUGS:			
ANY HISTORY OF REHAB TREATMENT:			

WHAT ARE YOUR GOALS OF TREATMENT:

Signature below is acknowledgement that you have received the Notice of Privacy Practices & Office Policies

OUR DUTIES

- **Notice Changes** - We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you and any PHI we receive in the future. Current copies of this notice will be available at registration locations. The current Notice will also be posted at our website. The effective date of the notice will be posted on the first page.
- **Cell Phone/Email Mail** - We ask you not to use your cell phone or email in contacting our healthcare providers, personally. Cell Phone and Emails sent to and from you are not secure and could be read by a third-party.
- **Complaints** - If you believe your privacy rights have been violated, then you have the right to submit a complaint to us. Any complaints shall be made in writing or by telephone to Wiregrass Behavioral Group, 256 Honeysuckle Rd. Ste 12 Dothan, AL 36305. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against or penalized in any way for filing a complaint. You may also file a written complaint with the secretary of the US Department of Health and Human Services, 200 Independence Ave. S W, Washington DC, 20201, or call toll-free 877-696-6775, by email to OCRCComplaint@hhs.gov or to Region V, Office for Civil Rights, US Department of Health and Human Services, 233 North Michigan Ave, Suite 240, Chicago, IL 60601, voice phone 312-886-2359, fax 312-886-1807, or TDD 312-353-5693.

Client / Legal Guardian Printed Name

Signature

Date

Witness – Printed Name

Signature

Date

Client’s Consent for Communications

Please initial below, with your selection:

_____ I **consent** to my cell phone, home phone or email being used for communications from Wiregrass Behavioral Group, LLC (that are non-clinical and non-urgent only)

_____ I **do NOT consent** to my cell phone, home phone or email being used for communications from Wiregrass Behavioral Group, LLC

Client’s Understanding

- I have read and understood the office policies and agree to abide by the rules listed therein
- I agree to be an active participant in my mental health recovery
- I have received a copy of the Office Policies
- I have received a copy of the Privacy Practices

Client / Legal Guardian Printed Name

Signature

Date

Witness – Printed Name

Signature

Date