Wiregrass Behavioral Group LLC

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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

_____Depression	_____Mood swings
_____Loss of interest	_____Anger
_____Crying spells	_____Irritability
_____Appetite or weight increase	_____Easily frustrated
_____Appetite or weight decrease	_____Racing thoughts
_____Appetite or weight unchanged	_____Restlessness or pacing
_____Decreased concentration	_____Inflated or high self esteem
_____Hopelessness	_____Euphoria or happiness
_____Helplessness	_____Increased energy
_____Guilty thoughts	_____Don't need as much sleep
_____Low self esteem	_____Spending sprees
_____Lowered hygiene	_____Sexual promiscuity
_____Isolating yourself	_____Socializing too much
_____Thoughts of death or dying	_____Legal problems
_____Thoughts of suicide or self harm	_____Traffic problems
_____Symptoms worse during the day	_____Impulsive behaviors
_____Symptoms are worse at night	_____Easily distracted
_____Problems falling asleep	_____Disorganized thinking
_____Problems staying asleep	_____Procrastination
_____Problems waking up too early	_____ADHD
_____Problems sleeping too much	_____Interrupting others
_____Nightmares	_____Rude behavior
_____Sleep talking or other behaviors	_____Road rage
_____Fatigue or easily becoming tired	_____Violence toward others
_____Loss of energy	_____Being a victim of violence
_____Excess worry	_____Bulimia or Anorexia
_____Difficulty relaxing, feeling tense	_____Exercising too much
_____Easily startled	_____Worried about weight & body
_____Anxiety or panic attacks	_____Hearing hallucinations
_____Obsessive thinking	_____Seeing hallucinations
_____Germophobia	_____Feeling hallucinations
_____Perfectionistic tendencies	_____Smelling hallucinations
_____Social anxiety	_____Feeling scared
_____Performance anxiety	_____Feeling someone is after you
_____Compulsive behaviors	
_____Rechecking what you did	
_____Rituals	
_____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
_____HEART DISEASE
_____CORONARY ARTERY DISEASE
_____CARDIOMYOPATHY
_____ENDOCARDITIS / MYOCARDITIS
_____HEART FAILURE
_____HIGH BLOOD PRESSURE
_____LOW BLOOD PRESSURE
_____ANEURYSM
_____ARRHYTHMIA / ABNORMAL BEAT
_____HEART VALVE DISEASE
_____STROKE
_____MINI-STROKE / TIA
_____CONGENITAL HEART DISEASE
_____HIGH CHOLESTEROL
_____VASCULITIS

RESPIRATORY SYSTEM
_____ASTHMA
_____CHRONIC BRONCHITIS
_____COPD
_____EMPHYSEMA
_____PULMONARY EMBOLISM

GASTROINTESTINAL SYSTEM
_____MOUTH SORES
_____ESOPHAGUS DIFFICULTIES
_____HEARTBURN / INDIGESTION
_____GERD
_____STOMACH ULCER
_____GALLSTONES
_____LIVER DISEASE OR CIRRHOSIS
_____HEPATITIS
_____PANCREATITIS
_____MALABSORPTION
_____CROHNS DISEASE
_____CELIAC DISEASE
_____IRRITABLE BOWEL DISEASE
_____CHRONIC CONSTIPATION
_____ANAL FISSURES
_____HEMORRHOIDS

BLOOD PROBLEMS OR CANCERS
_____ANEMIA
_____LOW IRON
_____LOW VITAMIN B12 OR FOLATE
_____BLEEDING OR CLOTTING PROBLEMS
_____SICKLE CELL DISEASE
_____THALASSEMIA
_____HODGKINS DISEASE
_____LYMPHOMA
_____MYELOMA
_____HEMOCHROMATOSIS
_____MONONUCLEOSIS
_____HIV / AIDS

MUSCULOSKELETAL
_____ARTHRITIS
_____RHEUMATOID ARTHRITIS
_____BRUXISM / TEETH GRINDING

ENDOCRINE DISORDERS
_____HYPOTHYROIDISM
_____HYPERTHYROIDISM
_____DIABETES MELLITUS
_____PARATHYROID PROBLEMS

NEUROLOGICAL SYSTEM
_____HEAD TRAUMA
_____HEAD TRAUMA WITH LOSS OF CONSCIOUSNESS
_____AUTISM / SPECTRUM DISORDER
_____BELL'S PALSY
_____BRAIN DAMAGE / HEAD INJURY
_____NEUROPATHY
_____VASCULITIS
_____MYOPATHY
_____STROKE / TIA
_____MULTIPLE SCLEROSIS
_____MYASTHENIA GRAVIS
_____DEMENTIA
_____SEIZURE DISORDER
_____TREMOR
_____MENIERE'S DISEASE
_____MIGRAINE
_____NARCOLEPSY
_____TIC DISORDER / TOURETTES
_____PARKINSONS DISEASE
_____HUNTINGTON'S DISEASE
_____RESTLESS LEG SYNDROME
_____TRIGEMINAL NEURALGIA
_____LUPUS
_____MENINGITIS
_____FAINTING SPELLS / SYNCOPE
_____LYME DISEASE
_____PSEUDOTUMOR CEREBRI
_____FIBROMYALGIA
_____CHRONIC FATIGUE SYNDROME
_____CHRONIC PAIN DISORDER

UROGENITAL SYSTEM
_____KIDNEY DISEASE
_____KIDNEY STONES OR CYSTS
_____PROLAPSED / FALLEN BLADDER
_____URINARY INCONTINENCE
_____URINARY TRACT INFECTIONS
_____INTERSTITIAL CYSTITIS
_____BENIGN PROSTATIC HYPERTROPHY
_____PENILE DISEASE
_____TESTICULAR DISEASE
_____ERECTILE DYSFUNCTION
_____LOW TESTOSTERONE
_____URETHRAL DISCHARGE
_____INFERTILITY
_____SEXUALLY TRANSMITTED DISEASES
_____PELVIC INFLAMMATORY DISEASE
_____PAIN WITH INTERCOURSE
_____VAGINAL SPASMS

OTHER MEDICAL PROBLEMS
:_____

SURGICAL HISTORY:

DATE OF SURGERY	TYPE OF SURGERY

FAMILY HISTORY: PLEASE INCLUDE PHYSICAL & MENTAL HEALTH & ADDICTION PROBLEMS

MOTHER	
FATHER	
SIBLINGS	
CHILDREN	
AUNTS/UNCLES	
COUSINS	
GRANDPARENTS	

CURRENT MEDICATIONS:

ALLERGIES: _____

MEDICATION	DOSE / DIRECTIONS	PRESCRIBING DOCTOR

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