



Wiregrass Behavioral Group LLC

256 Honeysuckle Rd, Ste 12
Dothan, AL 36305
Phone: (334) 792-6736
Fax: (334) 792-6737
www.WireBG.com

Leona Graham, MD
William Elkington, MD
Ruthanne Wilkes, MSN, FNP, PMHNP
Dallarie Jamison, MSN, FNP, PMHNP
Alexia Powell, MSN, FNP, PMHNP

Terry Bradley, MS, LPC
Penelope McDonald, MS, LPC
Fran Espey, MS, LPC
Walter Williams, MS, ALC
Stephanie Epding, MS, ALC

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

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

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	BUPROPION		CATAPRES	CLONIDINE
	REMERON	MIRTAZEPINE		TENEX	GUANFACINE
	SERZONE	NEFAZODONE		CYLERT	PEMOLINE
	PARNATE	TRANLYCYPROMINE		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	TRIHXYPHENIDYL
	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	ARIPIRAZOLE / 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		RE VIA 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