New Patient Paperwork

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Dr. Dhaliwal, MD

Please complete all sections to the best of your ability. If you have any questions or need assistance, as a front staff.

Last name: _____ First name: _____ MI: _____

Date of Birth: _____ / _____ / _____ Male _____ Female _____ SSN: _____ - _____ - _____

Phone Number: _____ Email: _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Grade level (if applicable): _____

Address: _____ Apt _____

City: _____ State: _____ Zip Code: _____ Who do you live with? _____

Current Employment Status: (Check one) Employed ____ Unemployed ____ Student ____ Retired ____

Occupation: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Insurance Information (if applicable):

Primary Insurance Company: _____ Policyholder Name: _____

Policyholder Date of Birth: _____ / _____ / _____

Policy Number:_____ Group Number: _____

Secondary Insurance (if applicable):_____

Policy Number: _____ Group Number: _____

Reason for Visit / Concerns

Briefly describe the issue(s) you are seeking help for: _____

_____

When did you first notice these symptoms or concerns? _____

How did you hear about us? (Check all that apply): _____

Pharmacy: _____ Address : _____

Mental Health History:

Have you previously received mental health treatment? (Check all that apply)

- Yes, therapy
- Yes, psychiatric medication
- Yes, hospitalization
- No

If yes, please provide details: _____

Do you have a history of any of the following? (Check all that apply)

- ADHD/ADD
- Depression
- Anxiety
- Bipolar Disorder
- PTSD
- Eating Disorders
- Substance Use
- Self-Harm
- Suicidal Thoughts
- Psychosis
- Other: _____

Medical History

Primary Care Physician: _____

Are you currently taking any medications and/or vitamins/supplements? (List medications and dosages)

_____

_____

_____

_____

Do you have any allergies? (medications, foods, etc.): _____

Past Surgical History: _____

_____

Substance Use History

Do you smoke cigarettes? YES ____ NO ____

Do you vape nicotine? YES ____ NO ____

Do you use alcohol? YES ____ NO ____ If yes, how often? _____

Do you use recreational drugs? YES ____ NO ____ If yes, what substances and how often? _____

Have you ever been treated for substance abuse? YES ____ NO ____ Last Treatment: _____

Family History

Does anyone in your family have a history of mental health issues? If yes, please specify: (including anxiety disorders, depression, bipolar disorder, schizophrenia, ADHD, history of substance abuse)

_____

_____

_____

Do you have children? Yes ____ No ____ If yes, how many and ages: _____

Do you have any of the following conditions:

- Anemia
- Asthma
- Cardiac Arrhythmia
- COPD
- Diabetes
- Elevated cholesterol
- Fibromyalgia
- Gastric Ulcer
- GERD
- Glaucoma
- Herniated Disc
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Ischemic heart disease
- Lupus
- Chronic Migraines/Headaches
- Myocardial Infarction/Heart Attack
- Seasonal allergies
- Seizures
- History of Stroke or Transient Ischemic Attack
- Vitamin B_{12} deficiency
- Vitamin D deficiency
- Other:

  _____

  _____

Legal History

Are there any legal issues currently affecting you? (including FMLA/short term/long term disability)

If yes, please provide details: _____

_____

Consent for Treatment

I consent to treatment and understand that my mental health provider may need to discuss my case with other healthcare providers when appropriate.

Patient Signature: _____ Date: _____

Privacy Policy and HIPAA Acknowledgment

I acknowledge that I have received and reviewed the Notice of Privacy Practices (HIPAA) and understand my rights regarding confidentiality and privacy.

Patient Signature: _____ Date: _____

REVIEW OF SYSTEMS:

Please select any symptoms you may be experiencing

GENERAL:

☐ Chills ☐ Fatigue ☐ Weight Gain ☐ Weight Loss

EYE:

☐ Blurred vision ☐ Itchy Eyes ☐ Eyesight problems

ENDOCRINE:

☐ Cold intolerance ☐ Excessive sweating ☐ Excessive thirst ☐ Heat intolerance

ENT:

☐ Decreased hearing ☐ Ear pain ☐ Ringing in the ears ☐ Snoring

GASTROINTESTINAL:

☐ Decreased appetite ☐ Diarrhea ☐ Difficulty swallowing ☐ Heartburn ☐ Nausea
☐ Vomiting

GENITOURINARY:

☐ Blood in urine ☐ Difficulty Urinating ☐ Increased frequency of urination
☐ Painful urination

CARDIOVASCULAR

☐ High Blood Pressure ☐ Irregular heartbeat ☐ Palpitations

RESPIRATORY:

☐ Cough ☐ Shortness of Breath ☐ Wheezing

MUSCULOSKELETAL:

☐ Joint pain ☐ Joint stiffness ☐ Muscle aches ☐ Muscle weakness

ALLERGIES:

☐ Hives ☐ Itching ☐ Rashes ☐ Seasonal allergies ☐ Watery eyes

NEUROLOGICAL:

☐ Dizziness ☐ Fainting ☐ Headaches ☐ Vertigo

HEMATOLOGY:

☐ Easy bruising ☐ Swollen glands ☐ Weakness

HIPPA AUTHORIZATION FORM

(PERMISSION FROM PATIENT/PATIENT'S LEGAL GUARDIN TO SHARE PERSONAL MEDICAL INFORMATION)

PATIENT NAME:_____

DOB:_____/_____/_____

STREET ADDRESS:_____

CITY, STATE, ZIP:_____

I, _____, hereby authorize Huntsville Neuropsychiatric Services and/or medical facility to release any and all medical information and test results that pertain to me, to the following individual(s):

Name:_____Phone#:_____Relationship:_____

Name:_____Phone#:_____Relationship:_____

Name:_____Phone#:_____Relationship:_____

I understand that I may revoke/cancel this authorization by notifying HNS in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____

Signature of Patient Date

Or, if applicable

_____ Date_____

Signature of Legal Guardian

Relationship to Patient:_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

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Policy for Divorced or Separated Parents

Our highest priority is the care of our patients. We have many patients whose parents are either separated or divorced and we are happy to work with either or both parents to make sure the child's healthcare needs are met.

When a child is seen by our staff and accompanied by either parent, we will assume that parent has the authority to make medical decisions for the child, unless we are instructed otherwise by legal documentation.

It is essential that both parents reach an agreement regarding their child's healthcare needs prior to arriving at our office as we will not medicate disagreements. We will discuss our assessments and recommendations with the adult who accompanies the child to the office, televisit or portal communication. However, we are happy to answer any questions regarding your child's health from either parent at any time.

Copays will be collected at time of service by the accompanying adult, regardless of divorce decree. If legal documentation states otherwise, we will be happy to provide a receipt at the time of visit for medical reimbursement to be settled privately between the parents.

As a collaborating office, we will not become involved in disputes between family members. Should a dispute interfere with your child's healthcare, or should an issue become disruptive to our practice, we have reserved the right to discharge the patient from further treatment.

Patient Signature: _____ Date: _____