UAB PSYCHIATRY

Dear Patient:

We appreciate your choice of health care providers. Please be aware of the following process that is in place to help us better serve you.

- If you are a new patient, please arrive at least 30 minutes prior to your appointment time.
- If you are a return patient, please arrive at least 15 minutes prior to your appointment time.
- Patients who arrived 10 minutes after their appointment time are subject to cancellation.
- Co-pay is due at time of arrival.
- Please allow extra time for parking.

Thank you for your assistance in this matter. If you have questions, please contact our office at 205-934-5151 between the hours of 8:00am-4:00pm.

UAB Psychiatry
Sparks Center

UAB Department of Psychiatry

- Our office hours are Monday-Friday 8:00am-5:00pm, except holidays.

- If you have an emergency please contact the **Crisis Center at 205-323-7777** or go to your nearest emergency room.

- Any call to the office received after 4:00pm may not be returned until the following business day. Your call is very important to us and will be returned as quickly as possible and in the order it was received. Please leave only one message. If your call is not returned within one business day, please call again.

- Please arrive to your scheduled appointment 15-30 minutes early to allow for checking-in, paying co-pays, and completing any needed paperwork. **If you are more than 10 minutes late your appointment will be rescheduled for a later date.**

- If you have not been seen within a 6 month period, or have failed to arrive for 2 appointments, no medications will be phoned in until you are scheduled to see your provider.

- We will only discuss patient issues with the patient, unless the patient has signed a release of information. **There will be no exceptions.** Please understand that these are federally mandated laws and are not just the policy of our clinic.

DOCTOR **APPOINTMENT DATE** **TIME**

UAB Department of Psychiatry

NO-SHOW POLICY

This form is intended to notify you as a patient of the Department of Psychiatry, at UAB that a 24 hour cancellation notice is required.

Please be aware that you will be charged a $50.00 no-show fee when you fail to arrive for your appointment or if you cancel your appointment without providing a 24 hour notice.

Your insurance does not pay for no-show charges.

You agree to be financially responsible for this fee should you fail to keep your scheduled appointment.

_____ _____

Patient Name Medical Record Number

_____

Signature of Patient or Guardian

_____

Date Signed

UAB Department of Psychiatry

CO-PAYS & BALANCES POLICY

This policy is for patients who choose to have services performed at the UAB Department of Psychiatry.

It is the policy our department, to collect any copayments and/or balances, at the time of service.

By signing this, you acknowledge that you understand this policy and will be responsible for any copayments required by your insurance, or any balances on your account.

If you are choosing to be seen without insurance coverage, you agree to pay the full cost of the appointment at the time of your visit.

_____ _____

Patient Name Medical Record Number

_____

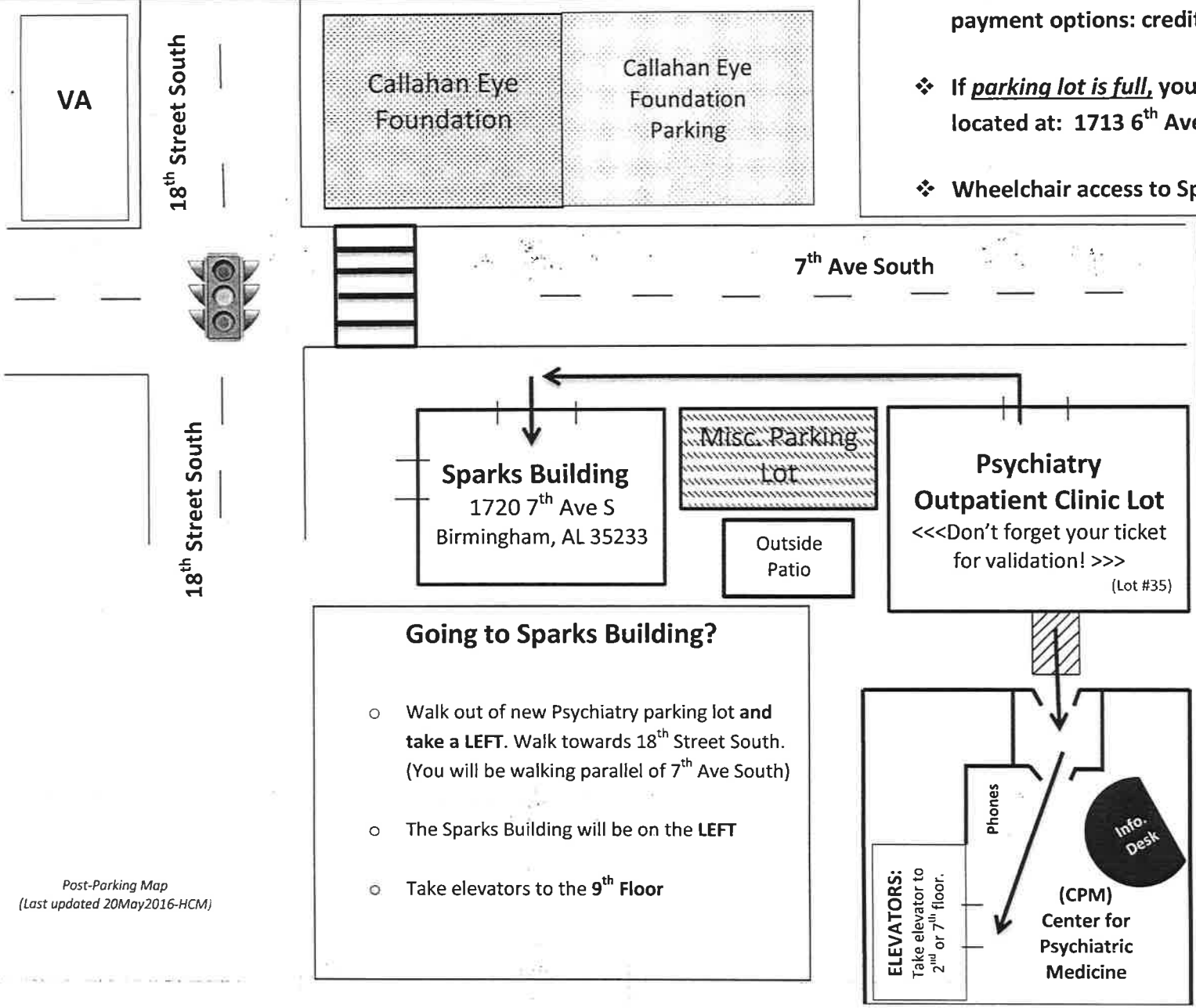
Signature of Patient or Guardian

_____

Date Signed

Walking from Psychiatry Outpatient Clinic Lot
to
Sparks Building - 9th floor, 1720 7th Ave S, Birmingham, AL 35233
or
Center for Psychiatric Medicine (CPM) – 2nd or 7th floor, 1713 6th Ave S, Birmingham, AL 35294

- ☺ ***Don't Forget Your Parking Ticket So We Can Validate it!***
  ****If your parking ticket is not validated, it will cost $25.00 to exit the parking lot. ****
- **Parking is $2.00 for the first hour, $1.00 for each additional hour, and up to $6.00 maximum daily rate. Parking payment options: credit cards, cash, or coins**
- **If *parking lot is full,* you can park in the CPM parking lot located at: 1713 6th Ave S. Birmingham, AL 35294.**
- **Wheelchair access to Sparks is available through CPM 2nd fl.**



Going to Sparks Building?

- Walk out of new Psychiatry parking lot **and take a LEFT**. Walk towards 18th Street South. (You will be walking parallel of 7th Ave South)
- The Sparks Building will be on the **LEFT**
- Take elevators to the **9th Floor**

Going to CPM 2nd or 7th floor?

- To enter the Center for Psychiatric Medicine (CPM) from the Psychiatry parking lot, you may access the building from the **back of the parking lot.**
- After entering the CPM building, go **through the double doors** to the lobby.
- Look for **elevators on RIGHT** and go to 2nd or 7th floor.
- If you have an appointment on the 7th floor, you will take a **RIGHT** when exiting the elevator on the 7th floor and walk through the clinic door to check in.

Post-Parking Map
(Last updated 20May2016-HCM)

Date of Appointment: _____

Child/Adolescent
Patient Information Form

This form is to be completed by the parent/legal guardian of the child to be seen at Children's Behavioral Health. If you have questions about any part of this form, please call 205-939-9193.

Name of legal guardian completing form **(write on above line)** Relationship to patient

Street Address City State Zip County

( ) ( ) ( ) ( )
Home Phone Cell phone Work Phone Other phone

( )
Name of Emergency Contact other than immediate family Phone Relationship to Patient:

Please provide information about your reasons for seeking treatment: You may use the back of this form for additional space.

Child/Patient Name Date of Birth Patient age Sex: ☐Male ☐ Female

Address (if different from legal guardian) City State Zip County

Insurance

( )
Name of person/Doctor/Therapist outside of CBH who referred you for treatment Phone

Patient's Problems as You See Them	When did Problem Begin
Example: *My child is aggressive and gets into fights about weekly at school. He has been suspended 4 times for fighting at school this year.*	*Two years ago*
1.	
2.	
3.	
4.	

Problem List: Check/Circle any boxes that apply to your child. **Please do not write in the bolded areas.**

Can't concentrate/ Pay attention	**Clinician use only: Do not write in this space.**
Restless or hyperactive	**Duration:**
Talks too much/ talks out of turn	**Settings: Home/ School**
Impulsive or Acts without thinking	**Teacher complaints since:**
Trouble staying seated	**Attention span estimate:**
Makes careless mistakes	
Fails to finish things he/she starts	
Daydreams/ Gets lost in thought	
Inattentive/ Easily distracted	
Has trouble following directions	
Forgetful/ Often loses things	

Angry/ Resentful	**Clinician use only: Do not write in this space.**
Does not mind/ Argues	**Duration:**
Annoys others purposely	**Settings: Home/ School**
Bullies/ Threatens/ Intimidates others	**Homicidal ideations**
Fights/ Aggressive	
Destroys Property	
Temper tantrums/ Loses temper easily	
Lies/ Blames others for own behavior	
Cruel to Animals	
Has set Fires	
Violates curfew/ Has run away	
Suspected smoking/ alcohol/ drug use	
Inappropriate sexual behavior/Suspected sexual activity	
Has trouble making/ keeping friends	
School suspensions/ Alternative School	

Frequent Sadness or Irritability	**Clinician use only: Do not write in this space.**
Tearful/ Cries Easily	**Duration:**
Low energy level	**Mood:**
Suicidal thoughts, threats, or actions	**Suicidal Ideations**
Low self-esteem or guilt	**Passive suicidal ideations**
Cuts, burns, or intentionally causes harm to self	**Self-injurious behaviors**
Loss of interest in favorite activities	
Unusual Worries or fears	
Feelings hurt easily	
Change in appetite	
Change in sleep patterns	
Frequent Body aches, headaches, or stomachaches	
Severe changes in mood when compared to peers	
Can go with little to no sleep for days	
Talks too much too fast, changes topics quickly	
Thoughts racing	
Increased goal-directed activities	
Unrealistic highs in self-esteem	
Worries about safety of self or others	

Panic Attacks	**Avoidance of trigger/ Palpitations/ trembling or shaking/ sweating/ sensation of smothering/ chest pain/shortness of breath/ nausea/ feeling lightheaded or dizzy/ fainting/ paresthesias/ hot or cold flashes/ feelings of impending doom.**
Panics or tantrums when separated from parent	
Obsessive thoughts	
Unusual behaviors that must be performed, such as dressing, bathing, mealtime, or counting rituals	
Nervous tics or other repetitive, abrupt nervous movements or vocal noises	

Sees or hears things that are not real	**Clinician use only: Do not write in this space.**
Confused thinking or beliefs	**Auditory hallucinations**
Feels people are "out to get" him or her	**Visual Hallucinations**
Unable to care for hygiene, nutrition, or basic needs	**Tactile hallucinations**
Odd or bizarre thoughts or behavior	**Olfactory hallucinations**

Behaves like a younger child	**Clinician use only: Do not write in this space.**
Has trouble communicating	
Avoids or seems obsessed with certain things	
Makes repetitive sounds or body movements	
Fascinated with odd objects or parts of toys	
Uses people as objects	
Lack of imaginary or pretend play	
Does not seek to share interests	
Does not make friends/ in his or her "own world"	
Does not keep eye contact	
Has rituals or routines that must be followed	
Problems with wetting or soiling self	

Please describe any stressful even or circumstance that may have triggered these problems:

_____

_____

_____

_____

_____

_____

Has your child ever witnessed or been exposed to domestic violence? No Yes If yes, please explain:_____

_____

_____

Custody Information

Are there any current custody issues? No Yes If yes, please explain:

Is there a history of physical abuse, sexual abuse, or neglect involving this child or a family member? No Yes

Name	Child or Adult	Victim or Perpetrator	Relationship to this child	Reported to DHR?

Has the Department of Human Resources (DHR) ever been involved with this child? No Yes
If yes, please list any situation requiring DHR, Family Court, or Juvenile Probation involvement:
Social worker/ Case worker: _____ Phone: (___)_____
Dates of involvement:_____ Reason for involvement:_____

Clinician use only: Do not write in this space:_____

Family Data

Please list **ALL** individuals living in the child's household:

Name	**Age**	**Relationship**	**Known to child as**	**Occupation**
Example: Jane Dow	52	Grandmother	"Mommy"	homemaker

Please list all **OTHER** family/caregivers **NOT** currently residing with the patient (this would be biological parents, step parents, siblings, etc.)

Name	Age	Relationship	Known to child as	Occupation
Example: Ashley Smith	*30*	*Biological Mother*	*Mama Ashley*	*Sales*

Married Status of Biological Parents:

Married/Remarried Divorced Living Together
Single/ Never Married Legally Separated Widow

If parents are separated or divorced, how old was the patient at time of separation? _____

Housing/Living Situation:
Adequate for needs Inadequate (i.e. Living in a shelter, living with relatives/friends)
Moved more than 2 times in the past 12 months Moved more than 3 times in the past 12 months

Are there transportation problems that may make it difficult to keep appointments?_____

Please describe any information regarding family that may contribute to stress for the child including visitations, step parents, foster care, adoption, or other custody issues:

_____
_____
_____

Clinician Use ONLY: DO NOT WRITE IN THIS SPACE:

DEVELOPEMENTAL HISTORY

Biological mother's age at child's birth_____. If child was adopted, child's age at adoption_____.
If not biological child of parent, is the child aware of this? **Yes** **No**
Planned Pregnancy: **Yes** **No**
Check the corresponding box if the biological mother used the following during pregnancy:

- o Alcohol
- o Over-the-counter medications
- o Prescription Medications
- o Recreational/ Street Drugs (Examples: Cocaine, Marijuana, Amphetamines, Heroin, etc.)
- o Cigarettes
- o Antibiotics
- o Other_____.

Please list any problems experienced by the mother during pregnancy: (Examples: high blood pressure, Diabetes, bed rest ordered etc. _____

_____

Were there any complications at birth? No Yes If yes, please specify:_____

_____

Was the baby premature? No Yes If yes, how early was the baby? _____

What was your child's birth weight? _____

What was your child's personality from age 0 to 1 year:
1) Easy going 2) Slow to warm up to others 3) Demanding and difficult to please
Other _____

At what age did your child first do the following:

Sit up _____
Crawl _____
Walk _____

Say single words _____
Say 2 or more words together _____
Become toilet trained _____

Clinician use only. Do not write in this space

Medical History

Who is your child's pediatrician? _____ Phone (___)_____
When was your child's last hearing screening? _____ Normal? No Yes
When was your child's last vision screening? _____ Normal? No Yes
Are your child's immunizations up to date? No Yes
Has your child ever had any of the following?

- ☐ Broken Bones_____
  Speech problems_____
  Lead Poisoning_____
- ☐ Seizures or convulsions_____
- ☐ Head Injury _____
  Hospitalization_____
- ☐ Surgery_____
  EKG or EEG_____
- ☐ Heart Problems_____

Please list any **current** health problems (Ex: Asthma, Allergies, Diabetes, heart condition, etc.):

_____ _____
_____ _____
_____ _____

Please list any **current** medications and the Dr. who prescribes them:

_____ _____

_____ _____

_____ _____

Please list any **past** health problems: _____

_____ _____

_____ _____

Does your child have any allergies to foods, medications, or latex? No Yes

If yes, please list with reaction: _____

_____

_____

Please note if your child has ever taken any of the following medications:

Medication / Dose *Example: Abilify -20 mg at bedtime*	Beneficial Effects *Helps him to not hear voices*	Side Effects *Headaches*	Duration *7/03 - Present*	Reason Stopped *Didn't work*
Abilify (aripiprazole)				
Adderall / Adderall XR (amphetamine salts)				
Anafranil (clomipramine)				
Atarax (hydroxyzine)				
Ativan (lorazepam)				
Aventil (nortriptyline)				
BuSpar (buspirone)				
Benadryl (diphenhydramine)				
Catapres (clonidine) tablets / patches				
Celexa (citalopram)				
Cogentin (benztropine)				
Concerta (methylphenidate)				
Cymbalta				
DDAVP (desmopresin)				
Daytrana Patch (Methylphenidate)				
Depakene (valproic acid)				
Depakote (divalproex sodium)				
Desyrel (trazodone)				
Dexedrine, Dextrostat (dextroamphetamine)				

Medication / Dose	Beneficial Effects	Side Effects	Duration	Reason Stopped
Effexor / Effexor XR (venlafaxine)				
Elavil (amitriptyline)				
EMSAM				
Eskalith (lithium carbonate)				
Focalin (dexmethylphenidate)				
Geodon (ziprasidone)				
Haldol (haloperidol)				
Inderal (propranolol)				
Klonopin (clonazepam)				
Lamictal (phenyltriazine)				
Lexapro (escitalopram oxalate)				
Lithobid, Lithonate, Lithotabs (lithium)				
Luvox (fluvoxamine)				
Mellaril (piperidine phenothiazine)				
Metadate ER / Metadate CD (methylphenidate)				
Methylin				
Norpramin (desipramine)				
Pamelor (nortriptyline)				
Paxil (paroxetine)				
Prozac (fluoxetine)				
Remeron (mirtazapine)				
Risperdal (risperidone)				
Ritalin / Ritalin LA (methylphenidate)				
Seroquel (quetiapine)				
Serzone (nefazodone)				
Sinequan (doxepin)				
Stelazine(trifluoperazine)				
Strattera (atomoxetine)				
Tegretol (carbamazepine)				

Medication / Dose	Beneficial Effects	Side Effects	Duration	Reason Stopped
Tenex (guanfacine)				
Thorazine (chlorpromazine)				
Tofranil (imipramine)				
Topamax				
Trileptal (dibenzazepine)				
Valium (diazepam)				
Vivactil (protriptyline)				
Vistaril, Atarax (hydroxyzine)				
VYVANSE				
Wellbutrin SR / Wellbutrin XL (bupropion)				
Xanax (alprazolam)				
Zoloft (sertraline)				
Zyprexa (olanzapine)				
Other:				

Past Psychiatric History

If your child has had prior counseling, psychiatric care, psychiatric hospitalizations, or testing please list:

Hospital or doctor's name	Phone #	Dates Seen	Recommendations

Clinician use only. Do not write in this space.

Biological Family Medical / Psychiatric History

Please write which family member had these problems if appropriate:

Past or Present diagnosis or symptoms	Biological Siblings	Biological Mother	Biological Father	Biological mother's family	Biological father's family	Others living In the home
1. ADHD						
2. Oppositional/Defiant						
3. Obsessive/Compulsive Disorder						
4. Antisocial behavior						
5. Learning disability / Special Education						
6. Mental Retardation						
7. Autism / Asperger's Disorder / PDD						
8. Psychosis / Schizophrenia						
9. Bipolar Disorder / Manic Depression						
10. Depression						
11. Suicide or suicide attempts						
12. Anxiety / Phobias						
13. Eating Disorders						
14. Tics / Tourette's syndrome						
15. Aggression or behavior problems						
16. Murdered or attempted to kill others						
17. Been arrested or spent time in jail						
18. Alcohol abuse						
19. Drug abuse						
20. Other psychiatric Problem						
21. Heart problems						
22. Seizures/Epilepsy						
23. Other medical problems						
24. Outpatient therapy						
25. Hospitalizations						

Clinician use only. Do not write in this space.

Educational History

Name of current school:_____ Grade:_____

Teachers:_____

Current Placement: Regular Alternative School Special Education:
for behavior only for learning difficulties Both Other:_____

How many schools has your child attended this school year? One(current) 2-3 3 or more

Any prolonged absences from school? No Yes When_____How long_____

Has your child repeated any grades? No Yes Which one(s)_____

Has your child been suspended **this school year**? No Yes How many times?_____
Please list reason for suspension:_____

Has your child been tested for special education placement by the school? No Yes
When?_____ **Please bring copies of testing and IEP's if available.**

Specific educational difficulties: Spelling Math Reading All subjects

Current Academic Performance: Very Good (all A's & B's)
Fair (C's & D's)
Poor (mostly F's)

Past Academic Performance: Very Good (all A's & B's)
Fair (C's & D's)
Poor (mostly F's)

Peer relationships: Aggressive/Fights a lot Very Friendly
Has no friends Teased/Bullied by others

Work History if applicable (attendance, relationship with boss):_____

Clinician use only. Do not write in this area.