

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 205-934-6054 between the hours of 8:00am-4:00pm.

UAB Psychiatry
Center for Psychiatric Medicine

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

Directions to the Center For Psychiatric Medicine – CPM

249 Center for Psychiatric Medicine, 1713 6th Avenue South
Birmingham, AL 35294-0018

Center For Psychiatric Medicine – From Birmingham International Airport:

Follow I-20/59 West/South toward downtown Birmingham. Exit at Highway 31/280 (Exit 126A). Proceed south and exit at 8th Avenue South (University Boulevard). Turn right onto 8th Avenue South and proceed to 18th Street South. Turn right and proceed to 6th Avenue South. Turn left. The entrance to the Center For Psychiatric Medicine will be midway down the block on your left. Airport transportation for international patients may be arranged by calling International Patient Services at 205.934.2096.

Center For Psychiatric Medicine – Southbound on I-65:

Exit 4th Avenue South (Exit 259B). Proceed to 18th Street South and turn right. Proceed to 6th Avenue South and turn right. The entrance to the Center for Psychiatric Medicine will be midway down the block on your left.

Center For Psychiatric Medicine – Northbound On I-65:

Exit at 8th Avenue South (University Boulevard/Exit 259). Proceed to 18th Street South and turn left. Proceed to 6th Avenue South and turn left. The entrance to the Center For Psychiatric Medicine will be midway down the block on your left.

Center For Psychiatric Medicine – East / Northbound On I-20/59:

Follow I-20/59 to the junction of I-65. Take I-65 South to 4th Avenue South (Exit 259B). Proceed to 18th Street South and turn right. Proceed to 6th Avenue South and turn right. The entrance to the Center For Psychiatric Medicine will be midway down the block on your left.

Center For Psychiatric Medicine / Westbound On I-20:

Follow I-20 to the junction of I-65. Take I-65 South to 4th Avenue South (Exit 259B). Proceed to 18th Street South and turn right. Proceed to 6th Avenue South and turn right. The entrance to the Center For Psychiatric Medicine will be midway down the block on your left.

Center For Psychiatric Medicine / Southbound On I-59:

Follow I-59 to the junction of I-65. Take I-65 South to 4th Avenue South (Exit 259B). Proceed to 18th Street South and turn right. Proceed to 6th Avenue South and turn right. The entrance to the Center For Psychiatric Medicine will be midway down the block on your left.

Center For Psychiatric Medicine / Westbound On U.S. 280:

Follow Highway 280 until it merges with Highway 31 North and becomes the Red Mountain Expressway. Proceed north and exit at 8th Avenue South (University Boulevard). Turn right onto 8th Avenue South and proceed to 18th Street South. Turn right and proceed to 6th Avenue South. Turn left. The entrance to the Center For Psychiatric Medicine will be midway down the block on your left.

Center For Psychiatric Medicine / Southbound On U.S. 31:

Follow Highway 31 through North Birmingham until it becomes the Red Mountain Expressway. Proceed south and exit at 8th Avenue South (University Boulevard). Turn right onto 8th Avenue South and proceed to 18th Street South. Turn right and proceed to 6th Avenue South. Turn left. The entrance to the Center For Psychiatric Medicine will be midway down the block on your left.

Center For Psychiatric Medicine / Northbound On U.S. 31:

Follow Highway 31 through Homewood until it becomes the Red Mountain Expressway. Proceed north and exit at 8th Avenue South (University Boulevard). Turn right onto 8th Avenue South and proceed to 18th Street South. Turn right and proceed to 6th Avenue South. Turn left. The entrance to the Center For Psychiatric Medicine will be midway down the block on your left.

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: <i>My child is aggressive and gets into fights about weekly at school. He has been suspended 4 times for fighting at school this year.</i> | <i>Two years ago</i> |
| 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? |
|------|----------------|-----------------------|----------------------------|------------------|
| | | | | |
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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 |
| | | | | |
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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 |
|------------------------------|-----------|--------------------------|--------------------|--------------|
| <i>Example: Ashley Smith</i> | <i>30</i> | <i>Biological Mother</i> | <i>Mama Ashley</i> | <i>Sales</i> |
| | | | | |
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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: |
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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:

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

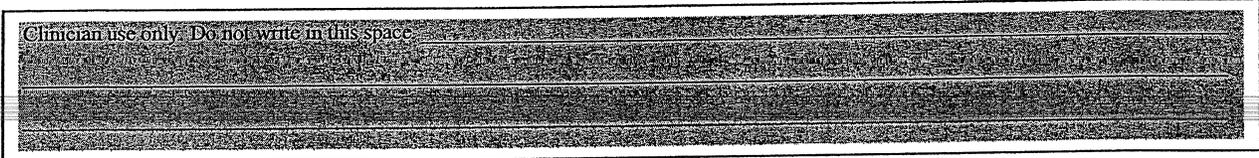
What was your child's birth weight? _____

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 _____ Say single words _____
- Crawl _____ Say 2 or more words together _____
- Walk _____ Become toilet trained _____



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 | Beneficial Effects | Side Effects | Duration | Reason Stopped |
|---|-------------------------------------|------------------|-----------------------|--------------------|
| <i>Example: Abilify -20 mg at bedtime</i> | <i>Helps him to not hear voices</i> | <i>Headaches</i> | <i>7/03 - Present</i> | <i>Didn't work</i> |
| 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 (dexamethylphenidate) | | | | |
| 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 |
|---------------------------|---------|------------|-----------------|
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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 | | | | | | |

