ALEXANDER ROAD ASSOCIATES
QUESTIONAIRE

DATE______________

NAME: ____
Last **First** **Middle**

AGE__________ **BIRTHDAY**____ /_____/______

CHECK ONE: **SINGLE**____________ **MARRIED**___________ **DIVORCED** ________

OCCUPATION____

EDUCATION (Highest level completed)____

ADDRESS ________________________
____
____
____
____
WORK # (   )_______________________
Cell # (   )_________________________

CONTACT/SPOUSE NAME________________
ADDRESS ______________________________
____
____
WORK # (   )_______________________
Cell # (   )_________________________

PROBLEM CAUSING YOU TO SEEK TREATMENT/EVALUATION:_______________
____
____
____
____
____
____
____
____
____
____

DOCTOR'S NAME & ADDRESS____
____

CURRENT MEDICAL PROBLEMS & MEDICATIONS______________________
____
____

Drug Allergies____

DATE OF LAST PHYSICAL EXAM______________________

CURRENT PSYCHIATRIC MEDICATIONS____________________________________
____

PRIOR PSYCHIATRIC MEDICATIONS______________________________________
____

<u>REVIEW OF SYSTEMS:</u> For each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask your doctor.

<u>Const. (Health in General)</u> ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other:____
____

<u>Ears, Nose, Mouth & Throat</u> ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other:____
____

<u>C-V (Heart & Blood Vessels)</u> ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.
Other:____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other:____

<u>GI (Stomach & Intestines)</u> ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:____
____

<u>GU (Kidney & Bladder)</u> ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.
Other:____
____

<u>MS (Muscles, Bones, Joints)</u> ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.
Other:____

<u>Integ. (Skin, Hair & Breast</u>) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other:____
____

<u>Neurologic (Brain & Nerves)</u> ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:____
____

<u>Psychiatric (Mood & Thinking)</u> ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions.
Other: ____
____

<u>Endocrinologic (Glands) ❑</u> No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.
Other: ____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.
Other: ____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.
Other____

CURRENT & PRIOR COUNSELING & EVALUATIONS:
Please list years, reasons for treatment, therapists and types of treatments.

____
____
____
____
____
____
____

PRIOR PSYCHIATRIC HOSPITALIZATION
Please list dates, reasons for admission and names of hospitals.

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____
____
____
____

PLEASE CIRCLE YES OR NO

Smoking YES NO Average number of cigarettes per day__________________________

Alcohol consumption YES NO Average use per week_____________________________

Prescription or other drug abuse YES NO
Please describe____
____

Prior Alcohol Addictions Treatment YES NO
Please describe____
____

EDUCATION

To the best of your ability please rate your school experiences related to academic learning:
(CHECK ONE)

Nursery school Good___________Average __________Poor________________________

Kindergarten Good___________Average __________Poor________________________
1st- 8th Grade Good___________Average __________Poor________________________
High School Good___________Average __________Poor________________________
Did you repeat a grade? If so, when?____
Did you ever have a Child Study team evaluation? If so when?________________________
If classified, what was your classification?____

College Attended/Degree:____
Graduate School Attended/Degree:____

What do you enjoy doing most?____
____
____
____

PRESENT MEDICAL STATUS

Present height_______ Present weight________
____
Operations:____
____
Hospitalizations for illness(es) other than operations:___________________________
____
Diet - Please Describe: ____
____
Exercise Regiment - Please Describe:____
____

Religious affiliation_______________________________ Practicing?_____ Inactive?______

FAMILY HISTORY:

Mother: Age_________ Education: Highest grade completed_____________________
Father: Age__________ Education: Highest grade completed_____________________
Did your parents divorce?_______
Number of Siblings_________

<u>Have any of your blood relatives experienced or been diagnosed with any of the following</u>
(check all that apply; specify diagnosis and how related):
Anxiety Disorder____
Autistic Spectrum Disorders____
Depressive Disorders____
Bipolar Disorders____
Attention Deficit/Hyperactive Disorders____
Autism, PDDNOS or Asperger's Syndrome____
Obsessive Compulsive Disorders____

Suicide attempts____
Alcohol/Drug abuse____
Schizophrenia____
Seizure Disorder____
Psychiatric Hospitalization____
Obesity______________________________Diabetes_______________________________
Elevated Cholesterol/Triglycerides____
Heart Disease/Cardiac Arrhythmia/Heart Attacks__________________________________

RELEASE OF INFORMATION IF DESIRED

I Name:___________________________ Date of Birth __/___/___hereby authorize
(Circle one) ---- Dr William Hayes ---- Dr. Jennifer Kearny
| ---- Dr. Asma Mian ---- Dr. Sara Popkin
at Alexander Road Associates to disclose information from my medical record.

If desired please complete so that we may communicate treatment information with the following individuals to facilitate your care: (Cross out any not applicable)

Family Physician: Dr.____

Group Name and Address:____

____

____Phone # (____)____________

Therapist: Name and Address:____

____

____Phone # (____)____________

Spouse: – Name & Address:____

____

____Phone # (____)____________

Other: Name and Address:____

____

____Phone # (____)____________

___________________________________ ___________________________________

(Date of signature) **(Patients signature)**

_______________________________ ____

(Witness) **(Signature of responsible party if applicable)**

I understand that by law, I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purposes specified above. I understand that my drug and alcohol treatment records are protected under the Federal regulations governing confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act (HIPPA) of 1996 45 C.R.F. pts 116 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. "A general authorization for release of medical records or other information is **not** sufficient for the purpose. " The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires one year after the signing date. I understand I am entitled to a copy of this document in its complete form.

(Revised 2/15/16)