3805 Henderson Drive
Jacksonville, North Carolina 28546-5228
Phone: 910-378-7669 | Fax: 910-939-2186
www.alphanbc.com

DEMOGRAPHIC INFORMATION

Date:	Email address:
Name: Preferred Name:	Gender: ☐Male ☐Female ☐Other Preferred Pronoun(s)_____
Date of Birth:	☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Other
Social Security Number:	Employment: ☐Employed ☐Unemployed ☐Retired ☐Student ☐Other
Mailing Address:	Race:
City / State / Zip:	Preferred Language:
Home Phone: Work Phone:	Mobile Phone:
Primary Care Provider:	Release Info. to Primary Care Provider: ☐Yes ☐No
INSURANCE INFORMATION	
Primary Insurance Company:	Secondary Insurance Company:
Policy Holder Name:	Policy Holder Name:
Policy Holder SSN:	Policy Holder SSN:
Policy Holder DOB:	Policy Holder DOB:
Policy ID Number:	Policy ID Number:
Group Number:	Group Number:
Relationship to Policy Holder:	Relationship to Policy Holder:

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree that in the event of nonpayment, to assume the cost of the interest, collection, and legal action (if required).
2. We are required by applicable federal and state law to maintain the privacy of your medical information. Our notice of Privacy Practices document informs you of our legal duties, and your rights concerning your medical information. We must follow the privacy practices described in our notice. You may request a copy of our notice at any time.
3. My right to payment for all pharmaceuticals, procedures, tests, supplies, and other major medical benefits for Services are hereby assigned to Alpha Neurobehavioral Clinic, PLLC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as a payment of claims for services. In the event my insurance carrier does not accept assignment of benefits, or if payments are made directly to me or my representative, I will insure such payment to Alpha Neurobehavioral Clinic, PLLC.

Signature: _____ Printed Name: _____

Responsible Party Signature: _____ Printed Name:_____

Relationship of responsible party: _____

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ATTENDANCE POLICY

At Alpha Neurobehavioral Clinic, your care and well-being are our greatest concern. We have an attendance policy for care at our practice. First, and most importantly, regular attendance at scheduled follow-up appointments is crucial to the success of your treatment. Additionally, missed appointments complicate access to the clinic for others and place our ability to continue to provide services in jeopardy. We schedule all appointments for an hour or more for your care. Being respectful of your time, other patients, and our provider's time, we require a minimum of 24-hour notice prior to any canceled appointment. This will allow us time to fill the appointment slot to maximize access to our clinic. Failure to provide 24 -hour notice prior to missing a scheduled
appointment or no-showing for an appointment will be treated the same.

- Each missed appointment will incur a $50.00 charge.
- If 2 (two) or more appointments are missed within a 6-month period with less than 24-hour notice or without notice, any future appointments will be canceled and the patient will only be allowed to schedule one appointment at a time.
- If more than 4 (four) appointments are missed within a 6-month period with less than 24-hour notice or without notice, the patient's care can be terminated with our clinic.

We will make every effort to work with you to schedule appointment times/days that are easiest for you to attend. However, no exceptions will be granted this policy.
We appreciate your cooperation and understanding.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to patient (if someone other than the patient signed policy): _____

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AUTHORIZATION AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, (Printed Name)_____(Date of Birth) _____ authorize the use and/or disclosure of my protected health information. I understand this authorization is voluntary. I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

May we discuss medical information regarding your care, test results, appointments or billing information with someone other than yourself? **YES** □ **NO** □

Protected Health Information to Be Used and/or Disclosed:
□ Appointments Only □ Psychological Test Results □ Neuropsychological Test Results
□ Summary of Treatment □ Progress Notes □ Other (specify)_____

Please list any individuals you wish to have this permission:

	Name	Phone Number	Date of Birth (To verify identity)	Relationship
1.				
2.				
3.				

May we leave a voicemail about your medical care? YES □ NO □ Number: (____)_____

May we send you appointment reminders via email? YES □ NO □ Preferred Email: _____

May we send you appointment reminders via Text Message? YES □ NO □ Number: _____
(Please note data charges may apply per your cell phone carrier)

EXPIRATION: This authorization will remain in place until a notice of change in provided in writing.

By signing this document, I, (Printed Name) _____ have read and acknowledge that I have been made aware of Alpha Neurobehavioral Clinic's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Alpha Neurobehavioral Clinic's Notice of Privacy Practices and asked by staff if I had any questions about this notice.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: _____ Relationship: _____Date: _____

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Name:_____Date_____2023

What is the purpose of your visit?_____
_____
_____
_____
_____
_____
_____

1. PERSONAL HISTORY:
   a. Where were you born? _____
   b. Where did you grow up? _____
   c. Are you: (circle) Single/Married/Divorced/Separated/Widowed/Other_____
      If you are married; How long?_____Total number of marriages? _____
   d. Do you have children? Yes/No If yes, how many & ages?_____
   e. Is your Father living? Yes/No. If yes, what type of relationship do you have with him? _____
      _____
   f. Is your Mother living? Yes/No. If yes, what type of relationship do you have with her? _____
      _____
   g. If your parents divorced, how old were you at the time? _____
   h. How many siblings do you have?_____Brothers _____Sisters
   i. Do you have social support and/or close friends in the area, whom you trust and rely on in a time of crisis? Yes/No
   j. Are you a spiritual and/or religious person? Yes/No
   k. Do you have hobbies? Yes/No. If yes, what are your hobbies?_____
   l. Is this evaluation part of a legal proceeding? Yes/No
   m. Is this evaluation part of a disability claim? Yes/No

2. ACADEMIC HISTORY:
   a. What is your level of education? GED, High School, AA, BA/BS, MA/MS Other:_____
   b. Overall, what grades did you make in school? A's B's C's D's F's
   c. Did you ever repeat a class? Yes/No If yes, which class(s) and why? _____
   d. If yes, which grade(s) and why? _____
   e. Did you ever repeat a grade? Yes/No
   f. Did you ever have special education classes? Yes/No If yes, what class(es): _____
   g. Were you ever diagnosed with any form of a learning disorder? Yes/No
   h. Were you ever diagnosed with Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder? Yes/No. If Yes, was medication prescribed Yes/No _____

i. Were you ever suspended from school? Yes/No If Yes, what reason(s) _____

j. Were you ever expelled from school Yes/No If Yes, what reason(s): _____

k. Were you ever suspected of having a concussion or head injury due to a sports injury Y/N?

3. MEDICAL HISTORY:
   a. Please list any significant medical conditions: _____
      _____
   b. Medications: _____
      _____
   c. Do any biological family members have significant medical problems that might affect your health? (circle any that apply and/or write in)
      High Blood Pressure, Diabetes, Heart Disease, Stroke, Cancer,
      Other_____
      _____

4. When was your last physical and/or visit to your primary health provider?_____

5. Have you had previous behavioral health treatment (i.e.,therapy, counseling, medications? Yes / No. If yes, please list, to be best of you knowledge dates of treatment and diagnosis(es):

6. Have you ever attempted to take your own life Yes/No? If yes, when and how_____
   _____

7. Have any biological relatives been treated for any of the following?
   Please circle any that apply depression, anxiety, panic attacks, bipolar disorder.

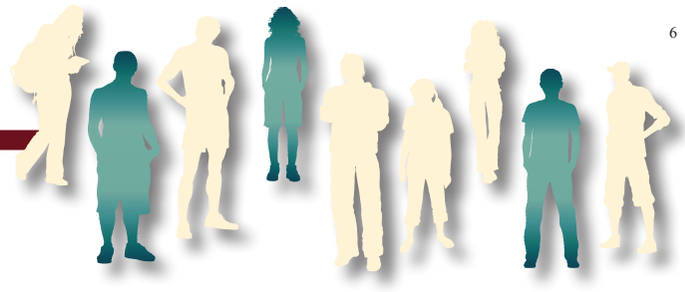
8. Have you ever been physically, emotionally, or sexually abused? Yes / No If yes, please circle which occurred and the approximate ages.

9. OCCUPATIONAL HISTORY:
   a. Employment Status: Full-time Part-Time Retired Partially Disabled Fully Disabled

   b. If currently employed, Job: _____ How Long? _____

   c. If not employed, most recent Job: _____ How Long? _____

The AUDIT



PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

PCL-5 with Criterion A

ID #:
Date:

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so):

_____ I don't feel comfortable describing the worst event.

_____

_____

_____

_____

How long ago did it happen? _____ (please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

_____ Yes

_____ No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____ Accident or violence

_____ Natural causes

_____ Not applicable (the event did not involve the death of a close family member or close friend)

Second, below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

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**
☐	☐	☐	☐

Neurobehavioral Symptom Inventory (NSI)

Please rate any of the following symptoms that you may experienced within the **last 2 weeks.**

---

0 = None – Rarely if ever present; not a problem at all.

1 = Mild – Occasionally present, but it does not disrupt my activities; I can usually continue what I'm doing; doesn't really concern me.

2 = Moderate – Often present, occasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.

3 = Severe – Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort; I feel I need help.

4 = Very Severe – Almost always present and I have been unable to perform at work, school or home due to this.

Symptom	0 1 2 3 4
Feeling dizzy	O O O O O
Loss of balance	O O O O O
Poor coordination, clumsy	O O O O O
Headaches	O O O O O
Nausea	O O O O O
Vision problems, blurring, trouble seeing	O O O O O
Sensitivity to light	O O O O O
Hearing difficulty	O O O O O
Sensitivity to noise	O O O O O
Numbness or tingling on parts of my body	O O O O O
Change in taste and/or smell	O O O O O
Loss of appetite or increased appetite	O O O O O
Poor concentration, can't pay attention, easily distracted	O O O O O
Forgetfulness, can't remember things	O O O O O
Difficulty making decisions	O O O O O
Slowed thinking, difficulty getting organized, can't finish things	O O O O O
Fatigue, loss of energy, getting tired easily	O O O O O
Difficulty falling or staying asleep	O O O O O
Feeling anxious or tense	O O O O O
Feeling depressed or sad	O O O O O
Irritability, easily annoyed	O O O O O
Poor frustration tolerance, feeling easily overwhelmed	O O O O O

Reference: Vanderploeg RD, Silva MA, Soble JR, Curtiss G, Belanger HG, Donnell AJ, Scott SG The structure of post-concussion symptoms on the Neurobehavioral Symptom Inventory: A comparison of alternative models, Journal of Head Trauma Rehabilitation, 20 November 2013