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Patient Registration & Authorization to Treat

(PLEASE PRINT CLEARLY AND COMPLETE ALL (PAGES))

PATIENT: (if responsible patient is not the responsible party; fill out information below)

FIRST NAME _____ LAST NAME _____ M. I. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME (_____) _____ WORK (_____) _____ CELL (_____) _____

EMAIL _____

AGE _____ DATE OF BIRTH _____ SEX _____

HOW DID YOU FIND (OR REFERRED) TO DR. BRIGHT? _____

MARITAL STATUS: (circle) SINGLE MARRIED DIVORCED WIDOWED

STUDENT STATUS: (circle): FULL-TIME PART-TIME

EMPLOYMENT STATUS: (circle): FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME _____ POSITION _____

In Case of an emergency notify _____

Relationship: _____ Telephone: _____

Have you ever been arrested? Yes No **Why?** _____

Have you been in treatment (for mental health issues and/or drug/alcohol) before?

CIRCLE) YES NO (If yes, please complete information below):

REASON FOR TREATMENT?	WHEN (dates)?	WITH WHOM AND WHERE?	OUTCOME?

Please go to next page

MEDICATIONS: (Please list medications you are presently taking):

MEDICATION	DOSAGE	TIMES PER DAY	FOR TREATMENT OF:

Medical Problems (Please list):

FAMILY

PHYSICIAN: _____

TELEPHONE #: (____) _____ FAX #: (____) _____

PRESENTING PROBLEM: (WHY ARE YOU CURRENTLY SEEKING Counseling/Neurofeedback SERVICES)?

WHAT ARE YOUR STRENGTHS?

WHAT ARE YOUR WEAKNESSES?

Please go to next page

PROBLEM INVENTORY

Please check problems any that apply

- Problems with my memory
- Knowing where or who I am
- Getting lost or confused

- People following me, out to hurt me, or talking about me
- People reading my thoughts
- Hearing voices
- Thoughts being put into my head, controlling me, making me do things
- Special messages to me from the TV or radio

- Feelings of worthlessness
- Feeling irritable, grouchy, or touchy
- Low energy or fatigue
- Difficulty getting to sleep, frequent wakening, or un-refreshing sleep
- Appetite (circle) increase or decrease
- Lack of interest in things I used to enjoy
- Poor concentration and/or forgetfulness
- Social withdrawal
- Feelings of guilt
- Feelings of sadness

- Preoccupied with sexual thoughts or urges
- Needing less sleep than usual
- Spending sprees
- Trouble making myself slow down or talk less

- Urges to do something harmful to myself or others
- Urges to set fires
- Difficulty controlling my temper

- Taking Laxatives to control my weight
- Vomiting to control my calorie intake
- Exercising frequently or vigorously
- Fasting to control my weight
- Feeling helpless about my eating habits
- Extreme changes in my weight

Do you drink Alcohol Yes No

Use street Drugs: Yes No

If yes list how what, how much, and frequency.

Please go to next page

- Fear of crowds or public places
- Specific fear of a thing or place (list)
- _____
- Attacks of fearfulness where I feel I need to run
- Heart palpitations
- Chest pains
- Feeling dizzy or unsteady
- Feelings of unreality
- Tingling in hands or feet
- Hot or cold flashes
- Feelings of smothering or can't get my breath
- Feeling trembly or shaky
- Fears of dying or going crazy
- Feeling the need to do things a certain number of times of for a certain length of time
- Feeling troubled by repetitive thoughts
- Feeling the urge to do something unnecessary
- Checking or counting things

- Feeling emotionally numb
- Recurring nightmares
- Frequently being startled
- Being troubled by painful memories

- Parts of my body not working well
- Feeling aches and pains all over my body
- Often feeling sickly
- Fear of getting or having a disease

- Marital Relationship Problems
- Physical/verbal Abuse
- Problems on the job
- Losing someone or something close to me (person, job, pet, moving, etc.)
- Problems with my children
- Sexual abuse
- Current problems from past sexual abuse
- Alcohol abuse
- Drug abuse

For Children:

- Problems with grades in school
- Problems with peers
- Problems paying attention
- Problems following through on tasks
- Problems sitting still
- Problems following instructions

THE UNDERSIGNED UNDERSTANDS AND AGREES:

- **PAYMENT IS DUE AT THE TIME OF THE SESSION BY CHECK OR CREDIT CARD.**
- A \$45.00 fee will be charged for all checks returned by the bank for NSF.
- **Prepaid-PACKAGE Sessions are not refundable.** You agree to making a commitment for all sessions.
- Sessions not canceled or rescheduled TWENTY-FOUR (24) hours in advance will result in a charge to the patient of \$125.00, except in the case of sudden onset illness, such as flu.
- I understand if I am more than 20 minutes late for the scheduled appointment, I may not be seen that day. *Please call if you will be more than 10 minutes late.*
- I understand it is my responsibility to **schedule and confirm** all appointments **by voice or text.**
- I will inform Dr. Bright in writing of any changes in address, and/or telephone numbers.
- Additional Fees are: \$150.00/ hour for report writing forms to be filled out, consultation with others, etc. (There is a minimum charge of \$50.00)
- The therapeutic session is approximately 50 minutes long from the scheduled start of the appointment.
- The patient or guardian when the patient is a minor, consents to counseling, and neurofeedback treatment, understanding that such treatment may or may not be of benefit.
- I understand that Dr. Bright is Licensed Professional Counselor and will not perform in a forensic capacity.
- I understand that if I miss two appointments without informing the office, all future appointment may be cancelled.

Please Print Patient's or Guardian or Responsible Parties Name:

Signature of Patient or Guardian or Responsible Party:

Date: _____

(Please Sign Name and date)

(Circle relationship to patient. Must be 18 years of age or older)

Patient; Parent; Legal Custodial Parent; Guardian