Grant Bright, Ph.D., LPC
1250 Jessie Jewell Pkwy Suite 300, Gainesville, Ga 30501

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:_____

TELPHONE #: (_____)_____ 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