Houston Family Psychiatry - Abigail Nodler, M.D.
PERSONAL DATA – ADULTS

PATIENT'S NAME : _____
DATE: _____ AGE: _____ DOB: _____
REFERRED BY: _____

HOME PHONE NUMBER: _____
HOME ADDRESS: _____
EMAIL ADDRESS:_____

PLACE OF EMPLOYMENT:_____
WORK PHONE NUMBER: _____

OTHER PHONE NUMBER:_____
FAX NUMBER:_____

SPOUSE'S NAME:_____

EMERGENCY CONTACT:_____
TELEPHONE NUMBER:_____

BIRTHPLACE: _____ CITIZENSHIP: _____ RACE: _____
RELIGION: _____

PERSONAL PHYSICIAN: _____
PHONE: _____
ADDRESS: _____

ALLERGIES: _____

CURRENT MEDICATIONS	DOSAGE	DURATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL MEDICAL HISTORY

GENERAL HEALTH: ____ Excellent ____ Good ____ Fair ____Poor

HAVE YOU EVER BEEN UNCONSCIOUS, BLACKED OUT, OR HAD A SEIZURE?
☐ YES ☐ NO

HAVE YOU EVER BEEN HIT IN THE HEAD OR EAR? ☐ YES ☐ NO

DO YOU HAVE VISION PROBLEMS? ☐ YES ☐ NO

DO YOU HAVE HEARING PROBLEMS? ☐ YES ☐ NO

PLEASE COMPLETE THE FOLLOWING:

ILLNESS	AGE	MILD/MODERATE/SEVERE	COMPLICATIONS
Measles	____	_____	_____
Chicken Pox	____	_____	_____
Whooping Cough	____	_____	_____
Diphtheria	____	_____	_____
Scarlet fever	____	_____	_____
Mumps	____	_____	_____
Flu	____	_____	_____
Pneumonia	____	_____	_____
High Fever	____	_____	_____
Tonsillitis	____	_____	_____
Sinusitis	____	_____	_____
Frequent colds	____	_____	_____
Epilepsy	____	_____	_____
Encephalitis	____	_____	_____
Meningitis	____	_____	_____
Ear Infections	____	_____	_____
Polio	____	_____	_____
Rubella	____	_____	_____
3 day measles	____	_____	_____
Migraines	____	_____	_____
Other	____	_____	_____
Other	____	_____	_____

OPERATIONS	AGE	LENGTH OF HOSPITALIZATION	COMPLICATIONS

HOSPITALIZATIONS : _____
_____

ACCIDENTS: _____
_____

ILNESSSES: _____
_____

TOBACCO USE:_____

ALCOHOL USE:_____

FOR WOMEN:

AGE OF MENARCHE:_____
DATE OF LAST PERIOD:_____
AGE OF MENOPAUSE:_____
BIRTH CONTROL: _____
HORMONE THERAPY:_____

CHILDHOOD HISTORY

ARE YOU AWARE OF ANY PROBLEMS DURING YOUR MOTHER'S PREGNANCY WITH YOU?_____
_____

ARE YOU AWARE OF ANY DIFFICULTIES DURING YOUR EARLY CHILDHOOD (E.G. MILESTONES, SLEEPING, FEEDING, TALKING, ETC.)?

_____
_____

DESCRIBE ANYTHING UNUSUAL OR STRESSFUL IN YOUR FAMILY DURING CHILDHOOD: _____
_____

EDUCATIONAL/OCCUPATIONAL HISTORY

HIGH SCHOOL:_____
COLLEGE/DEGREE:_____
GRADUATE SCHOOL/DEGREE:_____

DESCRIBE ANY DIFFICULTIES IN SCHOOL, INCLUDING AGE AND GRADE:

_____
_____
_____
_____

LIST ANY JOBS YOU HAVE HAD:

JOB	LOCATION	DATES
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

MOTHER'S EDUCATION: _____
OCCUPATION: _____
LIVING/DECEASED?

FATHER'S EDUCATION: _____
OCCUPATION: _____
LIVING/DECEASED?

SIBLING'S NAMES	GENDER	AGE	OCCUPATION	LOCATION?
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____

ARE YOU MARRIED/SEPARATED/DIVORCED/WIDOWED/SINGLE?

PREVIOUSLY MARRIED? □ YES □ NO

WHAT IS YOUR SPOUSE'S PROFESSION?_____

HOW LONG HAVE YOU BEEN MARRIED?_____

CHILDREN'S NAMES	GENDER	AGE	OCCUPATION	LIVING AT HOME?
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____

ANYONE ELSE LIVING IN YOUR HOME:

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY

HAVE ANY FAMILY MEMBERS HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS LISTED BELOW?

CONDITION	RELATIONSHIP	DESCRIPTION
Congenital defects	_____	_____
Mental retardation	_____	_____
Cerebral palsy	_____	_____
Muscular disorders	_____	_____
Psychiatric problems	_____	_____
Emotional problems	_____	_____
Nervous conditions	_____	_____
Heart disease	_____	_____
Eye disorders	_____	_____
Lung/respiratory disease	_____	_____
Allergies	_____	_____
RH negative blood type	_____	_____
Down's syndrome	_____	_____
Physical deformities	_____	_____
Learning disabilities	_____	_____
Alcoholism	_____	_____
Drug dependence	_____	_____

Infant death	_____	_____
Diabetes	_____	_____
Migraine headaches	_____	_____

PLEASE LIST ANY OTHER FAMILY MEDICAL INFORMATION THAT YOU BELIEVE MAY BE IMPORTANT: _____
_____
_____
_____

CURRENT/PAST PSYCHIATRIC HISTORY:

PLEASE LIST ALL EVALUATIONS YOU HAVE HAD IN THE PAST, INCLUDING MEDICAL, PSYCHIATRIC, EDUCATIONAL, PSYCHOLOGICAL, SPEECH/HEARING, ETC. (Bring copies of any evaluations with you if possible)

EVALUATION	CLINIC/PROFESSIONAL	ADDRESS	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST PSYCHOTROPIC MEDICATIONS	DOSAGE	DURATION	AGE
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____

Have you ever been in psychotherapy? ☐ Yes ☐ No
If so, with whom, for how long, and for what issues? _____
_____
_____
_____
_____

Please describe briefly the problem or situation that led you to seek our services at this time. _____
_____
_____

Has this problem occurred before? ☐ Yes ☐ No If so, when? _____

What are you hoping to gain and what type and length of treatment do you think you will need? _____
_____

Have there been any recent changes in your life that may cause stress, such as moves, births, deaths, changes in school, or relationships?_____
_____
_____

Do you take any street drugs? ☐ Yes ☐ No
If so, which ones, how much and for how long? _____
_____
_____
_____

Have you ever been exposed to emotional, physical, or sexual abuse? _____
_____
_____

Please check any of the following problems affecting your life:

- ☐ Relationship conflict
- ☐ Separation or divorce
- ☐ Parental problems
- ☐ Drug-Alcohol problems
- ☐ Chronic illness
- ☐ Recent illness
- ☐ Illness of a family member
- ☐ Sleep problems
- ☐ Parent-child problems
- ☐ Sadness/Depression
- ☐ Self harm, thoughts
- ☐ Self harm, behavior
- ☐ Harming others, thoughts
- ☐ Harming others, behavior
- ☐ Nervousness/Anxiety
- ☐ Family violence/Child abuse
- ☐ Sexual abuse
- ☐ Eating disorders

Please add anything else that you feel might be important for us to know.

_____
_____
_____
_____
_____
_____
_____

HIPAA Notice of Privacy Practices
Abigail Nodler, M.D.
2211 Norfolk St., Suite 500
Houston, Texas 77098

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information.
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected information may be provided to a physician or other health care provider to whom you have been referred to insure that the physician or other health care provider has the necessary information to diagnose or treat you.

Payment
Your protected health care information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital stay.

Healthcare Operations
We may use or disclose, a needed, your protected health information in order to support the business activity of you physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging other business activities. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, and workers' compensation. Under the law, we must make disclosures to you and when required to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures
These will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, exept to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. YOUR RIGHTS

You have the right to inspect your protected health information.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding; and protected health information that is subject t o law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means that you may ask us not to use or disclose any part of you protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification proposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request or receive confidential communication from us by alternative means or an alternative location.

You have a right to receive a paper copy of this notice from us.

You have the right to have your physician amend your protected health information.
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made of any of your protected health information.
We reserve the right to change the terms of this notice and will inform you of any such changes. You then have the right to object or withdraw as provided in this notice.

Complaints.
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

This notice becomes effective on/or before April 13, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with HIPAA Officer in person or by phone at the main office

By signing below, you acknowledge the accuracy of these forms and understanding of the HIPAA Notice of Privacy Practices.

_____

Patient Signature