R. Matthew Kamins, M.D. , P.C.

2786 North Decatur Road, Suite 210
Decatur, Georgia, 30033

telephone/fax. 404-499-1444
e-mail: KaminsMD@me.com

NEW PATIENT INFORMATION

Patient Information:			
First & Middle Names:		Last Name:	
Preferred Name:		Date of Birth:	
Employer:		XXXXXXXXXX	
Home Street Address:		Home City, State:	
		Home Zip:	
Home Phone:		Cell Phone:	
Private E-mail:		Relationship Status:	
Emergency Contact:		Their Phone No.:	
Referred by:		Primary MD:	
Others in Household:			
Where/How do we reach you for appointment reminders?			
Where/How do we reach you quickly for appt. changes or openings?			
Insurance Information: (As a courtesy, we will bill insurance for you; however, insurance payments are mailed directly to you.)			
Policy Holder (PH):		PH's Date of Birth:	
PH's Employer:		XXXXXXXXXXXXX	
Insurer:		Mental Health Phone:	
Member's ID:		Group Number:	
Does the policy have out of network, mental health coverage? Yes / No			
Is prior authorization required for your visits? Yes / No			
Does the plan limit the number of visits per year? Yes / No		Number of covered visits per year:	
Mailing address for Mental Health Claims: (This may be different from medical claims.):			
Company Name:			
Address:			
City, State, Zip:			

"I have received, read, and agree with the policies described in Dr. Kamins' 2010 Practice Information.

I understand that consultation does not promise ongoing treatment or benefit.

I agree to pay for services, including: missed appointments (not cancelled by the preceding business day), and any fees due to collection services.

I allow Dr. Kamins to provide my identifying information to obtain payment for services."

Signature:_________________________________ **Date:**_______________

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CONFIDENTIAL HEALTH HISTORY

Your Initials:		**Date:**
Birthday:	Age:	Primary Care Doctor:
Date of Last Examination:		Current Height and Weight:
What do you consider your ideal weight?		When were you last at that weight?

Symptoms: please check symptoms you have had in the last two months.

General:					
	Chills		Sweats		Dizziness
	Fainting		Fever		Numbness or Weakness
	Bloating		Diarrhea		Constipation
	Excessive Thirst		Gas		Hemorrhoids
	Indigestion		Rectal Bleeding		Abdominal Pain
Cardiovascular:					
	Chest Pain		High Blood Pressure		Irregular Heart Rate
	Poor Circulation		Ankle Swelling		Rapid Heart Rate
Skin:					
	Easy Bruising		Hives		Itching
	Changes in moles		Rash		Poor wound healing
Eyes, Ears, Nose and Throat:					
	Bleeding Gums		Blurred Vision		Crossed Eyes
	Difficulty Swallowing		Double Vision		Earache
	Ear Discharge		Hay Fever		Hoarseness
	Hearing Loss		Nosebleeds		Persistent Cough
	Ringing in the Ears		Sinus problems		Flashes or Spots in Vision
For Men: Do you regularly use condoms? ______________					
	Breast Lump		Erection Difficulties		Orgasm Difficulties
	Lump in Testicles		Discharge from Penis		Lack of Sexual Interest
For Women: When was your last menstrual period? _____________ Do you think you may be pregnant? ________					
	Breast Lump		Bleeding between Periods		Severe Menstrual Pain
	Irregular or Missed Periods		Hot Flashes		Nipple Discharge
	Painful Intercourse		Arousal Difficulties		Orgasm Difficulties
	Vaginal Discharge		Lack of Sexual Interest		Dryness
	PMS		Abnormal Pap Smear		
Genital/Urinary:					
	Blood in Urine		Frequent Urination		Lack of Bladder Control
	Delayed Urination		Genital Sores		Anal sores

Conditions: please check conditions you have, or have had, in the past.

	AIDS		Alcoholism		Anemia
	Anorexia		Appendicitis		Arthritis
	Asthma		Bleeding Disorders		Breast Lump
	Bronchitis		Bulimia		Cancer
	Cataracts		Chemical Dependency		Chicken Pox
	Diabetes		Emphysema		Epilepsy or Seizures
	Glaucoma		Goiter		Gonorrhea
	Gout		Heart Disease		Hepatitis
	Hernia		Herpes		High Cholesterol
	HIV Infection		Kidney Stones		Kidney Disease
	Liver Disease		Measles		Migraines
	Miscarriage		Mononucleosis		Multiple Sclerosis
	Mumps		Pacemaker Placement		Pneumonia

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	Polio		Prostate Problems		Psychiatric Care
	Rheumatic Fever		Scarlet Fever		Stroke
	Suicide Attempt		Thyroid Problems		Tonsillitis
	Tuberculosis		Typhoid Fever		Ulcers (Stomach)
	Urinary Infections		Visual Difficulties		Venereal Disease
	Head Injury		With Loss of Consciousness?		Other:

Current Medications:	Dose and Frequency:	When Started:	Prescriber:

Current Supplements, Vitamins, Herbs and Over-The-Counter Remedies:

Please list any Drug Allergies and Environmental/Food Sensitivities:

Medicine or Substance:	Reaction:

Family Health History:

Relative:	**Age:**	**State of Health:**	**Or Age and Cause of Death:**	**Have Any Blood Relatives Had:**	**Relationships to You:**
Mother				Arthritis or Gout	
Father				Alcoholism	
Brothers				Drug Abuse	
				Anxiety or Depression	
				Cancer	
				Diabetes	
Sisters				Heart Disease	
				High Blood Pressure	
				High Cholesterol	
				Immune Problems	
Spouse				Learning Problems	
Children				Stroke	
				Suicidal Behavior	
				Thyroid Problems	

Important Health Events: please list pregnancies, (serious) illnesses and injuries, surgeries, and hospitalizations.

Date:	Event:	Hospital?	Complications and Outcome:

Health Habits: please check which substances you use, and how much/often.

	Caffeine			Tobacco	
	Alcohol			Other Drugs?	

Thank you!

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CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Please help me to get to know you better by answering the following questions.
~~Please bring this survey with you to our first meeting.~~
(You may leave any item blank that you do now wish to answer.)

What would you like my help with?
What are some of the important stresses you now face?
With whom, or where, have you had prior mental health treatments?
What past psychiatric medicines have you tried?
What kinds of problems did you have with these medicines?
Are you aware of problems or side effects with your current medicines?
Please tell me about your typical day. (What kinds of work do you do?)
What kinds of work have you done in the past?

Your Initials: ___________ Date: _______________

Thank you!

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What school(s) have you attended? What was your major degree or field of study?
Did you have difficulties in school or in certain subjects?
What subjects or activities have you been good at?
Where are you from; and where is your immediate family now?
Did your mother experience any difficulties with your delivery or her pregnancy with you?
Are there any physical or mental illnesses that run in your family?
Has any near relative had difficulties with drugs or alcohol? Which relatives?
Has any near relative been suicidal or violent? Which relatives?
Have you suffered any traumas or assaults?
Did you serve in the military (Where, which branch)?
Have you had any legal difficulties?
Whom do you consider your best friends (and how long have you known them)? (Initials or first names are fine.)
With whom have you had important romances, marriages or partnerships? (Initials or first names are fine.)
Do you have any children?
Do you have any companion animals?
How do you enjoy spending your free time?

Your Initials: ___________ Date: _______________

Thank you!

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CONFIDENTIAL SYMPTOM QUESTIONNAIRE

Please help me to get to know you by answering the following questions.

IN RECENT WEEKS, HOW OFTEN HAVE YOU EXPERIENCED: *(Please specify or mark your choices.)*	(In the Past)	Never	Rarely	Often	Very Often
Difficulties with your mood? (up [ ] down [ ])					
Difficulty with pleasurable activities? (more [ ] or less [ ])					
Crying spells?					
Negativity or pessimism?					
Pressured or racing thoughts?					
Changes in appetite or weight? (up [ ] or down [ ])					
Overeating?					
Dieting?					
Intense fears of gaining weight or getting fat?					
Nausea or vomiting?					
Changes in sexual interest? (more [ ] or less [ ])					
Changes in sexual activity? (more [ ] or less [ ])					
Changes in your sleep? (more [ ] or less [ ])					
Trouble falling asleep?					
Trouble staying asleep?					
Trouble waking too early in the morning?					
Nightmares or bad dreams?					
Snoring or difficulty breathing at night?					
Muscle spasms or kicking when trying to sleep?					
Napping?					
Changes in your energy level? (more [ ] or less [ ])					
Changes in your social life? (up [ ] or down [ ])					
Changes in physical activity? (more [ ] or less [ ])					
Difficulty completing ordinary home or work tasks?					
Distractibility or forgetfulness?					
Memory Problems?					
Disorganization?					
Restlessness or agitation?					
Slowness or clumsiness?					
Physical aches, pains or discomforts? Where?					
Thoughts about death and dying?					
Thoughts about *how* to hurt *yourself*?					
Thoughts about *how* to hurt *others*?					
Attempts to hurt *yourself*?					
Attempts to hurt *others*?					
Irritability or aggressiveness?					
Difficulty with anger or temper?					

Your Initials: ___________ Date: _______________

Thank you!

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IN RECENT WEEKS, ***HOW OFTEN HAVE YOU EXPERIENCED:*** *(Please specify or mark your choices.)*	(In the Past)	Never	Rarely	Often	Very Often
Anxiety or worry?					
Muscle tension?					
Muscle or vocal tics or spasms?					
Biting or picking at skin, hair or nails?					
Anxiety attacks?					
Avoidance of public places?					
Avoidance of public speaking?					
Self-doubt or lack of confidence?					
Shyness?					
Specific fears or phobias, such as of: animals, heights, closed spaces,					
Unwanted, odd thoughts?					
Superstitious or compulsive rituals?					
Fear of being harmed?					
Intrusive memories or dreams of past events?					
Feelings of being distant, unreal, or in a trance?					
Difficulty recalling events?					
Feeling as if your mind is playing tricks on you?					
Hearing or seeing odd things that may not be real?					
Fears of being ill or becoming sick?					
Alcohol use?					
Caffeine use?					
Tobacco use?					
Recreational drug use? What kinds?					
Times when you *or others* think you have problems with alcohol or recreational drug use?					
Discomfort when you stop drinking or using drugs?					
Difficulty with reading?					
Difficulty with mathematics?					
Trouble knowing left from right?					
Difficulty expressing yourself in words?					
Trouble speaking or writing?					
Difficulty following directions?					
Difficulty following conversations?					
Difficulty filtering out background noise?					
Other behaviors that interfere with your happiness?					

Your Initials: ___________ Date: _______________

Thank you!