

Individuals, Couples & Family Practice

PATIENT INFORMATION

First Name	Middle	Last Name	Date of Birth	Sex	Marital Status
Social Security No.	Address	Street	Apt. No.	City	State Zip Code Home Phone No.
Occupation	Work Phone No.	Spouse's Name & Social Security No.			
Employer	Spouse's Occupation	Work Phone No.			
Employer's Address	Spouse's Employer & Work Address				

Nearest Friend or Relative Not Living in the Same Household Relationship to Patient Phone

Whom may we thank for referring you? \_\_\_\_\_

MENTAL HEALTH INSURANCE INFORMATION

(Be sure all information is listed including private, group, and spouse)

INSURANCE COMPANY NAME	POLICYHOLDER (Subscriber)	POLICY NUMBER OR CERTIFICATE NUMBER
1. _____	_____	_____
2. _____	_____	_____

PLEASE NOTE: We do not accept assignment from a secondary carrier. However, if you provide us with the necessary information and form(s), we will kindly file your claim so that the secondary carrier might reimburse you.

RESPONSIBLE PARTY

Please complete the section below if someone other than the patient is responsible for the payment of services.

Name	Address	Street	Apt. No.	City	State	Zip Code
Home Phone No.	Occupation	Relationship to Patient				
Employer	Employer's Address	City	State	Zip Code	Work Phone No.	

I have completed this form fully and completely, and certify that I am the patient, or a general agent of the patient authorized to furnish the information requested. I hereby authorize Gary Bailey to release necessary information acquired in the course of my examination and treatment. I hereby assign payment directly to Gary B. Bailey for services provided. I understand that I am responsible for payment of all services whether or not they are covered by insurance. If this account should become delinquent, I agree to pay all expenses including collection cost.

Preferred Method of Payment:  Cash  Check

Signature of Patient or Responsible Party

Today's Date

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First Name Middle Last Name

MEDICAL HISTORY

DIRECTIONS TO THE PATIENT: The following information about your health history is very important for us to provide you with the best possible care in a safe way. Incorrect information may be dangerous to your health. ALL questions must be answered completely and accurately. If you don't understand a question, or are unsure of the answer, or want to discuss it with Mr. Bailey, circle its number or letter. This Health History Questionnaire will become a part of the patient's mental health treatment record and will be considered confidential information.

Name of your Physician Office Phone

Address of your Physician

- 1. Are you in good health? Yes No Don't Know
2. Has there been any change in your health in the last year? Yes No Don't Know
3. Have you ever been hospitalized, had a major operation or serious illness? Yes No Don't Know
4. Date of your last visit to your doctor? Reason for last visit
5. Are you currently receiving treatment or regular medical care by your doctor? Yes No Don't Know
6. Are you experiencing any of the following symptoms? a. Using any type of drug including but not limited to alcohol b. Feeling anxious c. Tightness or pain in the chest d. Thoughts of harming myself e. Thoughts of harming someone else f. Fear of going out in public g. Experiencing parental stress h. Feel as if someone is out to get me i. Feeling of hopelessness j. Experiencing unusual amounts of headaches k. Hearing voices l. Having relationship problems m. Experiencing stress on the job n. Others, please list:
7. Do you have a family member with a drug or alcohol problem? Yes No Don't Know

HAVE YOU EVER HAD OR BEEN TREATED BY A DOCTOR FOR: (★★★★ NOTE: Circle your response and underline any condition(s) that apply):

- 8. Mania, migraine headaches, panic disorders, sexual dysfunctions Yes No Don't Know
9. Stroke, seizures, fainting spells, numbness or other neurologic problems? Yes No Don't Know

- 10. Phobias, severe anxieties, depression, psychoses, unusual fears, or other mental problems? . . . . . Yes No Don't Know
- 11. Have you lost weight without dieting or gained weight in recent months? . . . . . Yes No Don't Know
- 12. Do you now use or have you ever used recreational drugs? . . . . . Yes No Don't Know
- 13. How many packs of cigarettes do you smoke per day? \_\_\_\_\_
- 14. How many drinks of beer, wine, or liquor do you drink per day? \_\_\_\_\_ Yes No Don't Know
- 15. Are there any other problems about your health that you know of? . . . . . Yes No Don't Know

If yes, describe: \_\_\_\_\_

**SIGNATURE OF PATIENT:** *I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical status to Mr. Bailey at the earliest possible time, and I agree to do so. I give permission to Mr. Bailey to obtain from my physician any additional information regarding my medical history needed to provide me the best mental health treatment possible.*

**PERSON COMPLETING THIS FORM:** Signature \_\_\_\_\_ Date \_\_\_\_\_

If other than patient, indicate relationship: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

**SUMMARY OF HISTORY AND NOTATION OF SIGNIFICANT FINDINGS**

Height: \_\_\_\_ ft. \_\_\_\_ in. Weight: \_\_\_\_ lbs.

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Date \_\_\_\_\_

Gary B. Bailey, MSW, LCSW, DAPA

