Gary B. Bailey, MSW, LCSW, DAPA

Patient Information

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**

Gary B. Bailey, MSW, LCSW, DAPA — **Patient Health History**

Individuals, Couples & Family Practice

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
	If yes, please explain: _____	
3.	Have you ever been hospitalized, had a major operation or serious illness?	Yes No Don't Know
	If yes, please explain: _____	
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
	If yes, for what condition(s)? _____	
6.	Are you experiencing any of the following symptoms?	
	a. Using any type of drug including but not limited to alcohol	Yes No Don't Know
	b. Feeling anxious.	Yes No Don't Know
	c. Tightness or pain in the chest	Yes No Don't Know
	d. Thoughts of harming myself.	Yes No Don't Know
	e. Thoughts of harming someone else.	Yes No Don't Know
	f. Fear of going out in public	Yes No Don't Know
	g. Experiencing parental stress	Yes No Don't Know
	h. Feel as if someone is out to get me	Yes No Don't Know
	I. Feeling of hopelessness	Yes No Don't Know
	j. Experiencing unusual amounts of headaches	Yes No Don't Know
	k. Hearing voices	Yes No Don't Know
	l. Having relationship problems	Yes No Don't Know
	m. Experiencing stress on the job	Yes No Don't Know
	n. Others, please list: _____	
7.	Do you have a family member with a drug or alcohol problem?	Yes No Don't Know
	If yes, what family members? _____	

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? _____

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.

_____

_____

_____

_____

_____

_____

_____ Date _____

Gary B. Bailey, MSW, LCSW, DAPA

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