Melvin S. Gale, M.D.
& Associates

Patient Questionnaire

Name: _____ Date: _____

Preferred Name: _____ Sex: _____

Maiden Name: _____ Birthdate: _____

Address: _____ SS#: _____

City/State/Zip: _____

Home Phone: _____ Preferred Pharmacy Name and PH#:

Work Phone: _____ _____

Cell Phone: _____ _____

Which number do you prefer we call?

Home Work Cell

Marital Status:

Divorced Married Partner Separated Single Widowed

So that we may provide you with access to your PATIENT PORTAL, please provide a valid email address:

Email: _____ or (circle) DECLINE

Emergency Contact

Name: _____ Telephone: _____

Relationship to Patient: _____

Do you have a Power of Attorney or Guardian? (circle one) Yes No

If yes, Name: _____

Address: _____

_____

Phone: _____

Relationship to Patient: _____

Do you have an agency that provides a caregiver to you? (Circle) Yes No

If yes, please complete a Release of Information for the agency.

Do you have an individual you would like us to speak to about your care (ex: spouse, child, friend, etc)?

(Circle) Yes No

If yes, please complete a Release of Information for them.

Insurance Information

Primary Insurance Name: _____

Subscriber Name: _____ Subscriber DOB: _____

Patient Relationship to Subscriber: Self Spouse Child Other:

Secondary Insurance Name: _____

Subscriber Name: _____ Subscriber DOB: _____

Patient Relationship to Subscriber: Self Spouse Child Other:

Medical History

Primary Care Physician: _____ Phone Number: _____

Do you give us permission to collaborate with your primary care physician and share your medical chart?

Yes No

If yes, please include your signature here: _____

Date: _____

Do you see a therapist outside this office? Yes No

If so, who? _____ Phone Number: _____

Drug allergies? Yes No

If yes, list: _____

_____

_____

_____

Surgeries: Date:

_____ _____

_____ _____

_____ _____

Adult Medical History

Are you currently or have you ever been treated for:

Illness	**Explanation**
◯ Asthma	
◯ Bleeding Disorders	
◯ Blood Pressure	
◯ COPD	
◯ Diabetes	
◯ Ear/Sinus	
◯ Fainting	
◯ Gastrointestinal Problems	
◯ Heart Disease	
◯ Kidney Disease	
◯ Learning Disorders	
◯ Menstrual Problems	
◯ Muscular-Skeletal	
◯ Seizures	
◯ Sickle Cell Disease	
◯ Sleep Disorders	
◯ Stroke	
◯ Surgery	
◯ Thyroid Disease	
◯ Serious Injury	

Family History

Were you adopted? Yes No If so, at what age? _____

Do you have siblings? Yes No Sibling(s)' DOB: _____

Did your parents divorce? Yes No If so, how old were you? _____

Did your parents remarry? Yes No If so, how old were you? _____

Who raised you? _____

Please list any family members' physical illnesses:

_____

_____

Please list any family members' mental illnesses:

_____

_____

Patient's Early Development

How often did you move before turning 18 years old? _____

How old were you when you left home? _____

Have any immediate family members died? Yes No Who? _____

Have any committed suicide? Yes No Who? _____

Any trauma/abuse suffered, and by whom: _____

_____

Highest level of education completed: _____

Have you ever served in the military? Yes No

If yes, approximate dates of service: _____ Highest rank achieved: _____

Present Situation

Work Status: Full-time Part-time Student Unemployed Disabled

Sexual Orientation: _____ Are you sexually active? Yes No

Do you have any children? Yes No If yes, how many? _____

List anyone who lives with you: _____

Have you ever been arrested? Yes No If yes, when and why? _____

_____

_____

Have you ever used the following:

◯ Alcohol ◯ Pain Killers ◯ Marijuana ◯ Hallucinogens/LSD ◯ Heroin

◯ Methamphetamines ◯ Cocaine ◯ Stimulants (Pills) ◯ Ecstasy ◯ Methadone ◯ Tranquilizers

If yes to any, list frequency and dates of use: _____

_____

Are you a smoker now? Yes No Number of years? _____

Former smoker? Yes No Number of years? _____

Have you ever abused prescription drugs? Yes No

If yes, which ones? _____

Have you ever been treated for drug/alcohol abuse? Yes No

If yes, when? _____

Do you drink caffeinated beverages? Yes No How many per day? _____

Current/Past Medications

Name	Dose	Frequency	Started	Ended	Physician	Purpose

Is there anything else you would like our professional staff to know?

_____

_____

_____

_____

_____

I have read and understand the 2020 payment policies and agree to abide by them.

Initial: _____ Date: _____

I acknowledge that I have received and have been given an opportunity to read a copy of Melvin S. Gale MD and Associates' Notice of Privacy Practices.

Initial: _____ Date: _____

I understand that if I have any questions regarding my care or medical forms that I can contact Melvin S. Gale, MD at 2135 Dana Ave. Suite 410; Cincinnati, OH 45207.

Initial: _____ Date: _____

I consent to treatment and agree to participate in the mental health services provided by Melvin S. Gale and Associates.

Initial: _____ Date: _____

OFFICE USE	DATE/INITIALS
DL	
INS CARD	
ATHENA	