# MELVIN S. GALE MD and ASSOCIATES

**Name:** _____ **Date:** _____

**Preferred Name:** _____ **Sex:** _____

**Maiden Name:** _____ **DOB:** _____

**Address:** _____ **SS#:** _____

**City/State/Zip:** _____

**Home #:** _____ **Preferred Pharmacy Name/ PH#**

**Work #** _____ _____

**Cell #:** _____

**Which # do you prefer us to call?** **Home / Cell / Work**

***Marital Status:*** **Divorced / Married / Partner / Separated / Single / Widowed**

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

**Email: _____** **or (circle) DECLINE**

**<u>Emergency contact:</u>**

**Name: _____ Telephone #: _____ Relationship to patient:_____**

**Do you have an active Power of Attorney or Guardian? (circle one) YES or NO**

**If YES - Name/Address/PH#** _____

**Relationship to patient:** _____

**Do you have an agency that provides a caregiver to you? (circle one) YES or NO**

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

**(circle one) YES or NO**

**If YES - Name/Address/PH#** _____

## Insurance Information:

**PRIMARY Insurance Name:** _____

**Subscriber Name :** _____ **Subscriber's DOB:** _____

**Patient Relationship to Subscriber: Self/ Spouse / Child / Other:** _____

**SECONDARY Insurance Name:** _____

**Subscriber Name :** _____ **Subscriber's DOB:** _____

**Patient Relationship to Subscriber: Self/ Spouse / Child / Other:** _____

## Medical History

**Primary Care Physician:** _____ **Telephone #:** _____

**Most Recent Psychiatrist :** _____ **Telephone #:** _____

**Do you give us permission to collaborate with your Primary Care Physician and share your medical chart?**

**If YES, sign here:** _____ **Date:** _____

**Do you see a Therapist outside this office? Name:** _____

**Telephone #:** _____

**Drug Allergies:** **YES / NO**

**If Yes, List :** _____

_____

_____

**Surgeries:** _____ **Date:** _____

**Surgeries:** _____ **Date:** _____

**Surgeries:** _____ **Date:** _____

## Family History

**Were you adopted?** YES / NO **If yes, at what age?** _____

**Sibling's year of birth:** _____

**Did your parents divorce?** YES / NO **If yes, how old were you?** _____

**Did your parents remarry?** YES / NO **If yes, how old were you?** _____

**Who raised you?** _____

**Family member physical illnesses:** _____ .. _____

**Family member mental illnesses:** _____

## Patient's Early Development

**How often did you move before 18 Yrs 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 education level completed:** _____

**Have you ever served in the military?** YES / NO

**If yes, approx. dates of service:** _____ **Highest Rank achieved:** _____

## Present Situation

**Work:** □ Full-time □ Part-Time □ Student □ Unemployed □ Disabled

**Job title/company**_____

**Sexual orientation:** _____

**Are you sexually active?** YES / NO

**Do you have children?** YES / NO **If yes, how many?** _____

**List anyone else who lives with you:** _____

**Have you ever been arrested?** **YES / NO** **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/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** **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?** _____

**Are there any guns in your home?** **Yes / No**

**How often do you excerise?** _____

## Current/Past Medications

| Name | Dose | Frequency | Starting | Ending | Physician | Purpose |
|---|---|---|---|---|---|---|
| | | | | | | |
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## Review of Systems: please circle any symptoms you currently experience

**General: fatigue, weight change, night sweats**

**Endocrine: hot or cold intolerance, thyroid problems**

**Pulmonary: shortness of breath, cough, chest pain, chest tightness,snoring**

**Cardiovascular: chest pain, palpitations, rapid heart beat, heart murmur, swelling in the arms or legs**

**Cardiovascular (continued): clotting disorder, high blood pressure, family history of sudden cardiac death,**

**Cardiovascular (continued): structural heart defects, arrhythmia or irregular heartbeat**

**Gastrointestinal: nausea, loss of appetite, binge eating, vomiting, difficulty swallowing, heartburn**

**Gastrointestinal (continued): abdominal pain, abdominal swelling, jaundice, history of hepatitis, diarrhea,**

**Gastrointestinal (continued): constipation, peptic ulcer disease, gallbladder disease, pancreatitis**

**Neurological: headaches, migraines, balance issues, walking problems, falls, loss of consciousness**

**Neurological (continued): seizures, head injury, history of stroke, chronic pain**

**Musculoskeletal: joint pain, history of fractures**

## Past Medical History: please circle any illness you currently or have ever experienced:

**General: cancer**

**Endocrine: hypothyroidism, hyperthyroidism, diabetes**

**HEENT: hearing loss**

**Pulmonary: history of smoking, emphysema, chronic bronchitis, COPD**

**Cardiovascular: heart murmur, clotting disorder, high blood pressure, structural heart defects,**

**Cardiovascular (continued): arrhythmia or irregular heartbeat, heart failure, high cholesterol**

**Gastrointestinal: irritable bowel syndrome, Crohn’s disease, ulcerative colitis, pancreatitis, hepatiti**

**Genitourinary: kidney disease, menstrual problems, complicated pregnancy**

**Neurological: migraines, stroke, seizure, head injury, sleep disorder, learning disorders**

**Musculoskeletal: joint pain, history of fractures**

## Anything Else You Would Like our Professional Staff To Know

_____

_____

_____

_____

_____

**I have read and understand the 2022 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 4221 Malsbary Rd, Suite 102. Blue As, OH 45242**

**Initial** _____ **Date** _____

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

**Initial** _____ **Date** _____

| OFFICE USE | DATE/INITIALS |
|---|---|
| DL | |
| INS CARD | |
| ATHENA | |