MELVIN S. GALE MD and ASSOCIATES

NEW PATIENT QUESTIONNAIRE

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**

Martial 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**

Emergency contact:

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:** _____

Health History

Are you currently or have you ever been treated for:

Illness	Explanation
□ Asthma	
□ Bleeding Disorders	
□ Blood Pressure	
□ COPD	
□ Diabetes	
□ Ear/Sinus	
□ Fainting	
□ Gastro-intestinal 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 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

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

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 and Associates

Initial _____ **Date** _____

OFFICE USE	DATE/INITIALS
DL	
INS CARD	
ATHENA	