Bailey Behavioral Health, LLC

Treatment Questionnaire

(Please Print)
Patient Name_____ Date_____

Address:_____ City:_____

State:_____ Zip Code: _____

Age:____ Date of Birth:_____Social Security :_____

Home Phone Number: _____ Cell: _____

Marital Status: (Circle) S M D W Other

Employer:_____

Patient's Relationship to Insured Person:
___Self ___Spouse ___Child ___Other

Person Insured/
Guarantor:_____Date_____

Address:_____ City:_____

State:_____ Zip Code: _____

Age:____ Date of Birth:_____Social Security :_____

Home Phone Number: _____ Cell: _____

Marital Status: (Circle) S M D W Other

Employer:_____

Primary Insurance Plan Name:_____

Address for Claims:_____

ID #:_____Group #:_____

Plan #:_____

Secondary Insurance Information:_____

_____

Who referred You to this Office and Why?_____

_____

AUTHORIZATIONS

Insurance Reimbursement and Financial Policy
I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

HIPAA and Patient Health Information
I understand and agree to allow this healthcare office to use my Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. In order to learn more about the clinic's policies and procedures concerning the privacy of my Patient Health Information, I was given the opportunity to read the HIPAA NOTICE that is available to me at the front desk before signing this consent.

_____ _____ _____ _____
Patient's Signature Date Parent and/or Guardian Date

_____ _____
David Bailey, LCSW Date

BAILEY BEHAVIORAL HEALTH, LLC

PATIENT HISTORY

Name _____ **Date** _____

Purpose of this appointment, what is the presenting problem? _____

_____

_____

_____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe: _____

_____

_____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__ Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth (include dates): _____

_____

_____

Have you been treated for any health condition by a physician in the last year?

____ Yes ____ No. If yes, describe: _____

_____

_____

What medications or drugs are you taking? (List name and dosage)

Medication	Dose	Medication	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Physician Name:_____
Address: _____
Telephone #: _____

Please list any other health problems you have, no matter how insignificant they may be:

_____
_____
_____

SOCIAL HISTORY:

Do you drink alcohol beverages?_____ If so, how much per week?

_____

Do you use any tobacco products?_____ Do you smoke?_____ If so, packs per day: _____

Do you take vitamin supplements?_____ If so, please list:_____

_____

Do you consume caffeine?_____ If so, how much per day:_____

_____

Do you exercise?_____ If yes, what is the frequency and type of exercise?___

_____

Do you sleep well at night? _____ If no, why not?_____

_____

What are your hobbies?_____
_____

What percentage of time during the day (at home or at your job away from home) do you spend: Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

FAMILY HISTORY

Parents:

Father: ___ living ___ deceased (check one) Current age if still living:_____
Cause of death and age at death if deceased:_____

Mother: ___ living ___ deceased (check one) Current age if still living:_____
Cause of death and age at death if deceased:_____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____

FAMILY DISEASES (if applicable then indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__ Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

_____ _____ _____ _____
Patient's Signature Date Parent and/or Guardian Date

_____
Description of Personal Representative's authority

_____ _____
David Bailey, LCSW Date