Alamance Life Works
(ALW) EAP, PLLC

Gary B. Bailey, MA, MSW, Ph.D., LCSW, ACSW, CEAP
Individuals, Couples & Family Practice

Patient Information

Full Legal Name	Last:	First:	Middle:
Date of Birth		Social Security Number	
Gender (Identity)	Male ☐ Female ☐ Other ☐: ____________________		
Address	Street:	City:	State: Zip:
Contact Info	Phone:	Email:	
Marital Status	☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed ☐ Long-term Commitment		

Employer Information

Employer Name		Phone number:
Employer Address		

Spouse's Information (if applicable)

Full Legal Name	Last:	First:	Middle:
Date of Birth		Social Security Number	
Gender (Identity)	Male ☐ Female ☐ Other ☐: ____________________		
Address	Street:	City:	State: Zip:
Contact Info	Phone:	Email:	

Emergency Contact Information

Name		Relationship to you	
Phone Number			
Address			

Insurance Information

Insurance Company Name	Policyholder (Subscriber)	Policy Number
1.		
2.		
3.		

PLEASE NOTE: we do not accept assignment from a secondary carrier. However, if you provide us with information and forms, we will kindly file your claim so that the secondary carrier can reimburse you.

Responsible Party

Please fill this session if someone other than the patient is responsible for the payment of services

Full Legal Name	Last:	First:	Middle:
Address	Street:	City:	State: Zip:
Contact Info	Phone:	Email:	
Relationship to Patient			
Employer Name		Phone number:	
Employer Address			

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 and his associates at Alamance Life Works (EAP) PLLC to release necessary information required 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 they are covered by my insurance. If this account should become delinquent, I agree to pay all expenses including col/eel/on cost.

____

Signature of Patient/Responsible Party Date

Alamance Life Works
(ALW) EAP, PLLC

Gary B. Bailey, MA, MSW, Ph.D., LCSW, ACSW, CEAP
Individuals, Couples & Family Practice

Patient Health History

Directions to the patient: The Following information about your health 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. The health history questionnaire will become a part of the patient's mental health record and will be considered confidential information.

Patient's Name

Last:	First:	Middle:

Physician's Information

Physician's Name		Physician's Phone number:	
Physician's Address			

Questionnaire:

1. Do you have current health concerns? Yes ☐ No ☐
2. Has there been any changes in your health during the last year? (If yes, please explain: ____ Yes ☐ No ☐
   ____
3. Have you ever been hospitalized for major operations or serious illness? please explain: ____ Yes ☐ No ☐
   ____
4. Date of the last visit to your doctor Date: ______________
5. Reason for Visit: ____
6. Are you currently receiving treatment or regular medical care by your doctor? (if yes, what are your conditions?) _________________________ Yes ☐ No ☐
   ____

7. Are you experiencing any of the following symptoms?		
a. Using any type of drug (including but not limited to alcohol)?	Yes ☐	No ☐
b. Feeling anxious	Yes ☐	No ☐
c. Thoughts of harming yourself?	Yes ☐	No ☐
d. Thoughts of harming someone else?	Yes ☐	No ☐
e. Fear of going out in public?	Yes ☐	No ☐
f. Experiencing parental stress?	Yes ☐	No ☐
g. Feel as if someone is out to get you?	Yes ☐	No ☐
h. Feeling of helplessness?	Yes ☐	No ☐
i. Experiencing unusual amounts of headaches	Yes ☐	No ☐
j. Hearing voices	Yes ☐	No ☐
k. Having relationship problems?	Yes ☐	No ☐
l. Experiencing stress on the job?	Yes ☐	No ☐
Others, please list: ____________________ ____________________	Yes ☐	No ☐
8. Do you have a family member with a drug or/and alcohol problem? (if yes, what family member(s)? ____________________	Yes ☐	No ☐

9. Have you ever been treated for any of the following symptoms? (Please check all that apply):

☐ Mania	☐ Sexual Dysfunctions	☐ Numbness	☐ Depression
☐ Migraine	☐ Stroke	☐ Other neurological problems	☐ Psychoses
☐ Headaches	☐ Seizures	☐ Phobias	☐ Unusual Fears
☐ Panic Disorders	☐ Fainting Spells	☐ Severe anxieties	☐ Other psychological problems

Question	Answer
10. Have you lost weight without dieting or gained weight recently?	Yes ☐ No ☐
11. Do you now use or have you ever used recreational drugs?	Yes ☐ No ☐
12. Do you currently smoke? (if yes, how many cigarettes a day? #_____	Yes ☐ No ☐
13. Do you currently consume alcohol? (if yes, how many drinks a day? #____)	Yes ☐ No ☐

What are other problems with your health that you know of? ________________________________
____
____

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. Gary B. Bailey, and/or his associates at Alamance Life Works (EAP) PLLC, at the earliest time and as such I agree to do so. I give permission to Mr. Gary B. 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 SIGNS

________________________________ ____________________
Gary B. Bailey, MA, MSW, LCSW, DAPA Date