

Glen Feigelman, LCSW

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Date: _____

PATIENT QUESTIONNAIRE

Name: _____

Date of Birth: _____

Address: _____

City: _____ Zip: _____

Phone #: _____

Cell #: _____

Email: _____

Social Security #: _____

Insurance Information:

Physician's name: _____ Address: _____

Health Insurance Carrier: _____ ID #: _____ Group #: _____

Name and relationship of insured: _____

Credit or Debit Card #: _____ Expiration Date: _____ CVC _____

Occupation: _____ Employer: _____ Contact #: _____

Marital Status: _____ Name of spouse or partner: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Contact #: _____

CONFIDENTIALITY

All information between you and the provider is strictly confidential unless you specifically authorize release in writing, or in compliance with certain legal requirements. I am required to inform others to take protective measures if a patient presents a physical danger to self or others, or if child or elder abuse is suspected. Please discuss any concerns with me.

MISSED APPOINTMENTS

I make every effort to give you an appointment in a timely manner. When you fail to make your scheduled appointment time and I am not notified, I am unable to schedule someone else in your place. This makes it more difficult for me to see all patients requesting appointments, raises the cost of doing business, and impacts the insurance rates you are charged. If you are unable to make your scheduled appointment and do not cancel at least 24 hours in advance, you may be charged for the appointment.

RELEASE OF INFORMATION

I authorize the release of information regarding my care, including release of my mental health records to my health plan or insurance company for the payment of claims, certification/ case management decisions, quality improvement activities, and other purposes related to the administration of benefits for my health plan or insurance coverage.

RESPONSIBILITY OF PAYMENT

I agree to pay any fees I incur for services rendered by Glen Feigelman, LCSW regardless of insurance coverage. I understand that fees are due and payable at time of service. If the account is referred for collections, I as the party responsible, agree to pay all collection costs and attorney's fees.

Patient's signature _____

Date_____

Please describe why you are seeking help at this time. When did this problem start?	LEAVE BLANK
(Empty space for patient response)	

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety Level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A
Sleeping Habits	1	2	3	4	5	N/A
Sexual Functioning	1	2	3	4	5	N/A
Ability to Concentrate	1	2	3	4	5	N/A
Ability to Control Anger	1	2	3	4	5	N/A

NAME _____

PAST MEDICAL HISTORY	
Are you currently under treatment for any medical problems? Describe:	LEAVE BLANK
List all hospitalizations, dates, reasons.	
Have you ever had any serious illnesses?	
List all the medications you are taking currently, including dose, reason , and duration.	
Are you allergic to any medications?	
Have you ever had a seizure, concussion or loss of consciousness?	
Have you ever been treated for thyroid problems?	
Describe your use of alcohol:	
Has your use of alcohol ever caused problems or been of concern to others?	
Have you used any recreational drugs in the past five years? If so, please describe.	
Have you ever received treatment for alcohol or drug problems?	