Brian Buggie, MD ● 445 West 23rd Street, Suite 1EE ● NYC 10011 ● 646-580-8839

Date _____

Health Questionnaire

Patient's Name

Date of Birth Gender

Address

City State ZIP

Home Phone Cell Phone

Work Phone Email

Emergency contact Phone

Address Relationship to you

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Other

Occupation Employer, # of years

Education major or training emphasis Years of Education

Current Living Situation ☐ alone ☐ with spouse/mate ☐ with parents ☐ other:

Spouse/partner name Spouse/partner occupation

Children: ☐ Yes ☐ No Siblings: ☐ Yes ☐ No Names & Ages: (Please answer below.)

1. 2. 3.

Primary Care Physician: Phone

Psychiatrist: Phone

Therapist: Phone

Pharmacy: Phone

Referred by: Phone

How did you hear about my practice? (friend, therapist, doctor, web, etc.) ___________________

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MENTAL HEALTH HISTORY

Reason for Consultation:

Goals for treatment:

Have you ever seen a mental health provider for any reason (psychiatrist, psychologist, etc.)? ☐ Yes ☐ No
(If yes, when and why?)

Name and Profession	Type of Treatment (meds, therapy, both)	Reason for Treatment	Reason for Termination	Dates

Have you ever been psychiatrically hospitalized? ☐ Yes ☐ No
(If yes, please provide more information.)

Hospital & Doctor's Name	Reason for hospitalization	Dates

Have you ever had any thoughts of suicide? ☐ Yes ☐ No
Have you ever made a suicide attempt? ☐ Yes ☐ No
If so, when & why?

SYMPTOM SCREEN

Have you ever been sad or depressed for more than two weeks? ☐ Yes ☐ No
Have you ever had so much energy that you didn't need to sleep, and made big plans or bad decisions? ☐ Yes ☐ No
Have you ever been so anxious that you couldn't do anything, or even leave the house? ☐ Yes ☐ No
Do you often feel that you need to count, check or clean things in a special way? ☐ Yes ☐ No
Do you ever have several minutes of extreme anxiety and fear that comes out of the blue? ☐ Yes ☐ No
Do you ever feel that you can't control your thoughts or that people can read or control your mind? ☐ Yes ☐ No
Have you ever thought about someone so much that you followed them? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No

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MEDICAL HISTORY

Do you have any medical illnesses? ☐ Yes ☐ No
(If yes, please list.)

Allergies to any foods or medications? ☐ Yes ☐ No
(If yes, please describe.)

MEDICATIONS

List your **current** and **past** prescribed medications and over-the-counter drugs such as vitamins and herbal supplements.

Medication	Dose	Dates taken	Effectiveness	Side Effects	Reason for stopping

HEALTH HABITS

Exercise ☐ Sedentary (No exercise) ☐ Mild exercise (i.e. climb stairs, walk 3 blocks)
☐ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min.)
☐ Regular vigorous exercise (i.e. work or recreation 4x/week for 30 minutes)

Caffeine ☐ None ☐ Coffee ☐ Tea ☐ Soda _____ # of cups/cans per day

Do you drink **alcohol**? ☐ Yes ☐ No (If yes, what kind?) _____
How many drinks per week? _____
Are you concerned about the amount you drink? ☐ Yes ☐ No
Have you ever experienced blackouts? ☐ Yes ☐ No
Are you prone to "binge" drinking? ☐ Yes ☐ No
Have you received treatment for drug or alcohol addiction? ☐ Yes ☐ No

Do you use **tobacco**? ☐ Yes ☐ No
☐ Cigarettes _____ #/day ☐ other _____ _____ # of years, or year quit _____

Do you currently use **recreational or street drugs**? ☐ Yes ☐ No
☐ Cocaine ☐ Heroin ☐ Ecstasy ☐ PCP ☐ Amphetamine ☐ Marijuana ☐ GHB ☐ LSD ☐ Bath Salts

If yes, describe use and frequency. ___________________

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FAMILY MENTAL HEALTH HISTORY

Any family members with mental or emotional problems? ☐ Yes ☐ No (If yes, please list and describe.)

SOCIAL HISTORY

Where were you born and raised? _____
Did you develop normally as a child? (physically and mentally) ☐ Yes ☐ No
Did you have any problems in school? (discipline or behavioral) ☐ Yes ☐ No

Please check any of the following that applied to your childhood (please describe below):

☐ Hyperactivity ☐ Conduct problems ☐ Sleep walking ☐ Fears/worries
☐ Unhappy childhood ☐ Learning difficulties ☐ Night terrors ☐ Stammering
☐ Happy childhood ☐ Head injury ☐ Abuse: (☐ physical, ☐ emotional, ☐sexual)

Interests and hobbies

Education History

Work History

Relationship History

Sexual Orientation

LEGAL HISTORY

Have you ever been arrested? ☐ Yes ☐ No (If yes, please describe.)

Check if you have been involved in any of the following:

☐ Personal injury litigation ☐ Workers Compensation claims ☐ Bankruptcy
☐ Sexual Harassment complaints ☐ Any professional/administrative complaints
☐ Termination/suspension from a professional society or managed care/insurance panel

MISCELLANEOUS

Any other information that you feel would be helpful? ___________________

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Notice of Privacy Practices Acknowledgement

Patient's Name: ___________________

I understand that, under the *Health Insurance Portability & Accountability Act of 1996* (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's signature: Date signed:

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Consent to Release Protected Healthcare Information

Patient's Name: ___________________

I authorize Dr. Brian Buggie and the following persons/agencies listed below to disclose and share confidential information about me. This confidential information includes, but is not limited to: my alcohol and drug use history, psychological/psychiatric history, medical history; family history, legal and financial status, treatment history, results of diagnostic tests, urine tests, and clinical progress reports; current or planned treatment I may receive; all aspects of my treatment and clinical progress; and, all other information deemed important by Dr. Buggie to assist with my treatment and/or other personal or business matters including but not limited to insurance reimbursement, legal action, regulatory action, marital conflict, child custody, etc.

I authorize release of this information to and from the following persons, organizations, and/or agencies:

Your Initials: ___________

Your psychiatrist, psychologist, or other therapist (specify):

Your Initials: ___________

Your medical physician (specify):

Your Initials: ___________

Family members: (specify):

Your Initials: ___________

Your attorney (specify):

Your Initials: ___________

Others (specify):

I acknowledge that this consent can be revoked by me in writing and that I can do so at any time for any reason except to the extent that: (a) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; (b) disclosure has already occurred; and, (c) any pending action already taken and/or in progress that relies on this disclosure.

Patient's signature: Date signed:
____

Fax Results to 646-572-9137

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Financial Agreement

I, ________________________________, am authorizing Dr. Brian Buggie to charge my credit card in the event that I fail to show for a scheduled appointment as recorded on my bill, or do not notify Dr. Brian Buggie of my inability to attend a scheduled appointment at least 48 business hours in advance.

Furthermore, for outstanding payments of services rendered, I authorize Dr. Brian Buggie to charge my credit card for the full amount due. I will not dispute charges for sessions I have received or that I have not cancelled less than 48 business hours in advance. I further authorize Dr. Brian Buggie to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card #: ______________________ Expiration Date: ______________

Name as Printed on Card: ______________________

Verification/Security Code: __________ (3-digit code on back by signature line)

Billing Address: ______________________

____

(Street, City, State & Zip)

Signature: ______________________ Date: ______________

(Patient or financially responsible party)

Please note: This form will be securely stored in your clinical file and may be updated upon request at any time. Your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (e.g. appointment session) without payment rendered.