LESLIE AARON CLIENT INTAKE FORM

PLEASE FILL OUT BOTH SIDES COMPLETELY.

Patient Name:______________________________ Social Security #:__________________________

Mailing Address:____

City/State/Zip____

Picture ID Copied ☐ Verified ☐

Home Phone #________________ Work Phone #______________ Cell Phone # ______________

OK to leave message? YES/NO *YES/NO* *YES/NO*

Date of Birth:_________________ Referred by:____________________________________

Sex: FEMALE / MALE / _______ Primary Care Physician:___________________________

Employer / School_________________________________ Position/Grade____________________

Employer Address____

Emergency contact___________________________ Phone # ____________________________

If visit is related to auto accident: Date of Accident:_______________ State: _________

PRIMARY INSURANCE

Insurance Co.:________________________

Policy ID Number: ____________________
(*this may be a social security #)*

Group Number: ______________________

Policy Holder's Name:
____

Relationship to you: __________________

Policy Holder date of birth: _____________

SECONDARY INSURANCE

Insurance Co.:__________________________

Policy ID Number:______________________
(this may be a social security #)

Group Number:_________________________

Policy Holder's Name:
____

Relationship to you: _____________________

Policy Holder date of birth:________________

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS / CONTRACT

I hereby authorize Dr. Leslie Aaron to release to my insurance companies any medical information necessary to assist in the processing of my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf directly to Dr. Leslie Aaron. I acknowledge that I have received or been offered the enclosed Notice of Privacy Practices. I certify that all the above information is correct and I have read and will subscribe to the payment policy on my practitioner's disclosure form.

____ ____________________________________

Signature Date

LESLIE AARON INTAKE INFORMATION

PERSONAL INFORMATION

Where were you born/raised? ____

Are you currently practicing a religion / faith system? ______________________________

What, if any, religious / faith traditions were important in your upbringing? _______________

____

Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

MEDICAL HISTORY

LIST ALL PREVIOUS AND CURRENT ***PSYCHIATRIC*** MEDICATIONS:

Drug Name	Strength	Times/Day	Approximate start/end date	Results

ALL ***OTHER*** CURRENT MEDICATIONS (Including vitamins, herbal supplements and over-the-counter drugs):

Medication	Dosage	For What Purpose?	Date Started

Please list all current health care providers: _________________________________

____

____

Current medical (non-psychiatric) illnesses, problems, issues. Please be as complete as possible:

____

____

____

Previous medical illnesses, problems, and surgeries (include dates):

____

____

____

Allergies to medicines: ____

Alcohol/Drug/Tobacco/Caffeine use:

Past: ____

Present:____

MENTAL HEALTH HISTORY

Have you had mental health problems in the past (please explain)? ____________________________

____

____

Have you sought treatment for this or other mental health problems? Was it helpful? _______________

____

Were you ever hospitalized for psychiatric reasons? If so, when and where?

____

Have any of your relatives had problems with their mental health? If so, please describe: ____________

____

FAMILY SITUATION

RELATIONSHIP STATUS: single involved engaged cohabitating married separated divorced widowed

MARRIAGES, SIGNIFICANT RELATIONSHIPS, AND CHILDREN:

Partner/Spouse	Beginning Year	Ending Year	Names/ages of children from relationship	Where/with whom do they live?

Others living in your home, ages, relationship: ____

____

Your sources of social/emotional support (family, friends, spiritual community, etc.):

____

____

Current sources of income (circle all that apply)

Employment   Retirement   Disability   Family   Savings/Investments   Other:________________

EMPLOYMENT: (circle all that apply)

Full time   Part Time   Current Occupation: ____

Retired   Disabled   Student   Homemaker

Past Occupations: ____

GOALS FOR THERAPY/EVALUATION

What would you like to see happen as a result of your work here?________________________________

____

____

____

____   ____

Signed (Patient signature)   Date

SECTION BELOW IS FOR OFFICE USE ONLY.

CLINICIAN'S NOTES (for office use only)

Clinician Name: ____

Date	DX code	Diagnosis	Clinician signature