PARTNERS IN
BEHAVIORAL WELLNESS
PERSONAL WELLNESS DURING LIFE'S TRANSITIONS pb-wellness.com

Scott P Baron, PhD, LMSW

Today's Date -

Client Information *Please provide the following information below needed for our records. All information will be held confidential in your client file. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session or email a copy prior to your appointment.*

Name:	Gender:	DOB:
Legal Name (if different):	Pronouns:	
Phone Number(s): Ok to leave message Y / N	Email: *please note that email is not always considered confidential*	
Address (Street; City, State; Zip)		
Name of referring source (if any)		

Insurance Carrier____

Policy Holders Name: ______________________________Date of Birth: __________

Relationship to the Client: ____

Contract#______________________ Group#_____________

Insurance Phone# (back of card) _________________________________

Secondary Insurance Carrier____

Policy Holders Name: ______________________________Date of Birth: __________

Relationship to the Client: ____

Contract#______________________ Group#_____________

Insurance Phone# (back of card) _________________________________

I give my authorization to release medical records to assist in the processing of my insurance claims. I also authorize payments of my Claims to be mailed directly to Partners in Behavioral Wellness for providing my services. I understand that I am completely responsible for any charges incurred and that billing my insurance does not guarantee payment of the claim(s). If the provider of service does not receive payment in a timely fashion, I understand that I may receive a bill for services rendered. I have also received a copy of the HIPAA policies and practices.

____

Signature of Client (and/ or parent/guardian) Date

Office Use:
☐New Client ☐Current Client – Information Update
Diagnosis Code(s) ___________ ____________ ___________ ____________
Provider Name: ____

Name of parent or guardian (if under 18 years old):

____

(Last) (First) (Middle initial)

Emergency Contact Information:

(Name) (Relation) (Phone #)

Marital Status: ___ Never Married ___ Married ___ Divorced

___ Separated ___ Widowed ___ Domestic Partnership

Please list any children and ages: ___________________________________

______________________________ ______________________________

______________________________ ______________________________

Health and Medical
Have you previously received any type of mental health services, such as counseling or psychiatric services: ___ yes ___ no

If yes: ____
(Name) (Phone)

Please list current and past prescription psychiatric medication that you are taking or have taken, including dose and frequency:

How would you describe your current physical health (please circle one):

Poor Unsatisfactory Satisfactory Good Excellent

Please list any current medical conditions:

Are you having any trouble with your sleeping or eating patterns (if so, please describe):

Please check from the following list any items that you have experienced recently:

Loss of interest in previously enjoyed activities
___ Overwhelming sadness
___ Crying often
___ Feeling hopeless
___ Overwhelming anxiety, panic, or worry
___ Frequent physical complaints (headaches, etc)
___ Significant change in weight
___ Trouble falling asleep or staying asleep at night
___ Racing or disorganized thought patterns
___ Thoughts of suicide

___ Irritability or anger
___ Mood shifts
___ Overindulgence in alcohol
___ Overindulgence in sexual activity
___ Use of drugs recreationally
______________________ Any other experiences
____ Have you had any thoughts of self-harm?
____ Have you ever intentionally hurt yourself?
____ Have you ever had thoughts of killing you

Family History

Please list any medical (both physical and mental health) conditions that exist within your family, as well as the family member with the condition:

____
____

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:

____
____

Is there any history of suicide in your family? If so, please list
:____

Do you have any siblings? If so, please list with ages:
____

____

Who do you turn to for support in your family?
____

Do you have any religious affiliation we should consider? _____________

Occupational and Social

Are you currently employed? ____ yes ____ no

if yes, what is your current occupation: _______________________________________

Do you enjoy your current profession? ____ yes ____ no

if no what would you change: ____

Please list any current legal troubles at this time, if any:
____

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?
____
____

What do you view to be your strengths as a person?
____
____

Briefly describe what has brought you to therapy at this time and what goals you would like to accomplish during therapy.
____
____
____