Behavioral Wellness Center of South Florida, LLC

7100 W Camino Real, Ste, 203

Boca Raton, FL 33433

PATIENT INFORMATION (ADULT):

Name: _____

Date of Birth: _____ Age: _____ Sex: ____M ____F

Address: _____

_____

_____

Phone: Home:_____ Work: _____ Cell: _____

Email: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____

Name of person/s who referred you: _____

Phone Number: _____ Address: _____

Email: _____

……

BACKGROUND / FAMILY INFORMATION

Highest Education Level(please check) :

Some High School___High School Grad_____ Some College_____College Grad___ Grad Degree___

Your Occupation: _____

Marital Status (please check):

Single___ dating___ long-term relationship (not living together)___married / domestic partner___ separated___ divorced___ other___

Please list all individuals who are currently living with you:

Name	Relationship to You	Age

If you have children who are not living with you, write down the following information:

Child's name, Child's age, Where Child Resides

_____

_____

_____

Have there been any deaths/separations in your family? If so, please explain (include dates, relationship to you):

_____

_____

_____

Have you ever experienced a traumatic or significantly upsetting event?

_____

_____

Have any family members suffered from any of the following psychiatric problems? If yes, who? Was treatment sought?

Anxiety:	_____	Aggression:	_____
Depression:	_____	OCD	_____
Bipolar Disorder:	_____	Substance Use	_____
Panic Attacks:	_____	Other:	_____

MEDICAL HISTORY

Please list your medical problems:

_____

_____

Hospitalizations / Surgeries:

Dates Reason for Hospitalization / Surgery

_____

_____

_____

Current Medications & Diagnosis if Known:

_____ _____

_____ _____

PREVIOUS/CURRENT PSYCHO-SOCIAL TREATMENT

Have you ever received mental health treatment? Y N

Are you currently receiving mental health services of any kind? Y / N

Please list all present and previous mental health services received below in chronological order:

Mode of Treatment/ Dates/ Reason for Treatment

Outpatient psychotherapy:

Individual

_____

Family/Couple

_____

Group

_____

Other

_____

Psychiatric Hospitalizations _____

_____

_____

Psychotropic Medications _____

_____

Other Forms of Treatment

_____

If you are currently on psychotropic medication, please write the name and phone number of the psychiatrist or doctor who prescribes it:

_____

……

REASON FOR REFERRAL

Describe why you are seeking treatment/what issues you would like help with, When did these difficulties begin? Did any specific event occur prior to onset?

_____

_____

_____

_____

_____

Please check off any of the following problems with which you are currently struggling:

_____ sad/depressed mood	_____ Increased sleep	_____ Purging
_____ anxious	_____ Decreased sleep	_____Physical Aggression
_____ Panic Attacks	_____ Nightmares	_____ Truancy
_____ Angry Outbursts	_____ Drug Use	_____ Suicidal thoughts
_____ Withdrawn	_____ Poor attention	_____ Suicide attempt
_____ Fatigue	_____ hyperactivity	_____ Self injury (i.e. cutting)
_____ Decreased appetite	_____ Stealing	_____ Poor family relationships
_____Increased appetite	_____ Alcohol/drug use	_____ Poor peer relationships
_____ Excessive weight gain/loss	_____ Difficulty sleeping through the night	_____ inappropriate sexual behavior

Please use this space to describe any other problems, questions, or concerns you would like us to know about.

_____

_____

_____

_____

AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION

DATE:

I, _____, give permission for psychologist, Dr. Michelle W. Greenberg, to discuss my information and treatment (includes any pertinent psychological and medical background information and current issues) with the following parties:

1. Name: _____ Affiliation: _____

Address: _____

Phone Number: _____

2. Name: _____ Affiliation: _____

Address: _____

Phone Number: _____

3. Name: _____ Affiliation: _____

Address: _____

Phone Number: _____

I understand this authorization will expire at termination of treatment or at any time prior upon written request.

I hereby consent that this communication can take place through:

____ telephone _____ fax _____ email _____ mail

I understand that email is not a confidential method of communication and that there is a risk that email communications may be intercepted by a 3rd party or may be transmitted to unintended parties. I am aware that Dr. Michelle W. Greenberg will take all necessary measures to avoid using identifying information in email communications.

Date: _____

Name of Authorized Patient Representative (Print): _____

Signature of Authorized Patient Representative: _____

Authorized Representative's Relation to Patient: _____

Name of Party Accepting Authorization (Print): _____

Signature of Party Accepting Authorization: _____