
Theresa Price Aaron, L.C.S.W.

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General Information

1. Identifying Information

Name: _____

Birthdate: _____ Today's Date: _____ SSN: _____

Address _____

Phone numbers: Home _____; Work _____; Cell _____

Occupation _____; Employer _____

2. Reason for Visit

Please describe briefly your concerns and reasons for this visit _____

3. Current Medical Care

Please provide the name of your primary care physician.

_____ ; Phone # _____

When were you last seen by this person?

Are there any medical conditions relevant to the current concern? Yes/No

If yes, please specify _____

Are you currently taking any medications? (Please specify)

_____ ; Doctor who prescribes the medication_____

4. Previous Psychological Treatment/Evaluations

Have you received any previous psychological treatment or evaluations?

If so, please list the provider name(s) and dates of services

5. Insurance Information

Please provide the name of your insurance carrier(s):

Medicaid_____ Anthem_____ Southernhealth_____
Medicare_____ Cigna_____ Value Options_____
Aetna_____ Sentara_____ Blue Cross/Blue Shield_____

Other (Please specify)_____

Name of policyholder_____

Member Number: _____ Group Number: _____

Have you contacted your insurer regarding this visit? _____

Authorization number (if required) _____

6. Emergency Contact Information

Please provide the name of someone who may be contacted in an emergency:

Phone Number: _____