4800 Rowan Rd • New Port Richey, FL 34653 • Phone 727-847-0069
Fax 727-849-3780 • www.lifespanservices.com

Lifespan Services Inc.

CHILD INTAKE EVALUATION/PSYCHOSOCIAL ASSESSMENT

DATE: _____/_____/_____

CLIENT'S NAME: _____DOB:_____AGE:_____SEX:_____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE:_____

SSN:_____

HOME PHONE:_____-_____WORK PHONE:_____-_____CELL:_____ -_____

MAY WE LEAVE A MESSAGE (Please circle Y or N) AT HOME? Y / N AT WORK? Y / N CELL? Y / N

EMAIL ADDRESS: _____

PREFERRED METHOD OF APPOINTMENT REMINDERS: (CHECK ANY) ___ TEXT ___EMAIL ___VOICEMAIL

ETHNICITY ORIGIN (OR RACE): PLEASE SPECIFY : ___WHITE ___HISPANIC/LATINO

___BLACK/AFRICAN AMERICAN __NATIVE AMERICAN/AMERICAN INDIAN ___ASIAN/PACIFIC ISLANDER

OTHER:_____

Responsible Party for the client, please fill out the following information regarding the parent(s)/guardian(s):

NAME:_____ Relationship:_____ Phone:_____-_____-_____

NAME:_____ Relationship:_____ Phone:_____-_____-_____

MARITAL STATUS: M___S___D___ DRIVER'S LIC#_____

EMPLOYER: _____ ADDRESS:_____

INFORMATION FOR TWO PEOPLE NOT LIVING WITH YOU THAT WE MAY CALL IN AN EMERGENCY:

NAME:_____ RELATIONSHIP:_____ PHONE:_____-_____-_____

NAME:_____ RELATIONSHIP:_____ PHONE:_____-_____-_____

PERMISSION TO SHARE INFORMATION WITH EMERGENCY CONTACT: Y / N

CHILD: ANY KNOWN ALLERGIES? _____

CURRENT MEDICATIONS (Please List):_____

_____

PRIMARY CARE PHYSICIAN NAME & PHONE NUMBER: _____

DO YOU WANT TO SHARE INFORMATION WITH YOUR PHYSICIAN? Y / N

PSYCHIATRIST NAME & PHONE NUMBER: _____

DO YOU WANT TO SHARE INFORMATION WITH YOUR PSYCHIATRIST? Y / N

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INSURANCE INFORMATION MUST BE COMPLETED IN FULL

PRIMARY INSURANCE:

PRIMARY INSURED NAME:_____ DOB:_____ SEX:_____

SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ INSURANCE CO:_____

GROUP #:_____ POLICY #:_____MEMBER ID #:_____

SECONDARY INSURANCE (IF APPLICABLE):

PRIMARY INSURED NAME:_____ DOB:_____ SEX:_____

SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ INSURANCE CO:_____

GROUP #:_____ POLICY #:_____MEMBER ID #:_____

PAYMENT

Please provide a valid credit card or debit card with credit logo.

Credit Card Number:_____ **Expiration Date**:_____/_____

Check One: ___DISCOVER ___MASTERCARD ___VISA ___ AMERICAN EXPRESS

NAME AS PROVIDED ON CARD:_____ **BILL ZIP CODE**_____

ALL APPOINTMENTS MUST BE CHANGED OR CANCELLED 24 HOURS IN ADVANCE TO AVOID A* $50.00 *CHARGE

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS). I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I WILL NOTIFY YOU OF ANY CHANGES TO THIS INFORMATION. FOR YOUR CONVENIENCE, AFTER VISITS ARE DISCONTINUED, ANY REMAINING BALANCES WILL BE CHARGED TO YOUR CREDIT CARD ON FILE. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
THERAPIST SIGNATURE DATE

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Client Information

SCHOOL

SCHOOL ATTENDED:_____ GRADE:_____ TEACHER:_____

REFERRED BY SCHOOL? IF SO BY WHO?:_____

SPECIAL CLASSES? LEARNING DISABILITIES?:_____

DOES THE YOUTH LIKE SCHOOL? _____ WHAT ARE THEIR GRADES/ GPA?_____

HAVE GRADES DECLINED RECENTLY? PLEASE EXPLAIN IF YES_____

HOW MANY REFERRALS/ SUSPENSIONS THIS YEAR? WHAT WERE THE REASONS FOR THEM?_____

_____

OTHER BEHAVIORAL PROBLEMS AT SCHOOL? _____

CHILD'S REACTION TO STARTING SCHOOL, ANY GRADES SKIPPED OR REPEATED, HELPFUL TEACHERS /STAFF, SIGNIFICANT EVENTS AT SCHOOL, OTHER IMPORTANT SCHOOL INFORMATION?:_____

_____

PRESENTING PROBLEM(S) AND HISTORY OF PROBLEM(S):(please include time lines if possible i.e. weeks/months/years)

_____

_____

_____

_____

PLEASE CIRCLE ANY OF THE FOLLOWING IF EXPERIENCED BY THE CHILD:

Problems Eating Problems Sleeping Thumb Sucking Nail Biting Bed Wetting Difficulty Getting Along with Peers/Siblings Problems Getting Along with Authority Figures/Adults Other:_____

PRIOR TREATMENT (mental health, therapy, psychiatry, Baker Acts, etc) :

PLACE/PERSON/AGENCY DATE(S) OUTCOME

_____

_____

_____

MEDICATIONS/DANGER:

CURRENT MEDICATIONS :_____

ANY PAST MEDICATION FOR PSYCHIATRIC PURPOSES:_____

HISTORY OF SELF HARM?(ie: cutting):_____

_____

POTENTIAL FOR DANGEROUSNESS TO SELF: NONE_____ LOW _____ MODERATE _____ HIGH _____

POTENTIAL FOR DANGEROUSNESS TO OTHERS: NONE____ LOW _____ MODERATE _____ HIGH _____

PLEASE EXPLAIN ANY ANSWERS OF MODERATE OR HIGH: _____

_____

_____

FAMILY CONSTELLATION:

FOR EACH OF THE FOLLOWING INDIVIDUALS, GIVE THEIR NAME, AGE, EDUCATION, OCCUPATION, AND MARITAL HISTORY IF APPLICABLE

CHILD'S FATHER:_____

_____

CHILD'S MOTHER_____

_____

CHILD'S BROTHERS AND/OR SISTERS: _____

_____

_____

PLEASE LIST EVERYONE WHO LIVES IN THE HOME WITH THE CHILD:_____

_____

PLEASE LIST ANY OTHER FAMILY OR CLOSE RELATIONS THE CLIENT SEES ON A REGULAR BASIS WHO MAY BE A SUPPORT:_____

HAS CHILD EXPERIENCED ANY OF THE FOLLOWING, INDICATE CHILD'S AGE AT TIME:

DEATH OF A SIGNIFICANT PERSON: (WHOM) CHILDS AGE

_____

_____

SEPARATION FROM A FAMILY MEMBER: (WHOM) CHILDS AGE

_____

_____

HAS CHILD EXPERIENCED ANY OF THE FOLLOWING, INDICATE CHILD'S AGE AT TIME:

PHYSICAL ABUSE: (BY WHOM) CHILDS AGE

_____

_____

SEXUAL ABUSE: (BY WHOM) CHILDS AGE

_____

_____

OTHER TRAUMA OR SIGNIFICANT/SUDDEN CHANGES? (PLEASE INDICATE AGE)

_____

_____

_____

FAMILY PROBLEMS: (CHECK WHICH ONES APPLY)

_____ LEGAL PROBLEMS _____ MARITAL PROBLEMS

_____ FINANCIAL DIFFICULTIES _____ OTHER

PLEASE EXPLAIN:_____

_____

ADDITIONAL FAMILY HISTORY/FAMILY MENTAL HEALTH HISTORY/IMPORTANT INFORMATION:

_____

_____

_____

_____

PRENATAL INFORMATION:

COMPLICATIONS DURING PREGNANCY? _____

_____

DRUG/ALCOHOL/PRESCRIPTION MEDICATION DURING PREGNANCY?_____

_____

DELIVERY:

FULL TERM? YES_____ NO_____IF NOT, # OF WEEKSPREMATURE_____

VAGINAL?_____C-SECTION?_____

ANY MEDICAL DIFFICULTIES DURING OR AT BIRTH?_____

_____

DEVELOPMENTAL HISTORY: (CHECK WHICH ITEMS WERE DIFFICULT FOR YOUR CHILD)

RESPONDS TO SIGNIFICANT OTHERS:_____ SPEAKING WORDS: _____

SITTING UP:_____ TALKING IN SENTENCES: _____

WALKING:_____ TOILET TRAINED: _____

SEPARATION FROM PARENTS TO GO TO SCHOOL: _____

MEDICAL HISTORY:

ANY SIGNIFICANT ILLNESSES, ACCIDENTS AND/OR MEDICAL HOSPITALIZATIONS, INCLUDE AGE

_____

_____

APPETITE: GOOD: _____ FAIR: _____ POOR: _____ UP AND DOWN: _____

SLEEP DISTURBANCE: (CHECK WHICH ONES APPLY TO YOUR CHILD)

_____ PROBLEM GETTING TO SLEEP _____ WAKING EARLY

_____ PROBLEM STAYING ASLEEP _____ SLEEPS MORE THAN 8-10 HOURS

_____ PROBLEM GETTING UP _____ SLEEPS LESS THAN 6-8 HOURS

OTHER SLEEP PROBLEMS?: _____

BLADDER/BOWEL DIFFICULTIES:_____

LEGAL:

HAS YOUR CHILD HAD LEGAL PROBLEMS? IF YES, EXPLAIN:_____

_____

DRUG/ALCOHOL/TOBACCO HISTORY:

CHILD:_____

PARENTS:_____

CHILD'S INTERESTS, HOBBIES AND EXTRACIRICULAR ACTIVITIES :

_____

_____

_____

CHILD'S RELATIONSHIP TO PEERS:

_____

METHODS OF DISCIPLINE AND EFFECTIVENESS:

_____

WHAT DO YOU FEEL ARE YOUR CHILD'S STRENGTHS?:

_____

_____

WHAT DO YOU FEEL ARE YOUR CHILD'S CHALLENGES/LIMITATIONS?:

_____

_____

Child Custody: If the child's parents are separated or divorced, please check which situation applies:

____ Joint Custody - Who has primary residence?_____

____ Sole Custody - Mother

____ Sole Custody - Father

If shared visitation, what is the typical visitation schedule?:

_____

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It is the responsibility of the parent signing this form, not the therapist, to notify the child's other parent that his or her child is participating in counseling.

I certify that the information on this sheet is correct, and hereby authorize Lifespan Services, Inc., to provide therapy, counseling, or other psychiatric and/or psychological services as discussed in the preliminary treatment plan necessary for the client named above. I also authorize the release of medical, psychological, alcohol and drug abuse and psychiatric information necessary to provide therapeutic services, to collect fees for service from insurers or other third party payors, and for continuity of care between Lifespan Services and other professionals who also provide services for the client.

_____ DATE:_____
Signature of Client or Responsible Person

Therapist:_____ DATE:_____

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CLIENT ORIENTATION

Program Rules:

1. Lifespan Services, Inc. will provide outpatient counseling, evaluation, information and/or referral.
2. No drug or alcohol screening or "search and seizure" methods will be employed.
3. Clients must not be under the influence of alcohol or illegal substances at the time of the scheduled session. Should the client be under the influence of substances other than prescribed medication, the session will be canceled by the counselor and the client will be expected to pay for the session at the usual, agreed upon fee.
4. ***All appointments must be changed or canceled 24 hours in advance to avoid a $50.00 charge.***

Program Procedures:

1. Client's rights to confidentiality will be observed at all times, with the following exceptions:
    - In cases of probable imminent danger to self or others, in cases of child abuse, including sexual abuse.
    - Communicable diseases must be reported by the counselor to the appropriate county health department.
    - When you, the client, request that we release information.
    - Information is only shared with other outside entities (ie: doctors, attorneys, etc.) when you request it by signing an Authorization to Release Information form. In accordance with HIPPA privacy regulations, any information shared will reveal only the basic minimum information necessary.
    - When your therapist would like to consult with another Lifespan therapist (who has additional expertise in a certain area) for information that may be of help in your treatment. No names are ever used during his consultation.
2. We reserve the right to release only a Treatment Summary instead of detailed case notes.
3. A minimum requirement of 5 business days is needed for medical records, once a written request is received.
4. The undersigned will neither individually nor jointly involve the therapist or Lifespan Services (and its staff) in any litigation. The undersigned will neither request nor require that Lifespan Services or the therapist provide testimony in court. The reason for this is so that treatment is not compromised, the therapeutic relationship with the family is maintained, and a child can experience his or her play therapist in a clear, consistent, therapeutic role and not as an assessor or detective. If the services of a mental health professional are desired for court purpose, the services of a person outside of Lifespan Services, Inc. must be enlisted.
5. *Counseling Artwork:* Your confidentiality is protected. The use of photography typically involves pictures of children's play structures (i.e.: sand trays, block building, etc.) or pictures of the children with our therapy pet. Art work is sometimes used for training purposes, but the child's identity is protected.

If you have any questions about the above, please ask your therapist.

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Hours of operation: Business office hours vary. Available hours vary with each therapist and some nights may be available.

After Hours Emergencies:

In the event of a behavioral health emergency contact:

- **911**
- **National Suicide Prevention Line at: 1-800-273-TALK**
- or go to the nearest crisis center:

Bay Care Behavioral Center (Adults)
8002 King Helie Blvd. New Port Richey, Fl 34653 Phone: (727) 841-4430 (727) 841-4439
Morton Plant North Bay Hospital Recovery Center 21808 S.R. 54, Lutz, FL 33549
Phone: (813) 428-6100
Hernando County Outpatient / Inpatient 7074 Grove Road Spring Hill, Fl 34609
Phone (352) 540-9335
Morton Plant Mease Behavioral Health Care 300 Pinellas Street**,** Clearwater, Florida 33756
Phone: (727) 462-7000
Medical Center of Trinity West Pasco Campus 5637 Marine Parkway, New Port Richey, Florida 34652 Phone: 727-845-9180 24 hour inpatient intake line: (727) 298-6402

Payment of Fees for Service:

1. We accept cash, check, Visa, or insurance reimbursement.
2. All co-pays and private pay fees are due at the time counseling services are provided.
3. Client is expected to pay for services when services are rendered. If for any reason payment of services is received back from client's financial institution (e.g. NSF fee from bank) there will be a $25.00 fee collected prior to next appointment.

Acknowledgment/Consent:

1. I authorize the Release of Medical information necessary for my insurance company to process my claim. I also authorize the payment of benefits to Lifespan Services, Inc.
2. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.
3. I certify all information on the counseling intake forms is true and correct to the best of my knowledge. I will notify Lifespan Services of any changes to my insurance information, address, telephone numbers, and any other relevant changes.

By signing this form I am acknowledging receipt of a copy of this paper and agreement to the Orientation terms and conditions as provided by Lifespan Services, Inc.

Print Client's Legal Name	Signature of Parent/Guardian/Representative	Date