7702 Massachusetts Ave • 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):

Parent/Guardian Name:______________________________ Relationship:______________ Phone:_____-_____-_______

Parent/Guardian Name:______________________________ Relationship:______________ Phone:_____-_____-_______

Marital status of listed individuals : Married___Single___Divorced___ Driver's License#____________________________

Parent/Guardian Employer: _____________________________ Address:____

Information for two people not living in the home 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? ____

All Current medications (please list):____

____

Primary care physician name & phone number: ____

Do you want to share information with the child's physician? Y / N

Psychiatrist name & phone number: ____

Do you want to share information with the child's 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 Client:____________________________________

Employer:____________________________________ Insurance co:____

Group #:____________________ Policy #:____________________ Member ID #:______________________________

Secondary insurance (if applicable):

Primary insured name:____ DOB:________________ Sex:______________

SS# of Insured:______________________________ Relationship to Client:____________________________________

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:____________________________________ Billing zip code_________________

Important information

All appointments must be changed or cancelled 24 hours in advance to avoid a $50.00 fee

I understand that a 24-hour notice is required for appointment cancellations and when rescheduling already scheduled appointments. If I cannot make an appointment that is scheduled less than 24 hours away, I must still call and let you know that I cannot make my appointment. I understand that a $50.00 fee will be charged directly to me if I fail to give 24 hours notice for a missed appointment. In the event of multiple missed, cancelled, and/or appointments changed with less than 24 hours notice, it will be left to the therapist's discretion as to whether a discharge letter will be sent disengaging me from the practice and giving me 30 days to enroll with a new therapist. Not receiving an appointment reminder is not a valid reason for missing an appointment, reminders are a courtesy and cannot be guaranteed to reach me.

You are responsible for all appointment charges and notifying us of insurance changes

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 the information. For my convenience, after visits are discontinued any remaining balances will be charged to my credit card on file. I certify that the information I have provided is true and correct to the best of my knowledge.

____ __________________
Signature of parent or legal guardian Date

____ __________________
Therapist signature Date

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Client information

Presenting problem(s) and history of problem(s): **(please include time lines if possible i.e. Weeks/months/years)**

____

____

____

____

School

School attended:___________________________ Grade:______ Teacher(s):____

Referred by school? If so by who?:____

Special classes? Learning disabilities?:____

Does the youth have a 504 Plan or IEP? ____________Does the youth like school? _________________________________

What are their grades/GPA?___________________ Do they mostly complete and turn in their schoolwork? _____________

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?:____

____

Please circle any of the following if experienced by the child:

Problems eating   Problems sleeping   Thumb sucking   Nail biting   Bed wetting   Other:____________________

Difficulty getting along with peers/siblings   Problems getting along with authority figures/adults

Prior treatment (Mental health, Therapy, Psychiatry, Baker Acts, etc.) :

Place/person/agency   Date(s)   Outcome

____

____

____

Effectiveness of current medications if applicable:____

Any past medication for psychiatric purposes:____

History of self harm?(i.e.: cutting, suicide attempts/threats):____

____

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: ____

____

We do not prescribe medications and cannot provide any guidance on medications.

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 & reason for separation) 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 including family mental health history or other important familial information:

____

____

____

____

Prenatal Information:

Complications during pregnancy? ____

____

Drug/alcohol/prescription medication during pregnancy?___________________________________

____

Delivery of Child:

Full term? Yes_____ no_____if not, # of weeks premature______________________________

Vaginal?__________________C-Section?____

Any medical difficulties during or at birth?____

____

Developmental History: **(check which items were difficult for your child)**

Responding to significant others:______ Speaking words: ______

Sitting up:_____ Talking in sentences: _____

Walking:______ Toilet trained: ______

Separation from parents to go to school: _______ Other:_____________________________________

Medical history:

Any significant illnesses, accidents and/or medical hospitalizations, please include age(s):

____

____

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/Bedwetting difficulties:____

Legal:

Has your child had legal problems? If yes, explain:_______________________________________

____

Drug/alcohol/tobacco history:

Child:____

Parents:____

Child's interests, hobbies and extracurricular activities :

____

____

Child's relationship to peers/what is their social life like?:____

____

Methods of discipline used with the child and their 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 indicate which situation applies:

____ Joint Custody - Who has primary residence?____

____ Sole Custody - Relationship to child:____

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

____

Are there any court orders in place regarding medical decision making that limit or define which parent can make medical decisions? If yes, please provide details below and provide us with a copy of the court order(s):________________

____

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.

All appointments must be changed or cancelled 24 hours in advance to avoid a $50.00 fee.

I ______________________________(your name), understand that Lifespan Services **does not prescribe medications** or prescriptions of any kind to our clients. We cannot recommend, refer, advise, or facilitate your obtaining medications in any way.

____ Date:________________

Signature of parent or legal guardian

____ Date:________________

Therapist Signature

I _________________________________, certify that the information on this document 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 previously. 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 parent or legal guardian

____ Date:________________

Therapist Signature

Client orientation

Program Rules:
1. Lifespan Services, Inc. will provide outpatient counseling, evaluation, information and/or referral.
2. Lifespan Services, Inc. does not prescribe medications.
3. No drug or alcohol screening or "search and seizure" methods will be employed.
4. 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.
5. ***All appointments must be changed or canceled at least 24 hours in advance to avoid a $50.00 fee.***

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 (i.e.: doctors, attorneys, etc.) When you request it by signing an authorization to release information form. In accordance with HIPAA 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 this 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 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.

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

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DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: ______________________ **Age:** ____ **Sex:** ☐ Male ☐ Female **Date:** __________

Relationship with the child: ____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS**, how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS**, has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No	☐ Don't Know		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No	☐ Don't Know		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No	☐ Don't Know		
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No	☐ Don't Know		
XII.	24.	In the past **TWO (2) WEEKS**, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes		☐ No	☐ Don't Know		
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes		☐ No	☐ Don't Know		

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