7702 Massachusetts Ave ● New Port Richey, FL 34653 ● Phone 727-847-0069
Fax 727-849-3780 ● www.lifespanservices.com

Lifespan Services Inc.

Adult Intake Evaluation/Psychosocial Assessment

Client Information (please print)

Today's date: _____/_____/_____

Client's name: ____DOB:__________Age:_______Sex:_______

Home address: ____

City: ____ State:___________________ Zip Code:_______________

SSN:___________________________

Home phone: ______-______-_________Work Phone: ______-______-_________Cell:______-______-_________

May we leave messages (please circle Y or N) at: Home? Y / N At Work? Y / N Cell Phone? 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:____

Marital status: Married___ Single___ Divorced___ Driver's Lic#____

Employer: ___________________________________ Address: ____

Information for two people (at least one 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

Primary care physician name & phone number: ____

Do you want us to share information with your physician? Y / N

Psychiatrist name & phone number: ____

Do you want us to share information with your psychiatrist? Y / N

Do you want to provide a mental health advance directive? Y / N

A mental health advance directive is a document where individuals are able to express their preferences on where they would like to receive care and what treatments they are willing and/or unwilling to undergo. They are also able to identify an agent or representative who is trusted and legally empowered to make healthcare decisions on their behalf. Please ask us if this is something that you would like to know more about.

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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 Client Or Legal Guardian Date

____ __________________
Therapist Signature Date

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Intake Questionnaire

Prior to beginning therapy, we request that all clients complete this form. The questions are designed to help you clarify the changes you want to make in your life, and the expectations you have of the counseling relationship. Please give these questions some thought.

1.What brings you to therapy and/or what changes do you want to see happen in your life?:

____

____

____

2. What are some your self-defeating behaviors? That is, what do you do that seems to make things worse? (or just does not help you):

____

____

____

3. Have you ever been to therapy before? If yes, how long ago? For this current problem or another? Was it helpful?

____

____

____

4. Do you have any worries or concerns about attending therapy? Any questions?

____

____

____

5. How did you hear about us and/or who referred you to us?:____

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.

____________________________________ ____________
Signature of Client or Legal Guardian Date

____________________________________ ____________
Therapist Signature Date

Psychiatric medications/danger:

Current psychiatric/mental health medications (please list the medication and why it was prescribed):____________________________

____

____

Any past medication for psychiatric purposes (please list the medication and why it was prescribed): ____________________________

____

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

____

Your potential for danger/harm to yourself: none_____ low_____ moderate_____ high _____

Your potential for danger/harm to others: none_____ low_____ moderate_____ high_____

Please explain any answers of low, moderate, or high: ____

____

____

Have you ever been baker acted? (Hospitalized for mental health/psychiatric reasons) if yes, when and why:

____

____

FAMILY CONSTELLATION:

RELATION	NAME	AGE (DECEASED?)	LIVES WITH YOU?	SUPPORTIVE?/ GOOD RELATIONSHIP?
Father				
Mother				
Sibling(s)				
Sibling(s)				
Sibling(s)				
Sibling(s)				
Sibling(s)				
Spouse/ significant other				
Child				
Child				
Child				
Child				
Any other				
Any other				

Please list any other family or close relations you see on a regular basis who may be a support:________________________________

____

Have you experienced any of the following?

Death of a significant person: (how long ago and who)

____

____

Separation from a family member: (how long ago and who)

____

____

Physical, sexual, or emotional abuse : (by whom and at what age?)

____

____

Other trauma or significant/sudden life changes? (please indicate age when it happened)

____

____

____

Additional family history/family mental health history:

____

____

____

Prenatal/birth information: (these are about your mother's pregnancy with you and your birth)

Complications during pregnancy? ____

Drug/alcohol/prescription medication during pregnancy?_______________________________________

Any medical difficulties during or at birth?____

____

Developmental history: (check which items were difficult for you during childhood development)

Responding to significant others:____

Sitting up:_____

Walking:____

Speaking words: ______

Talking in sentences: _____

Toilet training: ______

Separating from parents: _____

Anxiety:_______

Behavior Problems:_______

Sleep disturbance: (check those that apply currently or recently)

_____Problems falling asleep

_____Problems staying asleep

_____Problems getting up

_____ Waking early

_____ Sleeping more than 8-10 hours

_____ Sleeping less than 6-8 hours

Other sleep problems?: ____

Appetite:

How has your appetite been lately? Has it changed?____

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Do you work? What do you do for work?:____

____

What is the highest level of education you have completed? Are you in any schooling or education programs now?

____

Do you have or had any legal problems? If yes please explain: ____

____

____

Drug/alcohol/tobacco history and current use: (please list what you use and how often, or when you quit)

____

____

Interests, hobbies and extracurricular activities (things you do for enjoyment) :

____

____

What is your social life like? (do you wish you got out more, had more friends, do you have supportive friends?)

____

____

What do you feel are your strengths?:

____

____

What do you feel are your challenges/limitations?:

____

____

Is there anything else that we should know to better help you?

____

____

____

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MEDICAL HISTORY

Date of last physical: ________________

Previous hospitalizations (please specify where (hospital/city), when, how long, reason):

____

____

Please list name, dosage, & how often taken of any current medications :

____

____

Any known allergies:____

Females: Any discontinued pregnancies? ______ How many? _____ Full term pregnancies? _____ How many? ______

Has anyone in your family (parents, brothers, sisters, cousins, aunts, uncles) had any of the following? Please check all that apply:

	Kidney Disease		Tuberculosis		Epilepsy		Cancer
	Mental Illness		Heart Disease		Diabetes		Other:
	Drug Abuse		Alcohol Abuse		Nervous System Disorders		Other:

Please check any of the following of which you had in the past, or are now experiencing:

PROBLEM	PAST	NOW		PROBLEM	PAST	NOW		PROBLEM	PAST	NOW
Blurred Vision				Compulsions				Blood Transfusions		
Double Vision				Excessive Blood Loss				Sinus or Frequent Colds		
Severe Headaches				Loss of Consciousness				Weight Gain		
Dizzy Spells				Jaundice				Drug/Alcohol Abuse		
Head Injury				Chest Pain				Excessive Worries		
Vomited Blood				Blackouts				Fears or Phobias		
Back Pain				Seizures				Difficulty Concentrating		
Hearing Loss				Hepatitis				Extreme Nervousness		
Mood Swings				Allergies				Bedwetting past age 6		
Pneumonia				Diabetes				Blaming Others Frequently		
Confusion				Extreme Sadness				Low Self-Esteem		
Stomach Pains				Blood in Bowel Movements				Sexual Problems		
Shortness of Breath				Tuberculosis				Frequent Accidents		
High Blood Pressure				Overweight				Underweight		
Change in Appetite				Strange Thoughts				Feelings of Hopelessness		
Kidney or Urine Infection				Blood in Urine				Heart Attacks		
Venereal Disease				Reactions to Medications				Nightmares		

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PROBLEM	PAST	NOW		PROBLEM	PAST	NOW		PROBLEM	PAST	NOW
Menstrual Difficulties				Swollen Ankles				Using More Alcohol than Before		
Bruise Easily				Weakness in Arms and Legs				Recurring or Unwanted Thoughts		

Please list any other health problems or concerns:____

____

____

____

I certify that the information I have provided in 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 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:____________________

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

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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 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 client 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. Art work is sometimes used for training purposes, but your 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, Mastercard, American Express, 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 Records necessary to my insurance company for audit or 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 Client/Client's Representative	Date

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DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ___________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**________

If this questionnaire is completed by an informant, **what is your relationship with the individual?** ___________________
In a typical week, approximately how much time do you spend with the individual? ____________________ **hours/week**

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

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**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. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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