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:_____

_____

_____

Does the child work? If so, where, and for how long? _____

_____

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.

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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

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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 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.

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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 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 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. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	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			