LifeSpring Counseling
Client Intake Form

Client Information

First Name _____Middle Initial ___

Last Name _____

Address _____

City _____

State _____Zip _____

Home Phone _____

Work/Cell Phone _____

Can we leave msg. at home ___ work/cell ___

Birthdate: _____Age:_____

Soc Sec # _____Marital Status: ____

E-Mail: _____

Occupation: _____

Employer: _____

Student/Employment Status: Full/Part-time
Please circle one Please circle one

Spouse's Name: _____

If a Minor (Must Sign Custody Addendum)

Parent(s)/ Guardian _____

Address _____

City, State, Zip _____

Home Phone _____

Work Phone _____ext _____

OFFICE USE ONLY

Supervision Yes No
Treatment Plan Yes No

Insurance _____

Deductible _____ Max Visits _____

Fee: $_____ Client: _____

Self pay ____
Church Assisted ____
Christ Church @ G. ____
Whitley Co EAP ____
Reduced Fee _____
Insurance (we file) ____

Medicaid Waiver ____
DD/SS/TBI/Autism
LSF ____
Benevolence ____
Brotherhood ____
Insurance (they file) ____

Insurance Information

(this must be filled out completely if we are filing your claims)

Primary Insurance _____

Name of Insured _____

Insured's Address_____

_____

City, State, Zip _____

Relationship to Client _____

ID # _____ Group # _____

Social Security # _____

Birthdate of Insured _____ Sex: M F

Place of Employment _____

Employer's Address (claims will not be filed without this information)

_____

City, State, Zip _____

Precert # _____

Case Manager #_____(For DD Medicaid Waiver Only)_____

Secondary Insurance _____

Name of Insured _____

Address_____

City, State, Zip _____

Relationship to Client _____

Policy # _____ Group # _____

Social Security # _____

Birthdate of Insured_____ Sex: M F

Place of Employment _____

Employer's Address (claims will not be filed without this information)

_____

City, State, Zip _____

Precert # _____

Responsible for Payment

Name/Agency_____

Address _____

City, State, Zip _____

Phone # _____

Contact Person (if an agency)_____

LSCC reserves the right to contact this person/agency and verify their agreement to be financially responsible.

Please Turn Page Over ⇨

INITIAL " ☐ " EACH TOPIC AFTER REVIEWED:

CONFIDENTIALITY

☐ Lifespring Counseling will maintain the practice of holding all communication between the therapist/mediator and the client in strictest confidence and will not allow information to be released to anyone without written permission or according to law. Your mental health record will be handled according to the following legal requirements: 1) Therapists are required to report circumstances wherein a client states an intention to harm self or others, in cases of recent or ongoing abuse, and with court related custodial concerns; 2) Indiana law requires reporting any activity wherein a child or adolescent describes participating in circumstances involving sexually oriented activities. It is LifeSpring Counseling's legal responsibility as a care provider to report such to the respective division of Family and Children's Services (welfare) and respective police department. Thus, such information cannot be considered confidential information within the counseling setting, and so it also cannot be maintained only between the client and therapist/care provider; 3) Court ordering of unlicensed therapists to do so; 4) Notice of Privacy Practices (attached sheet).

CANCELLATIONS

☐ Making an appointment is a contract between the therapist/mediator and the client that both will be present at the appointed hour. However, we are aware that genuine emergencies do arise which preclude the keeping of the appointment. Late cancellations, however, do not allow us to fill the hour with persons who are waiting for an appointment. **Cancellations require 24 hour notice. There is a minimum $20.00 fee for late cancellations or missed appointments*.**

☐ *Note: **Missed appointments without cancellation notice will be expected to be paid at the full-fee rate and cannot be billed to insurance**. Even if your therapist uses the reminder call system, you are still responsible for payment of missed appointments whether or not a reminder call was placed. LifeSpring reserves the right to exercise the option of discontinuing treatment after the second occurrence and assessing a full-fee charge against missed appointments.

FEES

☐ Checks are to be made payable to LifeSpring Counseling Center.

☐ I understand and agree that I am personally and fully responsible to pay for all services rendered; I am to pay in full at the time of appointment and I am responsible to file any claim for reimbursement with my insurance carrier, unless LifeSpring is contracted to do so (the therapist will provide reasonable information [e.g., Diagnosis Code] needed to process such claims). If I am covered by Medicare or have insurance with a carrier which has a contract with LifeSpring, LifeSpring will file claims on my behalf. I agree to pay any deductible or copayments required by my insurance company. I also agree to pay for any services not covered by my insurance carriers contract with LifeSpring.

☐ One working day's notice is required to release copies of any record for medical, billing or legal purposes (see Notice of Privacy & Practices). LifeSpring reserves the right to bill for these services, as is customary.

☐ I HAVE READ, UNDERSTAND THE ABOVE POLICIES & PROCEDURES, AND CONSENT TO TREATMENT.

☐ I HAVE RECEIVED THE INFORMATION SHEET.

Signed:_____ Date_____
Client/Guardian/Custodial Parent

Witnessed:_____ Date_____

PSYCHOSOCIAL & MEDICAL HISTORY Completed by: _____ Relationship to client_____

PRESENTING PROBLEMS

Why are you seeking counseling?

_____

_____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None This symptom not present at this time • **Mild** Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate Significant impact on quality of life and/or day-to-day functioning • **Severe** Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
aggressive behaviors	[ ]	[ ]	[ ]	[ ]	hopeless	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
alcohol to excess	[ ]	[ ]	[ ]	[ ]	irritability	[ ]	[ ]	[ ]	[ ]
anorexia	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]
anxiety	[ ]	[ ]	[ ]	[ ]	mood swings	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	obsessions/compulsions	[ ]	[ ]	[ ]	[ ]
bingeing/purging	[ ]	[ ]	[ ]	[ ]	panic attacks	[ ]	[ ]	[ ]	[ ]
conduct problems	[ ]	[ ]	[ ]	[ ]	paranoid thoughts	[ ]	[ ]	[ ]	[ ]
confused thinking	[ ]	[ ]	[ ]	[ ]	physically hurt others	[ ]	[ ]	[ ]	[ ]
defiant behavior	[ ]	[ ]	[ ]	[ ]	physically hurt self	[ ]	[ ]	[ ]	[ ]
depressed mood	[ ]	[ ]	[ ]	[ ]	victim of physical harm	[ ]	[ ]	[ ]	[ ]
drug abuse	[ ]	[ ]	[ ]	[ ]	poor concentration	[ ]	[ ]	[ ]	[ ]
elevated mood	[ ]	[ ]	[ ]	[ ]	poor grooming	[ ]	[ ]	[ ]	[ ]
excessive fears	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]
bowel/bladder disturbance	[ ]	[ ]	[ ]	[ ]	sexually harmed others	[ ]	[ ]	[ ]	[ ]
emotionally harmed others	[ ]	[ ]	[ ]	[ ]	seeing strange things	[ ]	[ ]	[ ]	[ ]
overemotional	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	sleep disturbance	[ ]	[ ]	[ ]	[ ]
grief	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]
guilt	[ ]	[ ]	[ ]	[ ]	suicidal thoughts	[ ]	[ ]	[ ]	[ ]
hear strange voices	[ ]	[ ]	[ ]	[ ]	other (specify) _____	[ ]	[ ]	[ ]	[ ]

Who do you talk to about problems? _____

How do you deal with stress? _____

MEDICAL/DEVELOPMENTAL HISTORY (check all that apply for the client)

What medications are you currently taking?

1.) Medication & Dosage_____ Frequency _____ Start date _____ End date _____

Physician _____ Side effects _____ Beneficial _____

2.) Medication & Dosage_____ Frequency _____ Start date _____ End date _____

Physician _____ Side effects _____ Beneficial _____

List any medications you have taken in the past: _____

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

Is there a history of any of the following for the client (S) or in the family (F):

S F	S F	S F
[ ][ ] tuberculosis	[ ][ ] tobacco use	[ ][ ] diabetes
[ ][ ] bronchitis/asthma (circle)	[ ][ ] mental deficiency	[ ][ ] cancer
[ ][ ] birth defects	[ ][ ] caffeine use/abuse	[ ][ ] Alzheimer's disease/dementia
[ ][ ] emotional/behavioral (circle) problems	[ ][ ] ear infections/tubes	[ ][ ] stroke/coma (circle)
[ ][ ] thyroid problems	[ ][ ] ulcers	[ ][ ] heart disease
[ ][ ] high blood pressure	[ ][ ] food sensitivities	[ ][ ] orthopedic problems

[ ][ ] alcoholism/drug abuse (circle), when & what happens(ed) behaviorally? _____

[ ][ ] allergies _____

[ ][ ] falls/accidents _____

[ ][ ] concussions/broken bones (list with age) _____

[ ][ ] other chronic or serious health problems _____

Name _____ _____ Client # _____

Last First Middle Date

Do you, the client, have a history for any of the following? (Check all that apply):

[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire setting
[ ] won't sleep alone
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behaviors
[ ] night terrors
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] overeating
[ ] other _____

FAMILY HISTORY/ FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

_____

Parents' current marital status:

[ ] married to each other
[ ] separated for ____ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of client at mother's death ____
[ ] father deceased for ___ years
age of client at father's death ____

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others
[ ] other _____

Describe Siblings (Brothers & Sisters): _____
_____
_____
_____

Describe parents:

Father
full name _____
occupation _____
education _____
general health _____

Mother
full name _____
occupation _____
education _____
general health _____

Client's Age at leaving childhood home: _____ **Circumstances:** _____

_____

Special circumstances in childhood: _____

_____

IMMEDIATE FAMILY

Intimate relationships:

[ ] single, never married
[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship
[ ] engaged _____ months
[ ] married for _____ years
[ ] divorced for ___ years
[ ] separated for ____ years
[ ] divorce in process ____ months
[ ] live-in for ____ years
[ ] ___ prior marriages (self)
[ ] _____ prior marriages (partner)

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

Describe any past or current significant issues in <u>intimate</u> (eg; spousal) relationships: _____

_____

_____

_____

List all persons currently living in client's household:

Name	Age	Sex	Relationship to client

List children not living in same household as client:

Name	Age	Sex	Relationship to client

Frequency of visitation of above: _____

Describe any past or current significant issues in other immediate family relationships: _____

_____

_____

_____

SOCIO-ECONOMIC HISTORY (check all that apply for client)

Living situation:
[ ] housing adequate
[ ] housing inadequate, why?_____

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income
[ ] impulsive spending
[ ] relationship conflicts over finances

Military history:
Branch in military: _____
Honorable discharge: Yes [ ] No [ ]

Social support system:
[ ] close relationship with family/friends
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison _____ time(s)
total time served: _____
describe last legal difficulty: _____

Years of Schooling Completed: _____
Current Employment, how long?: _____
Spouse's Employment (if applicable): _____
Employment Satisfactory? Yes [ ] No [ ]
If no, why? _____

Church/spiritual/recreational history:

Y N
[ ] [ ] Do you attend a church/religious group?
If yes, where? _____
[ ] [ ] Are you active in your church/religious group?
Describe your relationship with God/Higher Power: _____

_____

_____

Y N
[ ] [ ] Currently active in community/recreational activities?
[ ] [ ] Formerly active in community/recreational activities?
[ ] [ ] Currently engage in hobbies? _____
misc.: _____

_____

_____

FOR OFFICE USE ONLY

Yes No **Prior outpatient counseling/inpatient hospitalization (circle)**

[ ] [ ] If yes, on _____occasions. Longest treatment by _____ for _____ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

[ ] [ ] **Has any family member had outpatient psychotherapy/inpatient psychiatric? (circle)** If yes, who/why (list all):_____

_____

Medications used: _____

[ ] [ ] **Prior inpatient/outpatient (circle) treatment for a substance use disorder?**
If yes, on _____occasions. Longest treatment at _____ from ___/_____ to _____/_____
Name of facility/provider Month/Year Month/Year

[ ] [ ] **Has any family member had counseling/hospitalized treatment for a substance use disorder?** If yes,
Who used (list all):_____

What did they use: _____

_____

DSM-5 TR:

AXIS I: _____

_____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

MISC./COLLATERAL THERAPIST FINDINGS:

_____

_____

_____

_____

MEDICAID

This client requires treatment for the following reason:

_____ _____
Therapist's Signature Date

Psychologist HSPP Note:

_____

_____

_____

_____

HSPP/Psychologist's Signature _____ Date _____

Name _____ _____ Client # _____
Last First Middle Date