Life Development Resources, P.A.

Date____________________ Therapist____________________ DX Code________________

Patient Information

Patient Name (Print)____Date of Birth___________________________

Street Address____Home Phone___________________________

Okay to Leave Message?____Yes____No

City_____________________________State_________ZIP_____________Work Phone__________________________

Okay to Leave Message?____Yes____No

Soc Sec #____________________ Cell Phone_______________________

Emergency Contact___________________ Emergency Phone_______________________

Sex: ____M ____F Age________ Marital Status: ____Single ____Married ____Widowed ____Divorced ____Other

Employer___________________________________Occupation____

Referred by____

Primary Insurance

Primary Insurance Company____Phone_______________________________

Ins Claims Address_______________________________________City_________________State______Zip___________

Policy/ID____Group/Plan ID____________________________________

For Health Partners Only: Policy Holder's ID____

Name of Policyholder____ Relationship______________________________

Address____City__________________State_______Zip___________

Soc Sec #______________________Employer__________________________Date of Birth_________________________

Secondary Insurance

Secondary Insurance Company____Phone_______________________________

Ins Claims Address______________________________________City__________________State_______Zip__________

Policy/ID____Group/Plan ID____________________________________

Name of Policyholder____ Relationship______________________________

Address____City__________________State_______Zip__________

Soc Sec #______________________Employer__________________________Date of Birth_________________________

Responsible Party

Name____Relationship____________________________

Address____Phone_______________________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the healthcare provider to release all necessary information to A.C.E. Billing, Inc, to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

____ ______________________________ ____________________

Responsible Party Signature Relationship Date

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LIFE DEVELOPMENT RESOURCES, P.A.
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Ph: (952) 898-1133 Fax: (952) 435-6797

ADULT PSYCHOLOGICAL INTAKE

Your Name:_______________________________________ **Therapist Name:**___________________________

Date of Birth: _________________________ **Date of Intake:** __________________

1. Presenting Problems and Symptoms

♦ What are the main reasons for coming to therapy? ____

____

____

____

____

♦ How long has this been a problem for you? ____

THIS SPACE RESERVED FOR THERAPIST

____

____

____

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____

Social / Family History

Personal

♦ Who do you live with? ____

♦ Your Age: __________

♦ Where were you born? ______________________________________

♦ Ethnicity: ____________________________

♦ Sex: ____ male ___ female

♦ Marital Status: (Check all that applies & give dates)

___ Single
___ Married Date:________________________
___ Widowed Date:________________________
___ Engaged Date:________________________
___ Separated Date:________________________
___ Divorced Date:________________________

♦ Do you have a history of any of the following types of abuse?

	When	By Whom
Physical		
Sexual		
Emotional		
Neglect		

Family

- **Information about your spouse or significant other:**
  Name: ______________________________ Age: _________
  Occupation: ____
- **Children** (List their names & ages):
  ____
  ____
  ____
- **Step Children** (List their names & ages):
  ____
  ____
  ____
- **Your Parents**
  Father's Name: ___________________________ Age: ______ Living ____ Deceased ___
  Occupation: _________________________________ Where does he live? ____________________
  Mother's Name: ___________________________ Age: ______ Living ____ Deceased ___
  Occupation: _________________________________ Where does she live? ___________________
- **Your brothers and/or sisters or step-siblings** (list names, ages, occupations & where they live)
  ____
  ____
  ____
- **Family History**
  Does anyone in your family (parents, siblings, children, grandparents, etc.) have problems or previously have problems with depression, anxiety, confusion, drug or alcohol abuse, or other mental health issues?
  ____
  ____
  ____
  ____
  ____
  ____
  ____

Education

- Highest level of education:____
- Academic Issues ___ no ___ yes:____
  ____
- Learning Disability ___ no ___ yes: ____

Employment

Current

- Where do you work? ____
- What do you do? ____
- How long have you been there? ___________ How many hours per week do you work? _________

- Any significant work-related problems or difficulties? ____________________
____
____

Past

- Significant past occupations ____________________
____
____

Military - List military experience (if any). Also list: branch of service, highest rank, years of service, discharge status:

____
____

Legal Issues

- History of legal issues ___ no ___ yes: ____________________
- Arrests ___ no ___ yes: ____________________
- Convictions___ no ___ yes: ____________________
- DWI___ no ___ yes: ____________________
- Current legal issues?___ no ___ yes: ____________________

Religious / Spiritual

- Do you have a current religious affiliation? ___ no ___ yes: ____________________
- Name of church you attend or belong to: ____________________
- How important is your religion and/or spirituality to you? ____________________
- Were you raised with a religious background? ___ no ___ yes: ____________________
- Do you have spiritual concerns? ___ no ___ yes: ____________________

THIS SPACE RESERVED FOR THERAPIST (Social/Family)

2. Medical History

Physical

Ever been hospitalized for physical reasons? ___ no___ yes, for: ______________________________

Where?______________________________ When?______________________________

Current physical problems? ______________ ______________________________

____

____

____

____

Current medications? (Please list)

Name of medications Dosage What for? Prescribed by:

____

____

____

____

Past medications (only psychotropic) ______________________________

____

____

Physician

Physician's Name: ______________________________ Phone Number: (_______)______________________

Clinic Name & Address ______________________________

Date of last physical: ______________________

History of physical problems

Do you have a thyroid condition? ___ no ___ yes: ______________________________

Any allergies? ___ no ___ yes: ______________________________

Have you ever lost consciousness? ___ no ___ yes:______________________________

Have you ever had head injuries? ___ no ___ yes:______________________________

Have you ever had seizures? ___ no ___ yes:______________________________

Other

- Have you gained or lost weight in the past year? ___ no ___ yes: _____________lbs.
- Has your appetite changed during the past year? ___ increased ___ decreased
- Do you generally eat healthy? ____ no ___ yes
- How much exercise do you get per week and what kind of exercise do you do? ______________________

  ____

  ____

  ____
- Do you use a hearing aid or have difficulties hearing? ___ no ___ yes
- Do you have any problems walking or getting around? ___ no ___ yes
- Do you have any problems with shakes, tics, or tremors? ___ no ___ yes
- Do you have any problems with vision? ___ no ___ yes

THIS SPACE RESERVED FOR THERAPIST (Medical)

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4. Mental Health History

Psychiatric

- Ever been hospitalized for ***psychiatric*** reasons? ____ no ____ yes, for____
- Where ? ____
- When? ________________________________ How long? ____________________

(Use back of page if necessary)

Counseling -- Please list counselors or psychiatrists you have seen before or are seeing now:

- Name ______________________________ Phone Number (_____)______________
  Clinic & Address:____
  When? ______________________ Purpose: _________________________________

- Name ______________________________ Phone Number (_____)______________
  Clinic & Address:____
  When? ______________________ Purpose: _________________________________

- Name ______________________________ Phone Number (_____)______________
  Clinic & Address:____
  When? ______________________ Purpose: _________________________________

(Use back of page if necessary)

Testing

- Have you ever taken any psychological testing? ___ no ___ yes
- Who administered the testing? ____
- What testing did you do? (Intellectual? MMPI? Ink blots? Other?) ____

THIS SPACE RESERVED FOR THERAPIST (Mental Health)

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____

5. Symptoms

- What do you worry about? ____
- Do you have stress related to debts, credit cards, or other financial concerns? ___ no ___ yes
- Do you have any phobias? (fears of dogs, heights, insects, closed spaces, rodents, etc.)
  ___ no ___ yes:____
- Have you ever had a panic attack? ___ no___ yes:____
- Have you recently experienced any of the following:
  - shortness of breath? ___ no___ yes:____
  - headaches? ___ no___ yes:____
  - stomach aches? ___ no___ yes:____
  - faintness? ___ no___ yes:____
  - dizziness? ___ no___ yes:____
- Do you have any sexual problems? ___ no___ yes:____
- Have you had any personal losses lately -- someone dying, moving away, etc.?
  ___ no ___ yes: ____
- Do you have any thoughts you can't stop thinking about? ___ no ___ yes:____
- Do you have any compulsions – things you feel you need to do over & over? ___ no ___ yes:
  ____
- Do you have any unusual thoughts or thoughts that scare you? ___ no ___ yes: ____
- Do you ever hear or see things that others don't seem to hear or see? ___ no ___ yes: ____
- Do you feel like anyone is out to get you? ___ no ___ yes:____

- Sleep
  - Are you having any difficulties sleeping? ___ no___ yes:_______________
  - How many hours of sleep do you get per night? _______________
  - Do you have nightmares? ___ no ___ yes:_______________
  - Insomnia? ___ no___ yes:_______________
  - Do you wake too early in the A.M.? ___ no___ yes:_______________
  - Do you wake up frequently during the night? ___ no___ yes:_______________
- Have you ever tried to kill yourself? ___ no___ yes:_______________
- Do you currently feel like killing yourself? ___ no___ yes:_______________
- Have you ever done things to hurt yourself on purpose? (cutting, hitting, burning ,etc.)
  ___ no___ yes:_______________
- Do you currently feel like killing someone else? ___ no___ yes:_______________
- What makes you angry? _______________
- What do you do when you get angry? _______________

Drug and Alcohol Issues

- Have you ever had a chemical dependency evaluation? ___ no ___ yes
  When? _______________ Where? _______________
- Have you ever had chemical dependency treatment?
  When? _______________ Where? _______________
- Do you attend AA or NA? ___ no ___ yes:_______________
- Have you ever had a blackout? ___ no ___ yes:_______________
- Have you ever felt that you ought to **c**ut down on your drinking or drug use? ___no ___yes
- Have people **a**nnoyed you by criticizing your drinking or drug use? ___no ___yes
- Have you ever felt bad or **g**uilty about your drinking or drug use? ___no ___yes
- Have you ever had a drink or used drugs first thing in the morning (**e**ye-opener) to steady your nerves, e.g. get rid of a hangover, or to get the day started? ___no ___yes
- Do you smoke cigarettes? ___no ___yes: How often? _______________ How much? _______________
- Caffeine use? ___ cups of coffee per day ___ cans of pop per day (with caffeine) ___ other _______________
- Check off the substances you have used or tried:

___Alcohol	___LSD	___Cocaine	___Mushrooms	___Marijuana
___Ecstasy	___Crack	___Speed	___Crank	___Meth
___Heroin	___Inhalants – gas, glue, etc.		___ Other _______________	

  ___Prescription Drugs (used without prescription) What?_______________

  ___Medications other than aspirin or Tylenol, etc. (for example: pain medication or sleeping medication) What?
  ____
  ____

- Regarding any checked substances, name how much, how often, and for how long _______________
  ____

Other

- ♦ Do you gamble? ___ no ___ yes. If yes, how often? ___________________________________
- ♦ Do you spend a lot of time on the computer/Internet? ___ no ___ yes. If yes, how often? _________
- ♦ Do you think you may have any compulsive behaviors (e.g. spending, sex, etc.)? ___ no ___ yes

Anything else you think would be helpful for us to know?

THIS SPACE RESERVED FOR THERAPIST

SYMPTOM CHECKLIST

Please mark all of the symptoms that currently apply to you. If there are symptoms that you have also experienced in the past, please indicate these.

Past	Current	SYMPTOM
_____	_____	Marriage problems
_____	_____	Relationship problems
_____	_____	Difficulties with family
_____	_____	Step-family problems
_____	_____	Divorce issues
_____	_____	Difficulties with friends
_____	_____	School problems
_____	_____	Work problems
_____	_____	Serious physical illness (in yourself)
_____	_____	Serious physical illness (in someone else)
_____	_____	Death of family member
_____	_____	Death of friend
_____	_____	Depressed mood
_____	_____	Loss of interest in activities
_____	_____	Withdrawn/isolation
_____	_____	Weight loss
_____	_____	Weight gain
_____	_____	Increase in appetite
_____	_____	Decrease in appetite
_____	_____	Sleep difficulties
_____	_____	Feeling restless or agitated
_____	_____	Fatigue or loss of energy
_____	_____	Feeling worthless
_____	_____	Feeling guilty
_____	_____	Feeling hopeless
_____	_____	Feeling ashamed
_____	_____	Low self-esteem
_____	_____	Trouble with concentration
_____	_____	Trouble with memory
_____	_____	Attention problems
_____	_____	Confusion
_____	_____	Trouble making decisions
_____	_____	Suicidal thoughts
_____	_____	Suicidal urges
_____	_____	Suicidal plan
_____	_____	Self-injury (e.g. burning, cutting)
_____	_____	Crying spells
_____	_____	Anger
_____	_____	Irritability
_____	_____	Loss of temper/outbursts
_____	_____	Mood swings
_____	_____	Inflated self-esteem or grandiosity
_____	_____	Decreased need for sleep (e.g. feel rested after only 3 hours of sleep)
_____	_____	More talkative than usual

Past	Current	SYMPTOM
_____	_____	Racing thoughts
_____	_____	Distractible
_____	_____	Excessive energy
_____	_____	Overspending
_____	_____	Anxiety
_____	_____	Panic attacks
_____	_____	Fears of being outside the home alone
_____	_____	Fears of being in a crowd or standing in line
_____	_____	Phobia
_____	_____	Fears of social situations
_____	_____	Obsessive thoughts
_____	_____	Compulsive behaviors
_____	_____	Behavior to undo things
_____	_____	Physical abuse to others
_____	_____	Physical abuse by others
_____	_____	Verbal abuse to others
_____	_____	Verbal abuse by others
_____	_____	Sexual abuse to others
_____	_____	Sexual abuse by others
_____	_____	Intrusive memories
_____	_____	Recurrent distressing dreams
_____	_____	Recurrent flashbacks
_____	_____	Easily startled
_____	_____	Difficulties controlling worry
_____	_____	Restlessness
_____	_____	Feeling keyed up or on edge
_____	_____	Mind going blank
_____	_____	Episodes of lost time
_____	_____	Episodes of unexplainable actions
_____	_____	Excessive fantasy or daydreaming
_____	_____	Difficulty trusting others
_____	_____	Avoidance of conflict
_____	_____	Shy/uneasy around others
_____	_____	Muscle tension
_____	_____	Headaches
_____	_____	Stomach aches
_____	_____	Motor or vocal tic
_____	_____	Overeating
_____	_____	Not eating enough
_____	_____	Starving self to lose weight
_____	_____	Dissatisfaction with appearance
_____	_____	Gambling
_____	_____	Overuse of Computer or Internet
_____	_____	Alcohol Abuse
_____	_____	Drug Abuse

Past	Current	SYMPTOM
_____	_____	Hold grudges, unforgiving
_____	_____	Sexual problems
_____	_____	Low sexual interest
_____	_____	Sexual orientation concerns
_____	_____	Lack close friends
_____	_____	Unusual thoughts or perceptions
_____	_____	Stealing
_____	_____	Breaking the law
_____	_____	Impulsive
_____	_____	Physical Fights
_____	_____	Aggressive/Violent behavior
_____	_____	Fears of abandonment
_____	_____	Difficulties with identity
_____	_____	Chronic feelings of emptiness
_____	_____	Need to be center of attention
_____	_____	Require excessive admiration
_____	_____	Believe others are envious of you
_____	_____	Arrogant
_____	_____	Avoid school/work due to fear of criticism
_____	_____	Fear of failure
_____	_____	Unwilling to get involved in things unless certain of being liked
_____	_____	Feel socially inferior
_____	_____	Reluctant to take risks due to embarrassment
_____	_____	Need to be liked by others
_____	_____	Need to please others
_____	_____	Difficulty saying “no”
_____	_____	Feel uncomfortable when alone
_____	_____	Difficulty making decisions
_____	_____	Fear of disapproval
_____	_____	Very occupied with details, lists, order
_____	_____	Perfectionism
_____	_____	Difficulties throwing things away
_____	_____	Hoard things
_____	_____	Rigid
_____	_____	Stubborn
_____	_____	Excessive devotion to work
_____	_____	Often fail to give close attention to details or make careless mistakes in schoolwork, work, or other activities
_____	_____	Often have difficulty sustaining attention in tasks or activities
_____	_____	Often do not seem to listen when spoken to directly
_____	_____	Often do not follow through on instructions & fail to finish schoolwork, chores, or duties in the workplace
_____	_____	Often have difficulty organizing tasks and activities

Past	Current	SYMPTOM
_____	_____	Often avoid, dislike, or are reluctant to engage in tasks that require sustained mental effort (such as homework)
_____	_____	Often lose things necessary for tasks or activities (e.g. assignments, pencils, books, or tools)
_____	_____	Often easily distracted by extraneous stimuli
_____	_____	Often forgetful in daily activities
_____	_____	Often fidget with hands or feet or squirm in seat
_____	_____	Often leave seat in classroom or in other situations in which remaining seated is expected
_____	_____	Often feel restless
_____	_____	Often have difficulty engaging in leisure activities quietly
_____	_____	Often “on the go” or act as if “driven by a motor”
_____	_____	Often talk excessively
_____	_____	Often blurt out answers before questions have been completed
_____	_____	Often have difficulty awaiting turn
_____	_____	Often interrupt or intrude on others (e.g. butt into conversations or games)
_____	_____	Other symptoms not listed:
_____	_____	____________________________________
_____	_____	____________________________________
_____	_____	____________________________________

Are there any other concerns that you would like to alert me of or elaborate on at this time? (Please feel free to discuss concerns in person. This form is intended to help to obtain a great deal of information in a short period of time. It is not intended to replace important discussions with you.)