

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 _____

LIFE DEVELOPMENT RESOURCES, P.A.

10591 165th St. W., Lakeville, MN 55044

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

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? _____

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

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)

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 cut down on your drinking or drug use? ___no ___yes
- ◆ Have people annoyed you by criticizing your drinking or drug use? ___no ___yes
- ◆ Have you ever felt bad or guilty about your drinking or drug use? ___no ___yes
- ◆ Have you ever had a drink or used drugs first thing in the morning (eye-opener) to steady your nerves, e.g. get rid of a hangover, or to get the day started? ___no ___yes
- ◆ Do you smoke cigarettes or use smokeless tobacco? ___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 _____

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.

<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>	<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>
___	___	Marriage problems	___	___	Racing thoughts
___	___	Relationship problems	___	___	Distractible
___	___	Difficulties with family	___	___	Excessive energy
___	___	Step-family problems	___	___	Overspending
___	___	Divorce issues	___	___	Anxiety
___	___	Difficulties with friends	___	___	Panic attacks
___	___	School problems	___	___	Fears of being outside the home alone
___	___	Work problems	___	___	Fears of being in a crowd or standing in line
___	___	Serious physical illness (in yourself)	___	___	Phobia
___	___	Serious physical illness (in someone else)	___	___	Fears of social situations
___	___	Death of family member	___	___	Obsessive thoughts
___	___	Death of friend	___	___	Compulsive behaviors
___	___	Depressed mood	___	___	Behavior to undo things
___	___	Loss of interest in activities	___	___	Physical abuse to others
___	___	Withdrawn/isolation	___	___	Physical abuse by others
___	___	Weight loss	___	___	Verbal abuse to others
___	___	Weight gain	___	___	Verbal abuse by others
___	___	Increase in appetite	___	___	Sexual abuse to others
___	___	Decrease in appetite	___	___	Sexual abuse by others
___	___	Sleep difficulties	___	___	Intrusive memories
___	___	Feeling restless or agitated	___	___	Recurrent distressing dreams
___	___	Fatigue or loss of energy	___	___	Recurrent flashbacks
___	___	Feeling worthless	___	___	Easily startled
___	___	Feeling guilty	___	___	Difficulties controlling worry
___	___	Feeling hopeless	___	___	Restlessness
___	___	Feeling ashamed	___	___	Feeling keyed up or on edge
___	___	Low self-esteem	___	___	Mind going blank
___	___	Trouble with concentration	___	___	Episodes of lost time
___	___	Trouble with memory	___	___	Episodes of unexplainable actions
___	___	Attention problems	___	___	Excessive fantasy or daydreaming
___	___	Confusion	___	___	Difficulty trusting others
___	___	Trouble making decisions	___	___	Avoidance of conflict
___	___	Suicidal thoughts	___	___	Shy/uneasy around others
___	___	Suicidal urges	___	___	Muscle tension
___	___	Suicidal plan	___	___	Headaches
___	___	Self-injury (e.g. burning, cutting)	___	___	Stomach aches
___	___	Crying spells	___	___	Motor or vocal tic
___	___	Anger	___	___	Overeating
___	___	Irritability	___	___	Not eating enough
___	___	Loss of temper/outbursts	___	___	Starving self to lose weight
___	___	Mood swings	___	___	Dissatisfaction with appearance
___	___	Inflated self-esteem or grandiosity	___	___	Gambling
___	___	Decreased need for sleep (e.g. feel rested after only 3 hours of sleep)	___	___	Overuse of Computer or Internet
___	___	More talkative than usual	___	___	Alcohol Abuse
___	___		___	___	Drug Abuse

<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>
_____	_____	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

<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>
_____	_____	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.)