The Life Source Center, Inc.

INTAKE INFORMATION SHEET

Date_____

Patient's Last Name _____First Name _____M.I._____

Primary Care Physician _____Patient's S.S. #_____

Date of Birth _____Age_____ Gender ____Male _____Female Marital Status_____

Address_____Apt.Bldg/P.O Box #_____

City/State/Zip Code _____Home phone:_____

E-mail address _____Cell phone:_____

How were you referred to us?_____

Employer's Name &Address_____

Occupation_____Business Phone_____

Spouse's Name _____Spouse's Employer_____

Spouse's Employer's Address_____

Spouse's Occupation _____Business Phone _____

Whom may we contact in case of emergency_____Relationship_____Phone #_____

If patient is a minor or student:

Responsible Party's name_____Relationship_____

Address_____Home phone _____Business phone_____

Insurance Information (Person employed by the company)

Primary Insurance_____ **Secondary Insurance_____**

Subscriber's Name_____ **Subscriber's Name**

S.S.# _____ Date of Birth_____ **S.S.# _____Date of Birth_____**

Address_____ **Address_____**

ID #_____Co-pay_____ **ID# _____Co-pay_____**

____Welfare _____City _____State ID#_____

***Please note that an "hour" outpatient visit last from 45 to 50 minutes and paid as such by one's insurance.**

(Please read carefully and sign):

I request that payment of authorized benefits be made on my behalf to The Life Source Center, Inc., or my therapist for any services furnished to me by said supplier. I authorize any holder of medical information about me to release to LSC and its agents, or any supplier of medical benefits, any information needed to determine those benefits, or the benefits for related services. I understand that regardless of any insurance coverage I may have, it is my responsibility to pay your bill. I further understand that my insurance is designed to reimburse me for covered expense. I understand further that not all services are covered by Medicare or other insurance, and I acknowledge that I am responsible for and will pay for those services. I agree to pay all costs of collection, including reasonable attorney's fees incurred in the collection of any amount not paid, as required above. I also agree to pay a $50. no show fee if I fail to give 24 hours notice to cancel an appointment.

Patient/Responsible Party Signature_____

The Life Source Center, Inc.

PATIENT INFORMATION FORM

In order to better serve you, kindly fill out the following information

Name_____ **D.O.B.** _____ **Date** _____

Presenting Problem: Reason you are here now:

_____
_____

History of family background and relevant information as it relates to your being here today:

_____
_____
_____
_____

Education: _____

Current life stressors:

_____
_____
_____

Medical/behavioral health problems/diagnosis:

_____
_____

Please list all current **MEDICATIONS** and what medical problem the medicine is treating:

Medication	Dose	Medical Problem	Prescribing Physician	Date RX originally given
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Substance use history: (age started, last use, frequency/amount, treatment: inpatient/ outpatient)

Alcohol _____

Cocaine_____

Heroin_____

Marijuana_____

Pills_____

Triggers that cause you to do any of these drugs:

_____
_____

Behavior health counseling history:

Inpatient_____ Outpatient _____ Child/Adol. _____ Indiv. _____ Couple _____ Family _____

Describe:

_____
_____
_____

Family members with psychiatric hx. Y N (Describe)

_____
_____

Family members with substance abuse hx. Y N (Describe)

_____
_____

Abuse hx. Physical _____ Emotional _____ Sexual _____: (Describe)

_____

Increase/decrease : Libido_____ Sleep pattern _____ Appetite _____

Recurrent nightmares: (Describe) _____

Problems with anger: (Describe)_____

Suicidal thoughts or plans: (Describe) _____

Prior suicidal attempts: (Describe when & how)

_____
_____

Homicidal thoughts or plans: (Describe) _____

Fears_____ Phobias_____ Anxiety Attacks_____

How active is spirituality in your life: _____

Name your family/social supports:_____

Name your sources of stress:

_____
_____

What do you see as your strengths? _____

What do you see as holding you back in life?

_____
_____

What would you like to get out of coming here? (Be as specific as possible)

_____
_____
_____