The Life Source Center, Inc.

INTAKE INFORMATION SHEET

Download & Email form to: lifesourcecenter@aol.com

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/PO Box#_____
City/State/Zip Code _____
Home phone:_____ Cell phone:_____
E-mail address _____
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_____
Primary Insurance_____ Secondary Insurance_____
Subscriber's Name_____ Subscriber's Name_____
S.S.# _____ S.S.# _____
Date of Birth_____ Date of Birth_____
Address_____ Address_____
ID #_____ ID# _____
Co-pay_____ 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*_____ *Date* _____

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)

_____

_____

_____