Lake Country Associates

Name of Client: _____ Former or maiden name: _____

Date of Birth: _____ Age: _____ SSN# _____ Gender: ☐ Male ☐ Female

Mail Address: _____ Physical Address: _____

City: _____ State: _____ Zip: _____ County _____ Referral source: _____

Indicate best way to reach you ☐ Home #: _____ ☐ Cell# _____ Text OK ☐ Yes ☐ No

Do you difficulty with reading or writing? ☐ Yes ☐ No Name of person completing form: _____

Employer: _____ Occupation: _____

Employment: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never married

Education: 1 2 3 4 5 6 7 8 9 10 11 12 ☐ GED ☐ College/Vocational 1 2 3 4 5 6 Degree _____

Race: ☐ White ☐ Black/African American ☐ Native American/Alaskan
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino

Client Lives: ☐ Alone ☐ With immediate family ☐ With extended family ☐ With non-related

Client lives in: ☐ Private Residence (home/apartment) ☐ Shelter/Homeless ☐ Other Residential Setting
☐ Correctional Facility ☐ Other institution setting ☐ Other _____

Are you a Veteran? ☐ Yes ☐ No If Yes, date of discharge _____

Is the reason you are wishing to be seen at LCA military related? ☐ Yes ☐ No

Have you had a diagnostic assessment completed within the past year at another mental health agency? ☐ Yes ☐ No

If yes, please tell us the name of the agency _____

Does a copy of your assessment need to be forwarded to someone outside of this office? ☐ Yes ☐ No If yes, please tell us
Who _____ Office _____

People living in the same household:

Name	Age	Relationship	M/F	Employer	Phone

In case of emergency, who may we contact

Name	relationship to you	phone number

Client name: _____ DOB: _____ Today's Date: _____

Lake Country Associates

Acceptance of Financial Responsibility

Charges for services are to be billed to the following sources:

☐ Insurance (primary) Company_____ Subscriber Name_____
Group #_____ Subscriber dob _____
Policy # _____ Subscriber Relationship_____
Co-Pay Amount _____ Subscriber Address _____

☐ Insurance (secondary) Company_____ Subscriber Name_____
Group #_____ Subscriber dob _____
Policy # _____ Subscriber Relationship_____
Co-Pay Amount _____ Subscriber Address _____

☐ Medical Assistance Carrier _____ MA#_____

☐ EAP Provider Name _____ Number of Sessions Approved _____

I understand if coverage has lapsed, if services requested are not covered by the plan, if plan caps have been exceeded, or if the services are denied by the carrier but I wish to have them anyway, **that I will be responsible for the payment.** I also agree to any self-pay amounts indicated by the carrier contract. I authorize LCA to furnish information to the payment sources concerning my illness and treatments and hereby assign to Lake Country Associates all payments for services rendered to my dependents or myself. This authorization shall remain in effect until otherwise cancelled by Policy Holder or Representative. I understand my insurance carrier or other third party payer may inform the "subscriber" of any services billed to the payer.

_____ _____
Client or Guardian **Date**

Private Pay Clients:

☐ Name_____ Relationship_____
Address _____ Phone # _____

By signing below I agree that payment for services requested is the responsibility of the patient or guardian. I agree to accept the terms and conditions as indicated on the FEE SCHEDULE and PAYMENT CONTRACT. Any financial assistance that applies to these services is listed in the payment contract.

_____ _____
Client or Guardian **Date**

As a client of Lake Country Associates, I agree to the following statements with regard to payment for services:

1. Clients are required to pay for services received. A client may choose to bill third party insurance including Medical Assistance and Medicare. In the event that the third party insurance is billed, clients will be required to pay for all services which are not covered by insurance. Exceptions will include those items which are not appropriate to bill the client under the terms of the provider contract.
2. If clients choose to use insurance, they agree to provide insurance information to Lake Country Associates and agree to assist in billing for insurance reimbursement.
3. Self-pay clients are expected to pay for services at that time they are received. A 10% discount is offered for full cash payment at the time of service. Billing arrangements accepted by LCA other than full payment at the time of service are listed below under SPECIAL CONDITIONS.
4. If a billing arrangement is made, a minimum payment of $75 per month or 10% of the total bill, whichever is higher, will be expected.
5. Any services provided by LCA not covered by client's insurance which are 60 days in arrears will be charged monthly interest at a rate of 1.5% of the balance.
6. In the event of non-payment, the bill will be sent to collections.
7. LCA reserves the right to decline service or to require cash payment if a previous billing arrangement has not been honored.

The client agrees that if circumstances such as income, number of dependents, insurance or eligibility for various programs change, the client will notify LCA.

SPECIAL CONDITIONS:_____

_____

_____ _____ _____
Client or Guardian **Date** **LCA representative**

Client name:_____ DOB:_____ Today's Date:_____

WHODAS 2.0

Name: _____ Chart#: _____ Date: _____

This questionnaire asks about difficulties due to health conditions. Health conditions include disease or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the **past 30 days** and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

	In the past 30 days, how much difficulty did you have in:	**None**	**Mild**	**Moderate**	**Severe**	**Extreme Or cannot do**
S1	Standing for long periods such as 30 minutes?	☐	☐	☐	☐	☐
S2	Taking care of your household responsibilities?	☐	☐	☐	☐	☐
S3	Learning a new task such as how to get a new place?	☐	☐	☐	☐	☐
S4	How much of a problem did you have joining in community activities (festivities, religious or other activities) in the same way as anyone else?	☐	☐	☐	☐	☐
S5	How much have you been emotionally affected by your health problems?	☐	☐	☐	☐	☐
S6	Concentrating on doing something for 10 minutes?	☐	☐	☐	☐	☐
S7	Walking a long distance such as a half mile?	☐	☐	☐	☐	☐
S8	Washing your whole body?	☐	☐	☐	☐	☐
S9	Getting dressed?	☐	☐	☐	☐	☐
S10	Dealing with people you do not know?	☐	☐	☐	☐	☐
S11	Maintaining a friendship?	☐	☐	☐	☐	☐
S12	Your day-to-day work?	☐	☐	☐	☐	☐
	Total number of Xs in each column	_____	_____	_____	_____	_____

H1	Overall in the past 30 days, how many days were these difficulties present	**# of DAYS** _____
H2	In the past 30 days, how many days were you totally unable to carry out your usual activities or work because of any health condition?	**# of DAYS** _____
H3	In the past 30 days, not counting the days that you were totally unable, how many days did you cut back or reduce your usual activities or work because of any health condition?	**# of DAYS** _____

PHQ - 9 Depression Assessment

Over the past 2 weeks, how often have you been bothered by any of the following problems?
Circle the number under the correct answer heading for each question.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thought that you would be better off dead or hurting yourself in some way	0	1	2	3
Total Score of each column	_____	_____	_____	_____

If you checked any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

PHQ-9 Score	Depression Severity
1 to 4	None
5 to 9	Mild
10 to 14	Moderate
15 to 19	Moderately Severe
20 to 27	Severe

Total of all columns _____

Client name:_____ DOB:_____ Today's Date:_____

The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: ☐ **= Add Columns _____+ _____+_____**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not at all ☐Somewhat difficult ☐Very difficult ☐Extremely Difficult

Interpreting the Score:

Total Score	**Interpretation**
≥10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild Anxiety
10	Moderate anxiety
15	Severe anxiety

Client name:_____ DOB:_____ Today's Date:_____

CAGEAID

Alcohol: Age at first time used _____ Age at first used to intoxication_____

Last used _____ Last used to intoxication _____

What? How often? How much?_____

_____

Marijuana: Age at first time used _____ Age at first used to intoxication_____

Last used _____ Last used to intoxication _____

How often? How much?_____

_____

Other drugs or abuse of prescriptions: Age at first time used _____ Age at first used to intoxication_____

Last used _____ Last used to intoxication _____

What? How often? How much?_____

_____

CAGEAID

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐ YES ☐ NO
2. Have you ever had people annoy you by criticizing your drinking or drug use? ☐ YES ☐ NO
3. Have you ever felt bad or guilty about your drinking or drug use? ☐ YES ☐ NO
4. Have you ever had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves or get rid of a hangover or to get the day started? ☐ YES ☐ NO
5. Have there been negative events which occurred during alcohol or drug use? ☐ YES ☐ NO
   If so, what _____

_____

_____

_____

Do you use tobacco products? ☐ YES ☐ NO

What? How often? How much?_____

Do you drink caffeinated beverages? ☐ YES ☐ NO

What? How often? How much?_____

Client name:_____ DOB:_____ Today's Date:_____

Order for protection and restraining order policy (Please read and sign):
In order to ensure the safety of our clients and clinicians, it is mandatory that we be informed and provided copies of any current or future Orders for Protection and/or Restraining Orders concerning our clients. We are further bound to comply with existing OFP's and Restraining Orders. I understand and will comply with the LCA policy concerning disclosure of restraining orders.

Signature of client (or client's guardian) **Date**

Is there currently an Order for Protection (OFP) or Harassment Order in place from any state regarding a member of your household?

☐ Yes ☐ No If yes, name of family member _____

Name of other party involved _____

Expiration Date of Order _____

CHECKLIST OF CONCERNS

Describe what changes in your life you are seeking by coming to LCA:

_____

Please mark all of the items below that apply to you. Circle the one that is most important.

☐ Marital/family problems
☐ Social/interpersonal (not family) problems
☐ Coping with daily roles
☐ Medical/physical symptoms
☐ Depression
☐ Attempt, threat, danger of suicide
☐ Alcohol/drugs
☐ Court evaluation referral
☐ Program entrance evaluation
☐ Eating disorder
☐ Anxiety
☐ Abuse/assault victim
☐ Sexual abuse/rape victim
☐ Child behavior problems
☐ Major mental illness
☐ Psychiatric medication
☐ Other _____
☐ Perpetrator of sexual abuse
☐ Anger management
☐ Gambling
☐ Stress
☐ Codependency issues
☐ ADD/ADHD

Please continue checking all items that apply to you:

☐ Aggression, violence
☐ Career concerns, goals and choices
☐ Childhood issues (your own childhood)
☐ Children, child management, child care, parenting
☐ Concentration
☐ Compulsions (actions that are repeated)
☐ Custody of children
☐ Decision making, indecision, putting off decisions
☐ Delusions (false ideas)
☐ Dependence
☐ Emptiness
☐ Failure
☐ Fatigue, tiredness, low energy
☐ Fears, phobias
☐ Financial or money worries
☐ Work problems, workaholic, can't keep a job
☐ Grieving, mourning, deaths, losses, divorce
☐ Guilt
☐ Relationship problems
☐ Self-centeredness
☐ Self-neglect, poor self-care
☐ Shyness, over sensitivity to criticism
☐ Smoking and tobacco use
☐ Thought disorganization and/or confusion
☐ Weight and diet issues
☐ Recreation/hobbies
☐ Headaches, other kinds of pain
☐ Inferior feelings
☐ Impulsiveness, loss of control, outbursts
☐ Irresponsibility
☐ Judgment problems, risk taking
☐ Legal matters, charges, suits
☐ Loneliness
☐ Memory problems
☐ Menstrual problems, PMS, menopause
☐ Mood swings
☐ Motivation, laziness
☐ Nervousness, tension
☐ Obsessions (thoughts that are repeated)
☐ Overly sensitive to rejection
☐ Panic or anxiety attacks
☐ Perfectionism
☐ Pessimism
☐ Procrastination, work inhibitions
☐ School problems
☐ Self-esteem
☐ Sexual issues (dysfunction, conflicts, desire differences)
☐ Sleep problem (too much, too little, insomnia, nightmares)
☐ Suspiciousness
☐ Threats, violence
☐ Withdrawal, isolating
☐ Other concerns or issues_____

Lake Country Associates

Medical Information Supplement
page 1

In order to provide high quality care, please complete the following. This information will become part of the Diagnostic Assessment.

Are you allergic to any drugs? ☐ Yes ☐ No

If Yes, please list _____

Do you have any other allergies? ☐ Yes ☐ No

For example, foods, air borne, etc. If Yes, please list _____

Are you pregnant? ☐ Yes ☐ No

Who is your medical doctor? _____

Name of Clinic and location _____

When was your last physical examination? _____ Results: _____

Have you experienced a recent weight loss or weight gain? ☐ Yes ☐ No

Do you have any problems that might interfere with your receiving service at Lake Country Associates? ☐ Yes ☐ No

If Yes, please list _____

Have you received services for alcohol and/or drug problems in the past? ☐ Yes ☐ No

If Yes, where? _____

Have you ever been treated for any of the following?

☐ Birth or developmental problems in childhood
☐ ADHD
☐ Alcohol issue
☐ Anemia
☐ Anxiety
☐ Cancer
☐ Chronic pain
☐ Diabetes ☐ Type I ☐ Type II
☐ Depression
☐ Head injury (epilepsy, seizures, convulsions, confusion)
☐ Headaches, migraines
☐ Constipation ☐ Diarrhea
☐ Urinary incontinence
☐ Vision problems
☐ Hearing problems
☐ Low energy
☐ Skin problems
☐ Past surgeries
☐ Gastric bypass
☐ Chronic illness
☐ Hepatitis
☐ Heart disease
☐ High blood pressure (hypertension)
☐ Chest pain, palpitations
☐ Kidney disease
☐ Lung disease, pneumonia
☐ PTSD
☐ Serious injury or accident
☐ Sexual performance problems
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Ulcer
☐ Sexually transmitted disease
☐ Problems with appetite
☐ Gastrointestinal problems
☐ Ongoing pain or discomfort
☐ Other _____

If any of the above boxes are checked, please comment on length and duration of problem _____

_____

_____

Client name: _____ DOB: _____ Today's Date: _____

Lake Country Associates

Medical Information Supplement
page 2

Have you had any past suicide thoughts or attempts? ☐ Yes ☐ No

If so, please list _____

When _____

Have you had any visits to the Emergency Room in the last year? ☐ Yes ☐ No

If Yes ,what symptoms were you experiencing when you went to the ER? _____

_____

Have you had any hospitalizations related to mental health? ☐ Yes ☐ No

If Yes, when _____

Where _____

What symptoms were you experiencing when you were hospitalized? _____

_____

Are you currently or have you been treated for any mental health conditions? ☐ Yes ☐ No

If Yes, when _____

Where _____

Are you currently taking any medications? ☐ Yes ☐ No

If Yes, please list below

Medication Name	Dosage	How often	Prescribed by

Past Medications _____

_____

Do you take vitamins, herbal medications, diet supplements or over-the counter medications? ☐ Yes ☐ No

If yes, what type, how much and for how long? _____

Have you taken more of a prescription medication than recommended by your doctor? ☐ Yes ☐ No

If yes, what type, how much and for how long? _____

Do you have a Health Care Directive? ☐ Yes ☐ No

If yes, where do you keep it? _____

If no, would you like information on one? ☐ Yes ☐ No If yes, was information given to client? ☐ Yes ☐ No

Client name:_____ DOB:_____ Today's Date:_____