LIVING WELL CHRISTIAN FAMILY CLINIC --CONFIDENTIAL CONTACT FORM

Client Name: _____

Cell Phone _____ **E-mail** _____

Home Phone _____ **Address**_____

Other Phone _____ _____

Please describe any restrictions on the means and/or location you want us to use (e.g.- do not leave a message on home telephone number): _____

_____

_____

Appointment Reminders

As a courtesy, our office sends out appointment reminders prior to scheduled appointments. Our cancellation policy requires 24-hour notice for cancelling an appointment.

I prefer to receive my appointment reminders using:

text message ☐ _____

e-mail ☐ _____

I do **NOT** want to receive appointment reminders: ☐

Balance Notifications

Our office is transitioning to electronic notification of balances due on your account. This saves the expense of office printing and mailing paper statements.

These balance notifications contain a link sent to text message or e-mail. You must provide us the cell number and or e-mail you would like to use.

Upon clicking the link in your notification, you are taken to a payment portal where you can log in to see more information about your charges and payments.

I prefer to receive my balance notifications using:

text message ☐ _____

e-mail ☐ _____

I do **NOT** want to receive balance notifications, please mail me a paper statement: ☐

Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the individual (e.g.- minor child), complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Please refer to LWCFC Privacy Practice Notice for more information on confidential communication and HIPAA
10/22

Living Well Christian Family Clinic – Intake Form (Adult)

CLIENT

Name: _____D.O.B _____ Race: _____
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____
How long at current employer:_____
Church: _____ Past Military Experience: _____

SPOUSE / SIGNIFICANT OTHER

Name: _____D.O.B _____ Race: _____
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____
How long at current employer:_____
Church: _____ Past Military Experience: _____

MARITAL/FAMILY INFORMATION

Date married: _____ Present Status: _____

Prior marriages:

Name	Date From:	Date To:	Divorce	Death

Children

Name	Age	Grade	Describe relationship

Living Well Christian Family Clinic – Health Report

Name: _____ Age: _____ DOB: _____

HEALTH HISTORY:

What childhood diseases did you have?

_____

_____

What serious illnesses have you had?

_____

_____

What operations have you had?

_____

_____

List present health concerns:

_____

_____

What allergies do you have?

_____

_____

Please list any prescription or over-the-counter medications you are currently taking and why:

Medication	Dosage (i.e.- 15ml)	Frequency (i.e.- 2x/day)	Purpose

When was your last physical check-up? _____ Results: _____

_____

_____

How is your appetite? _____

Have you lost weight in the last three months? Gained?

If you have gained or lost weight, how much? _____

How many hours do you sleep on an average night? _____

Do you have problems sleeping?

Do you exercise? If so, what do you do? _____

How often? _____

How many packs of cigarettes do you smoke each day? _____

How many caffeinated drinks do you consume each day (coffee, tea, soda, energy drinks)? _____

How many alcoholic drinks per week? _____

Are you using other substances?

_____

_____

Is there a history in your family of any of the following? _____

☐ Abuse/Trauma	☐ Depression	☐ Neurological Disease
☐ ADHD	☐ Diabetes	☐ Obesity
☐ Alcohol Abuse	☐ Eating Disorders	☐ Schizophrenia
☐ Anxiety	☐ Gallbladder Disease	☐ Seizures
☐ Arthritis	☐ Heart Disease	☐ Stroke
☐ Autism	☐ High Blood Pressure	☐ Substance Abuse
☐ Bipolar Disorder	☐ High Cholesterol	☐ Suicide
☐ Cancer	☐ Hypoglycemia	☐ Upper Respiratory Problems
☐ Dementia	☐ Intellectual Disability	

Other health issues: _____

_____

Name of your Personal Physician: _____ Phone: _____

Clinic Name: _____ Clinic Address: _____

City: _____ State: _____Zip: _____

May we contact your Physician?

PRESENTING CONCERN:

Why are you seeking therapy/counseling? _____

_____

_____

_____

_____

_____

MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT HISTORY:

Please list any prior mental health treatment or counseling (include any hospitalizations or substance abuse treatment):

Dates	Location	Provider	Reason/Outcome

What did you like/dislike about your former experiences with counseling? _____
_____
_____
_____
_____

EDUCATIONAL/VOCATIONAL ISSUES:

Highest Grade Completed: _____

Did you have any learning or behavioral problems while in school?
_____
_____

Are you experiencing any issues related to your job/schooling due to the concern you are being seen for today?
_____
_____
_____
_____

FAITH / SPIRITUALITY:

Do you have any concerns related to your spirituality or faith and the reason you are being seen today that you believe may impact your care?
_____
_____
_____
_____

STRESSORS:

Please list any changes in your life that you would consider to be significant in the past several years:
_____
_____
_____
_____

Have any of these had a negative or positive effect on your daily life? _____
_____
_____

How would you describe your financial situation?

_____

SOCIAL/LEISURE:

Are you satisfied with your current social life/social supports?

Please describe
_____
_____

What do you do to manage stress?

_____
_____

What do you enjoy doing in your spare time?

_____
_____

ADDITIONAL DETAILS:

Is there any additional information you would like to share with your therapist relevant to your treatment?

_____
_____
_____
_____

Have you been a victim or at risk for emotional, physical or sexual abuse?

If yes, please share any details you are comfortable disclosing at this time.

_____
_____
_____
_____

Living Well Christian Family Clinic – Substance Use History

Name: _____ Age: _____ DOB: _____

Chemical Use History in past **ONE** year:

Type of Substance	Not in lifetime	Age of first use	Route of Administration	Rarely	1-3 times a month	1-5 times a month	Daily-Almost Daily	Last Date of Use
Alcohol								
Cannabis								
Cocaine (powder)								
Crack Cocaine								
Methamphetamine								
Heroin								
Other Opiates								
Sedatives/Barbiturates								
Mushrooms								
Tobacco								
Other:								

Have you experienced a blackout? _____ Describe: _____

_____

Experienced injuries as a result of use? _____ Describe: _____

_____

Increased tolerance since first use? Describe: _____

_____

How often do you spend more time than you planned using or obtaining substances: _____

_____

Withdrawal symptoms in past year? _____ Describe: _____

_____

Longest period of sobriety? _____

What made previous attempts at sobriety unsuccessful?

_____

_____

PLEASE COMPLETE REVERSE SIDE

Reason for use? _____

_____

_____

What supports do you feel you need for recovery? _____

_____

_____

Do you have support to assist you with recovery? _____ Describe: _____

_____

_____

Have you felt guilty/embarrassed about substance use? _____ Describe: _____
_____

_____

Do most of your friends use substances? _____ Relationship issues because of use? _____

Describe: _____

_____

Please list any substance use concerns within your family of origin: _____

_____

SUBSTANCE USE TREATMENT HISTORY

Date(s)	Clinic	Therapist/Counselor	Outcome

Additional information/comments _____

_____

_____

DSM-5-TR Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	