LIFE CONNECTIONS
COUNSELING CENTER

4903 Van Dyke Rd, Lutz, FL 33558

813-265-3859 Voice 813-265-3966 FAX info@lc-online.org www.LifeConnectionsOnline.org

Welcome to Life Connections

Welcome to Life Connections. We are pleased that you have chosen us to help you achieve emotional and relational health. We are committed to doing all we can to make your work with us as effective and helpful as possible. Although you will see only one counselor, we use a team approach, so each counselor is supported by all the others.

What follows is our intake materials. The information we request will give your counselor background information on you. Completeing it is part of your preparation for counseling.

Our sessions with you usually last 50 minutes each. How many times you meet with your counselor depends on the issues you bring and your commitment to the process. We believe that time spent in counseling is a powerful investment in your self and in your future.

We have several policies about fees that you should be aware of: (Please initial each blank, indicating that you have read and understood each policy.)

_____ **We collect fees when services are provided.** If you have insurance coverage, you have the responsibility of submitting claims to collect from your insurance company.

_____ **We bill for any additional professional services we provide beyond the office visit.** Additional services include, but are not limited to, unscheduled phone sessions, written reports for third parties, consultation with other professionals, and any reports needed for legal reasons.

_____ **If you and your counselor decide that a psychological assessment may be needed, you will be responsible for the fees for the assessment.**

_____ **Please notify us of cancellations at least 36 hours in advance**. You may cancel by leaving a voice mail message. If you cancel less than 36 hours before your appointment, we will bill you for the appointment.

_____ **If you cancel twice in a row with less than 36 hours notice, or if you miss a total of two scheduled appointments without notifying us, we reserve the right to suspend services**.

_____ **If you have provided us with a debit or credit card for billing purposes, that card may be used for payment in the event of a missed appointment with less than 36 hours notice**.

_____ **If we are seeing you or your children for counseling or psychotherapy, we are prevented by Florida law from serving as expert witnesses in legal matters dealing with child custody, fitness of parenting, or divorce.**

_____ **Digital communication with us vie email or cell phone may not be secure. We are obligated ethically and legally to protect the confidentiality of all communication with you. We have procedures and technology in place to protect all records we keep, but we can not protect digital communication that leaves our office.**

We also want you to know that we cannot guarantee around-the-clock availability. If you should experience a behavioral or emotional crisis and you cannot reach us by phone, you should contact the Hillsborough Suicide & Crisis Hotline at **813-238-8822** or **813-234-1234**. For Children's Crisis Services call **813-238-5909**. For the Mobile Crisis Unit call **813-237-3101**.

My Situation

Please complete the following items as completely and honestly as you can. Your answers will help us better understand you and your situation.

If you are completing this form anywhere other than our office, you are responsible for keeping the form confidential.

General Consent

I understand that by completing this form I am requesting services from Life Connections Counseling Center. I understand that Life Connections staff will use the information in this form to determine what services Life Connections staff may be able to offer. If Life Connections staff determine that they are not able to provide services, they will give me appropriate referrals to other professionals.

If Life Connections staff determine that they are able to provide services, I give my general consent to use the information in this form for treatment, payment, and health care operation purposes. This consent does not allow Life Connections to release any protected health care information to any person or organization outside Life Connections, except when mandated by law. I understand that this consent is governed by the practices described in the document titled *Notice of Privacy Practices for Protected Health Information*, which is at the end of this packet. I have received a copy of this document.

I also consent to digital communication with Life Conections staff via email and cell phone that may not be secure.

I hereby give permission to the staff of Life Connection to use my protected health information for purposes of treatment, payment, and health care operations.

_____

Signature Date

General Information

Date _____

Name _____

Sex **M** **F** Age _____ Date of Birth _____

Address _____

_____ Zip_____

Phones Day_____ May we leave a message? **Yes** **No**

Evening _____ May we leave a message? **Yes** **No**

Cell _____ May we leave a message? **Yes** **No**

Email Address_____

How did you learn about Life Connections?

_____

Presenting problem

Describe the problems you are having and when they began.

_____

_____

_____

Have you been court ordered to discuss this problem? ____YES ____NO

Rate the severity of this concern, with 1 being not at all severe, and 10 being very severe. ___

When did this problem begin?_____

_____

What seems to make the problem worse?_____

_____

What seems to make the problem better?_____

_____

What have you done to try to solve this problem?_____

_____

Please check any symptoms you are experiencing:

___Aggression or Anger outbursts
___ Alcohol abuse
___ Anxiety
___ Avoidance of people
___ Chest pains
___ Computer addiction
___ Depression
___ Difficulty concentrating
___ Difficulty thinking

___ Distractibility
___ Dizziness
___ Drug abuse
___ Eating disorders
___ Elevated mood
___ Fatigue
___ Fears (list)
_____
___ Gambling
___ Hallucinations
___ Headaches
___ Helplessness
___ Hopelessness

___ Impulsivity
___ Indecisiveness
___ Irritability
___ Loneliness
___ Memory problems
___ Mood swings
___ Muscle tension
___ Panic attacks
___ Racing thoughts
___ Restlessness or on edge
___ Sexual addiction

___ Sexual difficulties
___ Sleeping problems
___ Stressed out
___ Suicidal thoughts
___ Trembling
___ Weight gain/loss
___ Withdrawal
___ Worrying
___ Worthlessness
___ Other symptoms
_____
_____

List all previous mental health treatment and the provider.

_____

_____

_____

_____

Please list any mental health problems in your extended biological family.

_____

_____

_____

Please check current stressors:

___ Conflict with children
___ Conflict with parents
___ Conflict with siblings
___ Conflict with other family
___ Emotional problems
___ Financial problems
___ Health problems
___ Housing problems
___ Job loss or change
___ Legal problems
___ Marital conflict
___ Physical problems
___ Poor peer relations
___ Problems at school
___ Problems at work
___ Recent death of family or friend
___ Recent move
___ Sexual problems
___ Separation or divorce
___ Substance abuse
___ Victim of abuse
___ Other
_____
_____
_____

Please check any substance use

Substance	Past use	Use now	Amount used	Frequency	Date last used
Tobacco					
Caffeine					
Alcohol					
Marijuana					
Cocaine/Crack					
Heroin					
Amphetamines					
LSD					
Ecstasy					
Inhalants					
Prescription drugs					
Other drugs (please list)					

Medical history

Who is your primary care physician?

_____

Date of last visit _____ Date of last physical _____

Check which of the following you have experienced:

___ Arthritis
___ Asthma
___ Cancer
___ Chronic pain
___ Diabetes
___ Head injury
___ Headaches
___ Heart disease
___ Hepatitis
___ HIV
___ Hypertension
___ Hypoglycemia
___ High fevers
___ Kidney disease
___ Liver disease
___ Loss of consciousness
___ Lung disease
___ Meningitis
___ Memory problems
___ Migraines
___ Seizures
___ Sexually transmitted disease
___ TB
___ Thyroid problems
___ Other
_____
_____
_____

For each item checked above, please describe your age at onset and the treatment and outcome.

_____

_____

_____

List any hospitalizations or surgeries you have had.

_____

_____

Please list all current medications, prescribed and over the counter, including herbal supplements:

Medication	Dosage	Date started	Prescribed by	Condition prescribed for

What allergies do you have?

_____

Social history

Place of birth _____

Where did you grow up? _____

If your family moved around, please describe.

_____

_____

_____

How many siblings do you have? _____

Which family members are you close to?

_____

Describe your childhood.

_____

_____

_____

List any trauma you may have suffered (physical, sexual, emotional).

_____

_____

_____

Briefly describe your relationship with your FATHER when you were a child.

_____

_____

Describe your current relationship with your FATHER.

_____

_____

Briefly describe your relationship with your MOTHER when you were a child.

_____

_____

Describe your current relationship with your MOTHER.

_____

_____

Please describe any significant conflicts you have had with family members.

_____

Whom do you rely on for emotional support?

_____

_____

What belief system (moral, spiritual, cultural, religious) influences your life?

_____

_____

_____

If you attend a church, what is its name? _____

Relationship history

Friends

Do you make friends easily? ____Yes ____No If no, please describe why not.

_____

_____

Romantic relationships

What is your sexual orientation?

_____

What is your marital status?

____ Single ____ Married ____ Divorced ____ Widowed ____ Separated ____ Other

Describe your current relationship, including stressors.

_____

_____

_____

Describe any prior marriages or long-term relationships and the reasons for the divorce/breakup.

_____

_____

If you have children, list their names and ages.

_____

_____

List who currently lives with you.

_____

_____

What problems do you have with your children?

_____

_____

Educational history

What is the highest grade you completed? _____

What kind of student were you?

_____

If you received special educational services, describe them.

_____

How did you get along with your teachers and your peers?

_____

What discipline problems did you have in school?

_____

Occupational history

Are you currently employed? ___ Yes ___ No

Where do you work? _____

How long have you been there? _____

What is your position?

_____

What do you like about your job? _____

_____

What do you not like about your job? _____

_____

What job stressors are you experiencing? _____

_____

How do you get along with your work colleagues? _____

_____

If you have ever been laid off or fired, please describe.

_____

_____

Military history

If you served in the military, what branch did you serve in and when?

_____

If you served in combat or other high risk zones, please describe.

_____

If you were discharged, what type of discharge did you have?

_____

Legal history

Have you been court ordered, now or in the past, to receive counseling? ____Yes ____No

List any current involvement with either the criminal or civil legal system.

_____

_____

Risk assessment

	Past	Now
Have you ever had thoughts of hurting yourself?	____	____
Have you ever had thoughts of committing suicide?	____	____
Have you ever had a plan to commit suicide?	____	____
Have you made threats to kill yourself?	____	____
Have you ever made a suicide attempt?	____	____
Have you ever mutilated yourself?	____	____
Have you ever had thoughts of harming someone?	____	____
Have you ever had plans to harm someone?	____	____
Have you made threats to harm someone?	____	____
Have you ever attempted to harm someone?	____	____

What additional information would be helpful for your therapist to know?

_____

_____

_____

_____

_____

Please mark the times you are available

Time/Day	Mon	Tue	Wed	Thr	Fri	Sat
8 am						
9 am						
10 am						
11 am						
12 noon						
1 pm						
2 pm						
3 pm						
4 pm						
5 pm						
6 pm						
7 pm						

What phone number can we call to schedule an appointment? _____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Protected health information (PHI) is the information we record when we provide counseling services to you. Such information may include your reason for seeking counseling, assessment results, diagnosis, treatment plan, notes from your counseling sessions, and both billing and payment records.

With your consent, Life Connections is permitted by federal privacy laws to use and disclose your health information for purposes of treatment, payment, and health care operations. Here are examples of how we might use your PHI for each of these purposes.

- We use your PHI for treatment purposes when a counselor reviews notes about your last counseling session prior to your next session.
- We use and disclose your PHI for payment purposes when we submit a request for payment to your health insurance company or to any other organization, such as a church, that may be paying for a portion of your treatment costs.
- We use your PHI for health care operations when the Director reviews your records in order to evaluate how well clinical staff members are documenting their counseling services.

Your health information rights:

The health and billing records we maintain are the physical property of this office. The information in it, however, belongs to you. You have a right to:

- Request that we restrict our use and disclosure of your protected health information by delivering the request in writing to our office. We are not required to grant the request, but we will work to comply with any request granted or negotiate with you an acceptable alternative.
- Request that you be allowed to inspect and receive a copy of your health and billing records. You may exercise this right by delivering the request in writing to our office.
- Appeal a denial of access to your PHI except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your PHI.
- Obtain an accounting of all disclosures of your health information to third parties outside this office not associated with treatment, payment, or health care operations, or disclosures made to you.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office.

- Revoke any authorizations that you made previously to use or disclose information by delivering a written revocation to our office. This revocation does not apply to any disclosures your authorized and that have already taken place.
- Review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

If you want to exercise any of the above rights, please contact James Reed, PhD, Director of Life Connections, in person or in writing, during normal business hours. He will help you take the right steps to exercise your rights.

Our responsibilities

Life Connections is required to:

- Maintain the privacy of your health information as required by law
- Provide you with this notice that explains how we protect information that we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we cannot accommodate a requested restriction or request
- Accommodate your reasonable requests regarding methods to communicate health information to you.

Within our rights and responsibilities by law, we reserve the right to amend, change, or eliminate provisions in our privacy and access practices and to enact new provisions regarding the PHI we maintain. Any time our practices change, we will amend our Notice to reflect these changes.

To request information or file a complaint

If you want to file a complaint or report a violation of the privacy of your PHI, please contact James Reed, PhD, Director of Life Connections, in person, or in writing, during normal business hours. You may also file a complaint by mailing or emailing your complaint to the Secretary of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

When will we disclose your PHI

Life Connections will only release, or disclose, your PHI to any person or organization not a part of Life Connections if you give us written authorization to do so. By law, however, we *must* report to legal authorities if we suspect abuse of children, elderly persons, or disabled persons. Such a report would only disclose that you are receiving services at Life Connections. By law, also, we *may* disclose appropriate portions of your PHI if you are receiving services under workers compensation, if you are a danger to yourself or others, or if we are legally compelled by a court order or similar judicial action. In these cases, our practice will be to secure written authorization from you unless doing so is dangerous or will lead to harm to you. You may revoke any written authorization you have given to us at any time.