



239.599.5656 • Fax 239.599.5655
www.LSWpsychology.com • LSWpsychology@gmail.com
8359 Beacon Boulevard, Suite 503 • Fort Myers, Florida 33907

Adult Client Information Form

Full Name: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Primary Address: (street/city/state/zip) _____

Emergency Contact Information: _____

Additional Contact Information: _____

Date of Birth: _____ Age of Client: _____

Name of Current Primary Care Physician _____ Phone # _____

How did you hear about us? _____

Reason for Referral: _____

Insurance Information

Insurance Company: _____ Insurance Phone Number: _____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Subscriber's Social Security # _____ Subscriber's Employer: _____

Subscriber's Address: _____

Member ID# _____ Group# _____

Specialist Copay: _____ Specialist Coinsurance: _____

PLEASE NOTE: In an effort to facilitate communication, LSW Psychological Services sends **TEXT MESSAGE** confirmations the business day prior to your scheduled appointment. Our office will also **E-mail** receipts for payments or account statements to the provided E-mail address. If you would like to use a phone number or E-mail address other than the ones listed above to receive copies of your receipts/statements, please list them on the line below. If you **do not** want to receive these communications, please write "I decline" on the line below:



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Adult Background History:

Name: _____

Date of Birth: _____ Initial Appointment Date: _____

Handedness: _____ Language(s) Spoken: _____

Social History:

Where were you born? _____

Please list all of the different cities/states in which you have lived since birth:	Ages or Years

Parents' Names: _____

Is your mother living? Yes No

Is your father living? Yes No

If no, please explain when and how they passed away.

Are your parents still married to each other or together? Yes No

If not, please explain when they divorced/separated: _____

Are your parents re-married? Yes No

Mother's Job: _____ Father's Job: _____

If your parents were divorced how often do/did you see your parent who does/did not live with you?

How many sisters do you have? _____ How many brothers do you have? _____

Please list your sisters/brothers names, ages, current jobs and any learning problems.

Name	Age	Current Job	Any learning problems?	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Has how you were treated and raised as a child had more of a positive or negative effect on your personality? Positive Negative

If you circled negative, please explain:

Are there any traumatic events that have influenced your life?

Were you ever abused or mistreated? Yes No

If yes, please circle all that apply: _____ None

Sexual Abuse	Physical Abuse	Emotional Abuse	Neglect
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Was the Department of Children and Families (DCF) ever involved with your family as a child?

Yes No

Has anyone in **your family** been diagnosed with any of the following? _____ None

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Disability (MR)	Substance Abuse/Alcoholism	Autism
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Other			

Current Family History:

Have you ever been married? Yes No How many times? _____

Spouse Name	Date Married	Date Separated/Divorced

Who do you currently live with? _____

Do you currently have a boyfriend/girlfriend? Yes No

How long? _____

Describe any common problems in your romantic relationships:

Do you have difficulty making friends? Yes No

Do you have difficulty keeping friends? Yes No

Number of close friends: _____

How often do you spend time with them? _____

Describe any common problems in your relationships with friends:

Currently, what do you do for fun?

Do you have any children? Yes No

Name of child	Age	Current Job	Any learning problems?	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Custody Status: Full Time: _____ 50/50 Split: _____ Weekends: _____

No Contact: _____ Other: _____

Has DCF been involved with your current family? Yes No

If yes, explain:

Developmental History:

Circle any of the following that were problems with **your** birth or delivery. _____ Within normal limits

Premature	Low Birth Weight	Gestational Diabetes	Jaundice
C-Section	Mom drank alcohol	Mom smoked	Mom used illegal drugs

Circle below whether you met your developmental milestones on time:

Talking? Yes No Walking? Yes No Toilet Training? Yes No

Did you have any speech difficulties? Never As a child Currently

Did you ever receive speech therapy? Yes No If so, when? _____

Have you ever received occupational therapy? Yes No If so, when? _____

Have you ever received physical therapy? Yes No If so, when? _____

Medical History:

Place an "X" in the appropriate range if you have suffered from any of the following: _____ None

Medical Disorder	As a child/teenager	As an adult
Chronic Ear Infections		
Cancer		
HIV/AIDS		
Heart Attack		
Concussion		
Seizure/Epilepsy		
Broken Bones		
Chronic Stomach Problems		
Asthma		
Meningitis		
Multiple Sclerosis		
Thyroid Condition		
High Blood Pressure		
Diabetes		
Other		

Have you ever had surgery? Yes No If Yes, explain:

Any visual difficulties? Yes No Do you wear glasses or contacts? Yes No

Any hearing difficulties? Yes No Do you wear a hearing aid? Yes No

Circle any mental health disorder in which **you** have been diagnosed: _____ None

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Disability (MR)	Substance Abuse/Alcoholism	Autism
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Other			

Please list any prescription medications that you currently use: _____ None

Medication	For What?	Doctor Who Prescribed?

Mental Health History:

Circle any of the following which have been an issue for you over the past year:

Getting to work/school on time	Fidgeting	Eating too little/too much	Getting along with people
Nervousness/Anxiety	Sad most of the day	Suicidal thoughts	Paying attention
Poor communication	Restlessness	Emotional control	Anger management
Self-esteem	Not thinking before I act	Self-injury	Organization
Easily distracted	Talk too much	Risky/Illegal behavior	Obsessions
Irritability	Loss of interest in normally enjoyable activities	Phobia with _____	
Excessive spending	Sleep too much/too little	Vomit after eating	Hallucinations
Bizarre thinking	Hoarding	Unproductive rituals	Forgetfulness
Few close friends	Procrastination	Test Anxiety	Panic attacks

Have you been to counseling before? Yes No If so, when? _____

Who was the therapist? What were you treated for?

Have you ever received inpatient hospitalization for a mental health issue? Yes No

If yes, explain each placement.

Have you ever attempted suicide? Yes No How many times? _____

Please explain each attempt:

Drug and Alcohol Use:

Please circle all substances you have used in the past: _____ None
Alcohol, PCP (angel dust), marijuana, amphetamines (speed), cocaine, crack cocaine, hallucinogens
(acid, mushrooms), ecstasy, methamphetamine (meth), opium, heroin, sleeping pills, pain killers

Please include last use for any items circled _____

What substances do you currently use? How often?

Have you ever been treated for drug or alcohol abuse? Yes No

If so, when and where?

Have you ever lost a job or relationship because of substance abuse? Yes No

If so, when and what happened?

Have you ever been in legal trouble for drug or alcohol abuse? Yes No

If so, when and what happened?

Legal History:

Have you ever been in trouble with the law? Yes No

If so, when and what happened?

Offense	Date	Length of jail time, probation, or fine

Educational History:

Did you attend Preschool? Yes No If so, where? _____

Please list all of the schools you have attended.

School	City, State	Ages or Years or Grades Attended

Did you graduate high school? Yes No When did you graduate? _____

If you have not graduated, when do you expect to? _____

Did you graduate with a standard diploma? Yes No

If you did not graduate high school, did you get a GED? Yes No

Do you intend to go to college? Yes No

Have you attended any college? Yes No Major _____

Did you graduate from college? Yes No Degree _____

If you attended college but did not finish, please explain.

Did you have an Individualized Education Program (IEP)/504 Plan? Yes No

Were you in special education/Exceptional Student Education (ESE) in school? Yes No

If so, which grade were you in when you began special education? _____

Circle any disability that you were placed in ESE/special education for:

Reading learning disability	Math learning disability	Writing learning disability	Speech impaired
Hearing impaired	Visually impaired	Emotional disturbance	Mental retardation
Autism/Asperger's	Traumatic Brain Injury	Medical impairment	Other

What types of accommodations or help with school do/did you receive (mark all that apply)?

Extended time on tests	Tests taken in a quiet space	Tests taken in small group	Additional time to complete assignments
Intensive Reading	Intensive Mathematics	Social-Communication Classroom	Behavior Unit Classroom
Intensive English/Language Arts	Speech or Language Therapy	Occupational Therapy	Physical Therapy
Shortened Assignments	Subjects taught below grade level curriculum	Exempt from state-wide standardized tests	Functioning Living Skills Classroom

Did you ever have to repeat a grade? Yes No If so, what grade(s)? _____

Did you ever get in trouble at school? Yes No If so, when did it start? _____

Did you ever get detentions? Yes No Did you ever get suspended? Yes No

What types of behaviors did you get in trouble for at school?

Did you ever get expelled from school? Yes No What grade were you in? _____

If so, why were you expelled?

Please list any after school activities that you participated in (e.g., clubs, sports)

Daily Living:

Can you drive a car?	Yes	No
Do you have a driver's license?	Yes	No
Do you own/lease your own car?	Yes	No
Can you do your own laundry?	Yes	No
Can you calculate change?	Yes	No
Can you do your own grocery shopping?	Yes	No
Can you cook for yourself or your family?	Yes	No
Can you bathe and dress yourself without help?	Yes	No

Financial History:

Have you ever filed for bankruptcy? Yes No

If yes, please explain.

Describe your current debt: _____

You are financially dependent on (circle all that apply): Self Spouse Parents/Family
SSI/SSID Other: _____

Do you own your home or pay rent?

Are you able to pay your bills on time? Yes No

If No, explain why?

Do you have a checking account? Yes No

Describe any difficulties that you have maintaining your finances:

Job History:

In order, please list your job titles, where you worked, how long and why you left? _____ None

Job Title	Business Name	How long?	Why did you leave?

Can you complete a job application without help? Yes No

Circle any of the following that have made it difficult for you to find or keep a job?

Reading	Math	Writing	Medical	Alcohol/Drugs	Mental Health	Legal
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At work, do you have difficulty getting along with supervisors? Yes No

At work, do you have difficulty getting along with co-workers? Yes No

At work, do you have difficulty getting along with customers? Yes No

Have you ever been fired from a job? Yes No

If yes, please explain.

What strengths do you offer a job?

What are your weaknesses on the job?

What types of jobs would you like to do in the future?

What types of jobs would you not like to do in the future?



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**Patient Consent for Use and Disclosure
of Protected Health Information (HIPPA Acknowledgement)**

I hereby give my consent for LSW Psychological Services to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by LSW Psychological Services describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

LSW Psychological Services reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. LeighAnn Wong (239) 599-5656.

With this consent, LSW Psychological Services may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, LSW Psychological Services may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, LSW Psychological Services may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that LSW Psychological Services restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow LSW Psychological Services to use and disclose my PHI to carry out TPO.

in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LSW Psychological Services may decline to provide treatment to me.

Name of client

Date

Signature of adult client or parent/guardian of client



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Financial Responsibility and Guarantee of Payment for Services

Thank you for choosing LSW Psychological Services to work with you and/or your family. By signing this form, you agree to be charged for direct and indirect services that we provide. Direct services include but are not limited to: face to face counseling, assessment/evaluation, consultation, and observation. Indirect services include but are not limited to: attend IEP meeting, advocacy, report writing, and phone calls over 10 minutes. The standard hourly (50-minute) rate is \$180. Assessment/Evaluation services involve billing for actual hours spent testing and time spent scoring, interpreting, and writing up results. Comprehensive reports generally require 2 to 5 hours and insurance companies rarely pay for this service.

Appointments are specifically held for the client and it is important that you give us 24 hours notice if you intend to cancel. If we do not receive notification within that time frame then we cannot fill that time slot with another client; therefore, we will charge you up to our standard hourly rate (\$180/hr) for the late cancellation. For returned checks, you are expected to pay the bank fee and the full charge for those services in cash.

By signing this form, you are also consenting to allow LSW Psychological Services to contact your insurance company regarding payment of services. It is your responsibility to understand your insurance plan. Any precertification which is required by your insurance company must be done prior to your appointment. This must be submitted to LSW Psychological Services before services are rendered. It is difficult to understand all of the caveats of each insurance company and you will be responsible for payments which are not covered by your insurance company. Any issues with reimbursement are the responsibility of the client and the insurance company, not LSW Psychological Services.

If you would like to have a credit card on file, please provide the credit card information below. We do not accept American Express: **VISA MASTERCARD DISCOVER** _____ I decline

Full name on card _____ Expiration Date _____

Credit Card # _____ Security Code _____

By signing below, you authorize LSW Psychological Services to charge your card for any unpaid balance after insurance discounts. If your carrier does not pay within 30 days and you are notified by phone/email, you will be given an additional 10 days to settle the balance. If not, your card will be charged for the unpaid balance.

Name of client

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Informed Consent

I, _____, voluntarily give consent to LSW Psychological Services for the purposes of psychological services. (*If applicable*: This consent also includes psychological services for my child/children _____.) These services may include but are not limited to: psychological assessment or evaluation, counseling, consultation, parent training, and study skills enhancement. I understand that psychological services are confidential with the exception of the following scenarios: (A) knowledge or reasonable suspicion of harm to self or others, (B) knowledge or reasonable suspicion of child or elder abuse, and (C) court order for information regarding your case. Psychological services are intended to be beneficial in the improvement of mental health or academic concerns; however, none of these benefits are guaranteed. You may disagree with the opinions offered to you and emotional distress may result from sensitive matters which are addressed during the course of psychological services. Alternative referrals to another health care provider will be given if desired. LSW Psychological Services provides only outpatient mental health services and does not guarantee emergency intervention, particularly if it is necessary after business hours. If you require emergency services after business hours, please call 911 or Lee Mental Health Care (239) 275-3222.

By signing below, I confirm that I have read this form in its entirety or it was read to me, and I understood the information included in it. I have no additional questions and I have clarified any information with which I disagree. I concur that my consent is voluntary and can be revoked at any time.

Name of client

Signature of adult client or parent/guardian of client

Date