LAKES
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Lakes Psychiatric Center
Adult Life History Questionnaire

Please answer as completely as you can and return this form at your scheduled appointment.

Appointment Date:	Interested in online sessions?
How did you hear about Lakes Psychiatric Center?	

Name	Age	Sex	Date of Birth
Address City, State Zip	Social Security Number (needed for insurance)		
May we send discrete appointment reminders to your email? YES ☐ NO ☐ ***Check boxes below for what numbers we can leave messages on.***	Primary email address ☐		
Home Phone ☐	Cell Phone ☐	Work Phone ☐	Secondary email address ☐
Emergency Contact Name	Relationship	Address Phone Number	
Marital Status: Single ☐ Married ☐ Other ☐ _____ Employed ☐ Fulltime Student ☐ Part-time Student ☐ Unemployed / Other ☐ _____ Children: YES ☐ NO ☐ If YES, ages: _____			
Religion	Ethnicity		

INSURANCE

Primary Insurance Company	Contract Number	Group Number
Name of Subscriber	Subscribers Date of Birth	Relationship to Subscriber
Employer	Subscribers Address	
Effective Date	Mental Health Ins (if diff)	Prescription coverage YES ☐ NO ☐
Secondary Insurance Company	Contract Number	Group Number
Name of Subscriber	Subscribers Date of Birth	Relationship to Subscriber
Employer	Effective Date	Mental Health Provider

PRESENTING PROBLEM

What is the **problem that brought you to LPCC**? _____

When did this episode begin? _____

Is there a **prior history** of these episodes? YES ☐ NO ☐ If yes, how many? _____

Does it effect: Relationships? YES ☐ NO ☐ Work? YES ☐ NO ☐ School? YES ☐ NO ☐ Leisure Time? YES ☐ NO ☐

Name three (3) things you would like changed in your current situation:

1. _____
2. _____
3. _____

MENTAL HEALTH HISTORY

Have you ever had a significant period of time in which you have experienced:

Serious **Depression**? YES ☐ NO ☐ If yes, explain: _____

Serious **Anxiety**? YES ☐ NO ☐ If yes, explain: _____

See or hear things others can't? YES ☐ NO ☐ If yes, explain: _____

Trouble understanding, **concentrating** or remembering? YES ☐ NO ☐ If yes, explain: _____

Mood swings? **Irritability**? **Racing thoughts**? YES ☐ NO ☐

Serious thoughts of **suicide**? YES ☐ NO ☐ If yes, explain: _____

Self harm (without intent to die)? YES ☐ NO ☐ if so, what behaviors?

Have you experienced **trauma or abuse**? Physical ☐ Emotional ☐ Sexual ☐ Other ☐
Explain:

What **treatment** have you had in the past for these issues? (**provide medication information on page 3**)

Talk Therapy ☐ Explain: _____

Hospitalization/Day Treatment ☐ (approx. year and reason): _____

ECT ☐ TMS ☐ Ketamine ☐ Explain: _____

Would you like us to obtain copies of your **old records**? YES ☐ NO ☐
If yes please bring the treater's contact information to your appointment and ask to complete a consent form.

OFFICE USE – MENTAL HEALTH _____

MEDICAL HISTORY

Present state of **general physical health**: Excellent ☐ Good ☐ Fair ☐ Poor ☐ **Current weight**?_____

Describe your **present sleeping pattern** (hours per night, restful or not, problems getting to sleep or waking early):

Did you have any **medical problems during childhood** or adolescence? YES ☐ NO ☐ Explain: _____

Do you have any **current medical problems**? YES ☐ NO ☐
Explain: _____

List any significant **hospitalizations** or surgeries: _____

ALLERGIES: ***Check here if NONE*** ☐ _____

MEDICATIONS *Check here if attaching a separate list* ☐

List all *current* medications or over the counter medications

Medication	Dose	Frequency	How Long?	For	Prescribed by: PCP	Psychiatrist
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

List any *previous* psychiatric medications

Medication	Highest Dose	Was it effective?	Side effects	Prescribed by: PCP	Psychiatrist
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

OFFICE USE – MEDICAL/MED _____

SUBSTANCE USE HISTORY or NONE ☐

Indicate the amount and frequency of use of the following:

	Amounts	Frequency	Currently using?	How Long?
Alcohol			YES ☐ NO ☐	
Nicotine			YES ☐ NO ☐	
Caffeine			YES ☐ NO ☐	
Marijuana			YES ☐ NO ☐	
Illicit Drugs			YES ☐ NO ☐	
Prescription med abuse			YES ☐ NO ☐	

Indicate **substance(s) of preference**: _____

Substance abuse **treatment** type & dates: _____

Was this treatment prompted/ordered by criminal justice system? YES ☐ NO ☐ Explain: _____

ADULT/MARITAL HISTORY

Name (spouse, children, others living w/ you)	Relationship	Age	Quality of Relationship	**Mental Disorder?**
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

What mental disorders? _____

Any significant **issues with your children** as they are/were growing up? _____

Currently? _____

Who is your **support system**/provides guidance? _____

With whom do you spend most of your **leisure time** with? Family ☐ Friends ☐ Alone ☐ Other ☐

Favorite activity or hobby?

Never Married ☐ Married ☐ How Long? _____ Separated ☐ Widowed ☐ Divorced ☐

Living Together ☐ How long? _____

Date of present marriage or date you began living with your present partner: _____

What are your feelings about the above relationship in general? _____

How is the sexual relationship? _____

Describe your partners characteristics as a person: _____

Previously Married? YES ☐ NO ☐ If yes, length of marriage/how long/any conflicts with ex-spouse/children?

CHILDHOOD/FAMILY/EDUCATION HISTORY

How was your **relationship with your Mother/Female caregiver** growing up? _____

Currently? _____

How was your **relationship with your Father/Male caregiver** growing up? _____

Currently? _____

How did your **parents/caregivers get along with *each other*** while you were growing up? _____

Currently? _____

How was your **relationship with your siblings**/other children growing up? _____

Currently? _____

Name (your parents and siblings)	Relationship	Age	Quality of Relationship	**Mental Disorder?**
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

What type of mental health issues? _____

List **any other relatives with a history of emotional or mental disorder or suicide** (include diagnosis and treatment if known):

Have any of your **relatives ever had a serious problem with drugs or alcohol**? YES ☐ NO ☐

If so, relative: _____ Substance: _____

If so, relative: Substance:

YOUR BIRTH HISTORY and DEVELOPMENT

Did your mother use alcohol or drugs during pregnancy? YES ☐ NO ☐ UNK ☐

Did your mother have any problems during pregnancy? YES ☐ NO ☐ UNK ☐

Did your mother have any problems during labor or delivery? YES ☐ NO ☐ UNK ☐

Did you have any problems immediately after birth? YES ☐ NO ☐ UNK ☐

Did you have any developmental delays? YES ☐ NO ☐ UNK ☐

EDUCATION

Did you have any specific learning issues **in school**? YES ☐ NO ☐ UNK ☐

Were you: Frequently absent ☐ Suspended ☐ Expelled ☐ Bullied ☐

If yes explain: _____

Highest level of **education**: _____ Degree: _____

OFFICE USE – PERSONAL HISTORY _____

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

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **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	

EMPLOYMENT

What has been your **usual employment pattern** in the past 5 years? Full-time (35+hrs per week) ☐ Part-time ☐
Military Service ☐ Student ☐ Retired ☐ Disability ☐ Unemployment ☐ Other: _____

Current Occupation: _____ Employer: _____

How long have you worked at your present job? _____ FULL TIME ☐ PART TIME ☐

How **satisfied** are you with your present job? _____

Any **significant problems in past or present job situations**? _____

How are you **relationships with fellow employees**?

With Supervisors? _____ With Subordinates? _____

Are you or have you been on: **Social Security Disability (SSD)** ☐ Supplemental Security Income (SSI) ☐ Workers Comp ☐

How many people depend on your **income**?

LEGAL HISTORY or NONE ☐

Any past or present litigation or **legal problems**? YES ☐ NO ☐ If YES, please explain: _____

How many times have you been arrested and charged with any of the following:

	Major Driving Violation		Burglary or Robbery	Other:
	Driving While Intoxicated		Weapons Offense	
	Public Intoxication		Assault	
	Disorderly Conduct		Parole/Probation Violation	
	Drug Charges		Contempt of Court	
	Shoplifting		Domestic Violence	

Have you ever been ordered by the court for treatment? YES ☐ NO ☐ If YES, please explain: _____

Have you ever been: Incarcerated ☐ Arrested ☐ Community Service ☐ Treatment Programs ☐ Probation ☐
Other ☐ Explain: _____

Date	Length of Incarceration	Reason

MILITARY HISTORY or NONE ☐

Have you served in the **military**? YES ☐ NO ☐ How Long: _____
Type of discharge: _____
Combat exposure ☐ Traumatic experiences ☐ Service connected disabilities ☐ Explain: _____

Thank you for completing this detailed form. It will be saved in your clinic record and is kept confidential.

_____ _____
Form completed by: Print Name **Date**

_____ _____
Reviewing LPCC Staff Date

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Primary Care Physician Notification Form

THIS IS **NOT** A REQUEST FOR MEDICAL RECORDS

ATTENTION PRIMARY CARE PROVIDER-- Your patient is being seen at:
Lakes Psychiatric Center, 2300 Haggerty Rd., Ste. 2160, W. Bloomfield (P): 248-859-2457 (F): 248-859-2473.
With patient authorization, we herein provide diagnoses and medications, including medication changes. Please retain for your records.

Patient Name: _____

DSM Diagnoses (including codes): _____

_____

Treatment Information, including medications: _____

_____

_____

_____

_____

Therapist/Psychiatrist Signature Print name and credentials

ATTENTION PATIENT-- If you would like us to notify your primary care doctor that you are receiving services here, please provide the complete name, phone number and fax number of your primary Care Physician.

Primary Care Physician or Clinic Name: _____

Phone number: _____ Fax number: _____

Please read and complete the following:

I (name)_____ DOB: _____ authorize Lakes Psychiatric Center to exchange information regarding my mental health, substance abuse or medical health for the purposes of continuity of care, as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on my mental health or substance abuse treatment as protected under 42 CFR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care provider and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for 1 year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to LPCC. I also understand that it is my responsibility to notify my behavioral health care provider if I chose to change my primary care physician.

If you **do not** want to authorize us to notify your primary care physician, please complete the section below:
_____ I don't have a primary care/family doctor.
_____ I don't want my primary care/family doctor to know I'm receiving services.
_____ I just don't want to.

_____ _____
Patient Signature or Parent/Guardian if patient is a minor Date

_____ _____
Witness Signature Date

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The following pages provide important information about our practice. Please ***review and then remove them from the packet*** *and keep for your future reference. By* ***initialing below*** *you acknowledge that you*

_____have been made aware of my rights and responsibilities as a client

_____have been informed of practice specific information and given an orientation to services

_____are aware of LPCC privacy practices and know I can ask for a detailed description

_____understand confidentiality and the limits of it as it pertains to adults/minors

_____ have reviewed and understand the LPCC financial agreement and how to contact the billing department with questions or issues

_____give permission to bill your insurance and agree to pay out of pocket costs (toward deductibles, copays, coinsurance fees, previous missed appt fees or additional service fees as listed in the agreement) at the time of the appointment

My signature below indicates my understanding of the above policies and I consent to treatment at Lakes Psychiatric Center. I understand I can ask for further information and retain the ability to terminate my consent at any time.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Reviewing LPCC Staff **Date**

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Practice Orientation and Agreement

Your Rights and Responsibilities as a Client:

- You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
- You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
- You have the **right to privacy and confidentiality** regarding the services you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act. Information may be disclosed for various reasons including: to provide treatment, for payment purposes, health care operations, appointments, as required by law, public health, descendents, health and safety, and workman's compensation. (detailed description provided upon request)
- You have the responsibility to provide **informed consent to services** offered to you.
- You have the responsibility to **follow our financial agreement**. (detailed on the following page)

Services Offered:

Lakes Psychiatric Center **offers an array of mental health and substance abuse services**. These services include: individual psychotherapy, DBT, family therapy, marital therapy, psychiatric evaluations and medication therapy. We also provide a ketamine based treatment. Appointments may be in-office or online. Your clinician will provide you with a detailed description of the nature of services, expected benefits and potential risks.

Operations:

Appointments may be **individually arranged from 8:00 am and 10:00 pm, 7 days a week**. Not all clinicians are available during all hours. Office staff hours depend on the day and volume of patients. Please call the office to verify hours for that day. Appointment dates and times, and after-hours contact, will be arranged between you and your treating clinician. **In case of an emergency, you can also contact the nearest crisis center (Oakland County Crisis Line at 800-231-1127) or you may visit the nearest emergency room.** We practice in a non-smoking environment. Illicit drugs and weapons are not allowed on the premises. Persons in possession of either will be asked to leave immediately.

Minors and Parents:

Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that clients over age 14 can consent to (and control access to information about) their own mental health treatment (although that treatment cannot extend beyond 12 sessions or 4 months). Lakes Psychiatric Center policy is to request (but not require) an agreement from any client between ages 14 and 18 and their parents allowing clinicians to share general information with parents about attendance at scheduled sessions and progress in treatment.

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Financial Agreement:

Standard fees for services are available upon request. I understand that these are the charges established for services by Lakes Psychiatric Center, PLLC and these charges will be submitted to my insurance company. I also understand if I fail to sign the HIPAA forms and the financial agreement, my insurance company will not be billed for my services and I will have to pay direct out of pocket fees set by Lakes Psychiatric Center, PLLC
Lakes Psychiatric Center, PLLC will check your insurance coverage as a courtesy. When we call, we are always told that the information given by the insurance company is not a guarantee of benefits or payment and the information provided may not be current. **Ultimately, it is your responsibility to understand your individual coverage. Therefore, we strongly encourage you to check with your insurance company prior to any services.**

The billing staff will charge you according to the information quoted to us by your insurance company on the date of service. When we receive payment, if your insurance company has determined you owe additional charges, as required by law, you will be billed. If we determine you have overpaid, we will offer different options for a refund.

Please keep in mind all payments are due at the time of service. **Balances must be kept below $200 to continue treatment or receive refills on medications.** Any paperwork, samples or medication pick up from our office require balances to be paid when receiving them. For **prior authorizations, refills, or the provision of medical records there may be a fee charged to your account for $10-$50 depending on complexity. For any requested letters, form completions and phone consultations which require your therapist or doctor additional time outside of your appointment you may be charged up to $150 an hour.** You may pay over the phone with a credit card, with a check to LPCC or with cash.

In order to continue services, please make sure your account is below our office policy standard of $200 or you have an active payment plan set up with the billing department. Each time a delinquent statement is sent by email or mail, there will be a $10 late payment fee added to your account. Lakes Psychiatric Center, PLLC does not mail statements out regularly. When we do delinquent account mailings, roughly every three months, we will send a bill to your house with this $10 fee added. If you need a bill before that time for any reason, you must contact the billing department and request a bill to be sent to you. If you need to set up a payment plan, please contact our **billing department at (248) 313-9550**.

If you are doing **online appointments**, a credit card must be kept on file for online appointments and phone appointments. You must fill out a Credit Card Authorization Form so that the payment may be made at the time of service. It is your responsibility to inform the staff member or clinician to charge your card on each and every visit.

Keep in mind that all appointments need to be cancelled with a 24-hour business day notice in order to not be **subjected to a missed appointment fee, which can be up to $150**. Please contact your individual provider for more information about missed appointment fees as each have their own rates and decide if cancellation fees are charged or waived. Payment of missed or late cancelled appointments are to be paid before your next service with Lakes Psychiatric Center, PLLC or treatment and medication refills may be suspended.

Please remove these 2 pages and keep for future reference