



Adult Intake

In order to ensure a full understanding of your health history please complete the following questionnaire.

Name _____

DOB: _____

Occupation _____

Address _____

Phone numbers, circle best contact

H _____ C _____ W _____

E-mail _____

In Case of Emergency Contact:

Phone _____ Relationship: _____

Name and ages of children _____

Married? Divorced? Widowed? Partnered? Single?

Primary Care Physician _____ Phone: _____

Date of last physical _____

Serious Medical Illnesses/Accidents (Identify and give dates)

Are you on any medications? Y N If yes, please list. _____

1121 Olivette Executive Parkway
Suite 205
St. Louis MO 63132

314 991-9058
lee@leebascom.com

Any previous counseling? Y N

With whom? _____

When? _____

Helpful? _____

Are you or have you been under the care of a psychiatrist? Y N

If yes, with whom and when?

Have you ever been treated for alcohol or drug abuse? Y N

If so, when and where

Have you been the victim of physical or sexual abuse? Y N

Do you have suicidal thoughts? Y N

Have you had a suicide attempt? Y N

Describe _____

Do you smoke? _____ Yes _____ No

What brings you to see me today?

What do I need to know about you to work effectively together? _____

How will we know when things are better?

Is there anything else I need to know to be helpful?

Consent to Treatment

I do hereby seek and consent to take part in the treatment by Lee Bascom, MSW, LCSW. I understand that developing a treatment plan with this clinical social worker and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this clinical social worker. I am aware that I may stop my treatment with this clinical social worker at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must call to cancel an appointment at least 24 hours (1day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the clinical social worker may stop my treatment. My signature below shows that I understand and agree with all of these statements.

Signature of client or guardian

Date

I, Lee Bascom, MSW, LCSW have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Clinical Social Worker

Date

FINANCIAL AGREEMENT AND CANCELLATION POLICY

You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage which requires another arrangement. You will always be expected to pay the insurance co-pay at the time of service.

Returned checks will be charged a \$30 fee for insufficient funds.

In the event that I bill your insurance company and they do not pay, you will be responsible for payment in full.

If I am not a participating provider on your insurance plan, I will provide you with a billing statement that you can file with your insurance company. I will expect you to pay me at the time of each session unless we make other arrangements.

Please let me know if you are not able to keep your scheduled appointment at least 24 hours in advance.

Appointments missed without notification or cancelled within 24 hours may be charged the full cost of the appointment.

I will understand if you come to the appointment late but please know that we will end on time so that we will not be cutting into someone else's appointment.

Signature _____

Print Name _____

Date _____

AUTHORIZATION TO USE UNENCRYPTED EMAIL TO COMMUNICATE PROTECTED HEALTH INFORMATION

Thank you for your request to communicate with me via email. I want to make sure you know that email communications between us are not encrypted and therefore are not secure communications. If you elect to communicate with me from your workplace computer, you also should be aware that your employer and its agents may have access to email communications between us. Finally, email communications may become a part of your client file. The types of transactions available by email are limited consultation, prescription refills, and patient education.

Incoming email communications will be reviewed and answered as soon as possible. If you have not heard from me with 24 hours, please call me at (314) 991-9058 during regular office hours (8:30-4:30).

EMAIL SHOULD NEVER BE USED IN THE CASE OF AN EMERGENCY OR FOR URGENT REQUESTS FOR INFORMATION.

Please sign below if you accept these terms and conditions.

ACCEPTED:

Signature of client/guardian _____

Client name (if child) _____

Authorized e-mail address of client/
guardian _____

Date: _____

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Client Name: _____
DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lee Bascom's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lee Bascom, MSW, LCSW at (314) 991-9058.

Signature of Client **Date**

Signature or Parent, Guardian or Personal Representative **Date**

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Client Refuses to Acknowledge Receipt:

Adult Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- I have no problem or concern bringing me here
- Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores—quality, schedules, sharing duties
- Inferiority feelings

- Interpersonal conflicts
 - Impulsiveness, loss of control, outbursts
 - Irresponsibility
 - Judgment problems, risk taking
 - Legal matters, charges, suits
 - Loneliness
 - Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
 - Memory problems
 - Menstrual problems, PMS, menopause
 - Mood swings
 - Motivation, laziness
 - Nervousness, tension
 - Obsessions, compulsions (thoughts or actions that repeat themselves)
 - Oversensitivity to rejection
 - Panic or anxiety attacks
 - Parenting, child management, single parenthood
 - Perfectionism
 - Pessimism
 - Procrastination, work inhibitions, laziness
 - Relationship problems (with friends, with relatives, or at work)
 - School problems (see also "Career concerns . . .")
 - Self-centeredness
 - Self-esteem
 - Self-neglect, poor self-care
 - Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
 - Shyness, oversensitivity to criticism
 - Sleep problems—too much, too little, insomnia, nightmares
 - Smoking and tobacco use
 - Spiritual, religious, moral, ethical issues
 - Stress, relaxation, stress management, stress disorders, tension
 - Suspiciousness
 - Suicidal thoughts
 - Temper problems, self-control, low frustration tolerance
 - Thought disorganization and confusion
 - Threats, violence
 - Weight and diet issues
 - Withdrawal, isolating
 - Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- Any other concerns or issues:

Please look back over the concerns you have checked off and choose the one that you most want help with.