LifeSteps Lewisville I
Adult Counseling Registration Forms

Welcome to our facility! We would appreciate you taking a few minutes to complete this in its entirety. If you need help or have any questions, please do not hesitate to contact one of our fine staff. Thank you!

PATIENT INFORMATION			
Patient's Name:		DOB:	❑ Male ❑ Female
Address:			
City:	ST:	Zip:	SSN:

FAMILY INFORMATION				
Individuals Living in the Home		**Parents or Siblings Living Outside the Home**		
Member	Relationship	Age	Member	Relationship

EMERGENCY CONTACTS		
Contact Name	Telephone Number	Relationship
1.		
2.		

PHYSICIAN INFO			
Primary Care:			
Address:			Work #:
City:	ST:	ZIP	Fax#:
Referring Physician (if different from above):			
Address:			Work #:
City:	ST:	ZIP	Fax#:

BILLING INFO				
Funding Source:	❑ Private Pay	❑ Medicaid		

LifeSteps Lewisville I
Adult Counseling Registration Forms

BACKGROUND	*Please answer the following questions by checking the appropriate answer*			
1.	What are your main concern/the reason you have chosen to seek help?			
2.	When was the problem first noticed and by whom?			
3.	Has there been an abrupt change since problem was first noticed?	❑ Yes	❑ No	
4.	Are you being seen by any other specialist?	❑ Yes	❑ No	
	If so, what kind?			
5.	Have you recently received any diagnosis?	❑ Yes	❑ No	
	If yes, please explain:			
6.	Please describe your concerns:			
7.	Any other issues?	❑ Yes	❑ No	
	If yes, please explain:			
8.	What language(s) do you speak primarily?	❑ English	❑ Spanish	❑ Other

FAMILY & PATIENT GOALS	*Please answer the following question*	
1.	What are your goals for your nutrition?	
ALLERGIES	*Please list any types of allergies you have, if known*	
1.		

I certify that the above information is correct to the best of my knowledge. I will not hold my therapist/doctor/ nurse or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.			
Patient/Guardian Signature:		Date:	
Reviewed By:		Date:	

REVIEW OF SYMPTOMS

CLIENT NAME: **DOB:**

Yes	No		ADHD
		Impulsivity	
		Physical or verbal over activity	
		Inattention	
		Difficulty with organization	
		Distractibility	
Yes	**No**		**ODD**
		Tantrums	
		Argumentative	
		Blames others	
		Challenges rules	
		Easily frustrated	
Yes	**No**		**MOOD**
		Depressed, irritable or expansive	
		Social withdrawal or isolation	
		Wt., appetite, sleep, or energy changes	
		Motor retardation, acceleration, agitation	
		Psychic retardation, acceleration, agitation	
		Feeling worthless	
		Indecisiveness	
		Suicidal ideation, attempt or plan	
		Morbid preoccupation	
		Grandiosity	
		Hypersexuality	
		Homicidal ideation, attempt or plan	
Yes	**No**		**CONDUCT**
		Verbal or Physical aggression	
		Destruction of property	
		Deceitfulness or theft	
		Violations of rules	
		Run away behavior or truancy	

LifeSteps Therapy for Kids

REVIEW OF SYMPTOMS

CLIENT NAME: **DOB:**

		Fire Setting	
Yes	**No**	**MOTOR**	
		Tics	
		Stereotypies	
Yes	**No**	**ANXIETY**	
		Worries or fears	
		Nervous habits, obsessions compulsions	
		Separation, school refusal, avoidance	
		Somatization	
Yes	**No**	**PSYCHOSIS**	
		Hallucinations/ delusions	
		Bizarre behavior, beliefs or speech	
		Disorganized thoughts	
Yes	**No**	**PDD**	
		Impaired social interactions	
		Ritualistic, repetitive behaviors	
		Loss of skills	

Comments: ____

____

Are Immunizations Current: YES NO

Nutritional Needs/Medications: ____

Medication Allergies: ____

Other Allergies: ____

Surgeries: ____

Medical History: ____

Completed by: ____

LifeSteps Therapy for Kids

PSYCHOSOCIAL HISTORY

CLIENT NAME: **DOB:**

Evaluation of Problem: ____

____

____

Custody/Visitation Issues: ____

____

Activities/Hobbies: ____

____

Mother's Family of Origin: ____

____

____

Father's Family of Origin: ____

____

____

Other Significant Family Circumstances/Stressors: ____

____

____

____

Family Dynamics: ____

____

____

____

Barriers to Learning: ____

____

Additional Referrals ____

____

Completed by: ____

LifeSteps Therapy for Kids

TREATMENT PLAN

CLIENT NAME: **DOB:**

PROBLEM LIST:

1. ____
2. ____
3. ____

DIAGNOSIS:

Axis I: ______________________ R/O ______________________
______________________ R/O ______________________
______________________ R/O ______________________

Axis II: ______________________ R/O ______________________
______________________ R/O ______________________

Axis III: ______________________ R/O ______________________
______________________ R/O ______________________

Axis IV: ____

Axis V: Current: _________ Highest in last 12 months: _________

DATE	PROBLEM#	SHORT TERM GOALS	LONG TERM GOALS	INTERVENTION APPROACH	MEASURED BY	REVIEW DATE	PARENTAL APPROVAL	DATE ACHIEVED

Time In: ____________ **Time Out:** ___________

Completed by: ____ Date: ____________________

Referring Physician Signature: ____________ Referring Physician Name: __________________Date:______

Facility Physician Signature: ______________ Facility Physician Name:____________________ Date:______