Ann L. DeLucas, Ph.D.
Clinical Psychologist
CA License PSY 18018

Lake Medical and Chiropractic
1146 San Marino Drive
San Marcos, CA 92078
(760) 471-2033

ADULT INTAKE QUESTIONNAIRE

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____

Address: _____

City, State, Zip _____

Home phone: Ok to leave message? Yes No

Work phone: Ok to leave message? Yes No

Cell phone: Ok to leave message? Yes No

Ok to send text message? Yes No

Email: _____

Referred by: _____

Reason you are seeking services:

_____

_____

_____

_____

Are you a victim of an accident or personal injury? Yes No

If yes, please complete the Accident or Personal Injury Patient Questionnaire

Attorney's Name: _____

Address: _____

Phone: _____

Is this a Workman's Compensation referral? Yes No

Case Number? _____

Who is your Primary Physician (name and phone number)?

_____

Case Manager (name and phone): _____

CURRENT SYMPTOMS – please check any that apply to you at this time.

_____ Generalized Anxiety (across many situations)

_____ Specific fears/phobias (list):

_____ Panic attacks

_____ Social Anxiety

_____ Obsessive thinking or compulsive behaviors

_____ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)

_____ Sadness or Depression

_____ Emotionally overwhelmed

_____ Frequent crying

_____ Loss of energy

_____ Loss of pleasure in life

_____ Problems falling asleep

_____ Problems sleeping through the night (middle of the night waking or early morning waking

_____ Trouble waking up

_____ Fatigue/tiredness during the day

_____ Nightmares

_____ Problems with attention or concentration

_____ Racing thoughts

_____ Problems making or keeping friends

_____ Problems controlling temper

_____ Relationship/Marriage problems

_____ Problems with intimacy

_____ Problems with job

_____ History of abuse (emotional, physical, sexual)

_____ Financial problems

_____ Legal situation

Other:

_____

Self-injurious / Self-harm behavior

_____ Thoughts of suicide

_____ Problems with eating

_____ Self-cutting, burning

SUBSTANCE USE

How much alcohol do you consume on the average week? _____

Has anyone (friends, family, coworkers, etc) expressed concern about your drinking Y N

Have you tried (unsuccessfully) to quit drinking ? Y N

Have you experienced blackouts? Y N Withdrawal symptoms? Y N

Used alcohol for a morning "eye opener"? Y N

Do you currently use illicit drugs? Y N If yes, What? When? _____

Have you ever misused prescription drugs? Y N. If yes, What? When? _____

Do you use any other mood-altering substance?

Do you smoke? Y N If yes, how often? _____

Do you drink caffeinated beverages? Y N. If yes, what? How much? _____

Do you take any herbal products? Y N If yes, what? How often? _____

MENTAL HEALTH HISTORY

Describe any previous mental health services you have received (evaluations, therapy, hospitalization, medication). Include the provider, any diagnoses, and length of treatment.

_____

_____

What do you wish to accomplish (what are your goals) in seeking services at this time?

_____

_____

FAMILY INFORMATION:

Marital Status (circle one):

Single Living with Partner Married Separated Divorced Widowed

Rate quality of present relationship/marriage (if applicable):

___ very good ___ good ____ fair _____ poor ____ very poor

Your occupation: _____

Occupation of Spouse/Partner: _____

Children and ages: _____

If divorced, what are the custody arrangements? _____

Who currently resides in your home? _____

GENERAL HEALTH:

Your current health: _____ excellent _____ good _____ fair _____ poor

For the following, please use back of form if additional space needed:

Primary Physician's name/address/phone number: _____

When was your last physical exam? Any relevant findings? _____

Are there any other physicians you see on a regular basis? _____

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (surgeries, etc.). _____

_____

_____

List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medicines, vitamins, and supplements. _____

Any problems with sleep? Describe. _____

Any problems with eating? Describe. _____

Please rate the overall level of stress in your life:

_____Very Low _____Low _____Average _____High _____Very High

What do you consider to be the greatest source of stress at this time?

FAMILY HISTORY:

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

Yes	Condition	Family Member
☐	Mental Retardation	_____
☐	Speech or Communication Disorder	_____
☐	Attention-Deficit / Hyperactivity / Impulsivity	_____

- ☐ Learning Problems / Disabilities _____
- ☐ Autism Spectrum / Asperger's Disorder _____
- ☐ Sleep disorders _____
- ☐ Generalized Anxiety (across many situations) _____
- ☐ Social Anxiety _____
- ☐ Obsessive-Compulsive Disorder _____
- ☐ Phobias _____
- ☐ Depression _____
- ☐ Manic-Depression / Bipolar Disorder _____
- ☐ Suicide attempts / Suicide _____
- ☐ Schizophrenia or other psychosis _____
- ☐ Alcohol / Substance Abuse _____
- ☐ Seizures or other neurological disorder _____
- ☐ Genetic Disorder (e.g., Down Syndrome, Fragile X) _____
- ☐ Other: _____

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries?

Please list: _____

EDUCATIONAL HISTORY:

Your highest level of education completed: _____

Any problems with attention, learning, or behavior in school? _____

Grades repeated and reason: _____

Served in Special Education? _____

Additional Comments: _____

LEGAL HISTORY

Have you ever filed or been involved in any litigation? Please explain

_____

_____

_____

MILITARY HISTORY

Are you or have you ever served in the military? Y N

If so, what branch? _____ When? _____

Type of discharge: _____

Is there any other information that has not been asked that would be helpful to understanding your problems?

_____

_____

_____

NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

Welcome to Lake Medical and Chiropractic. This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your doctor/therapist is considered privileged and confidential. We will not release any information without your written release. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes. The only exception to these conditions may occur in situations such as child abuse; imminent danger to life; Workers' Compensation; personal injury recovery (see Lien agreement attached if applicable) or where by law other action is permitted. Please discuss this with your doctor/therapist.

OFFICE HOURS

The office staff are typically available from 9:00 a.m. to 5:00 p.m. Monday, Wednesday and Friday. 9:00 am to 4:00 pm Tuesday and Thursday. When the office staff are not available, please leave a message and or contact number. If you need to reach the therapist directly, you may call or text (858) 414-1299. The first priority and our primary concern is your well being. If this is an emergency, please call the San Diego County Adult Crisis Line at **1-888-724-7240**, go to the nearest hospital emergency room (ER) or dial 911.

SCHEDULING APPOINTMENTS

An appointment can be scheduled by either your doctor/therapist or our office staff.

APPOINTMENT LENGTH:

Individual therapy is billed on the basis of a 45-50 minute hour. If an appointment runs longer, you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

The first session involves assessment and usually lasts for one to one and one-half hours. Your doctor will discuss with you any further assessment or testing that they feel is appropriate and necessary. The fees for these services will also be discussed at this time.

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from someone else in need. **Therefore, except in the case of an acute emergency, we require a 24 hour notice of any cancellation; otherwise, your account will be charged for the visit.** In addition, because we are unable to bill insurance for missed appointments, you will be held financially responsible for these charges. If our office is closed, leave a message on your therapist's voice mail to inform us of your cancellation so the time may be used appropriately.

FEES:

Payment for professional services are due and payable at the time they are rendered unless other arrangements have been made. All clients are expected to take care of their fees as services are rendered. Any other arrangement is considered a special . We accept checks, Visa, and Mastercard.

ASSESSMENT AND/OR TESTING:

Testing is billed on the basis of the type of test and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with information about the type of test and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. The written report, if requested, is generated after payment in full for testing services is received.

REPORTS:

Reports not included in assessment and/or testing fees will be billed as a separate procedure. Requests for such reports and the fees will be discussed with you in advance.

I have read and understand these policies. I acknowledge responsibility for all fees incurred.

Date: _____

_____

Client's Name

_____

Client's Signature

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to psychological services by Ann L. DeLucas, Ph.D.
This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.
I understand that the potential benefits of receiving psychological services may include obtaining a professional opinion, reduction of psychological symptoms, and an increased understanding of psychological issues. I understand that potential risks may include possible disagreement with the professional opinions offered, possible emotional distress when addressing my difficulties, and limitations in the ability to make predictions based on results of psychological assessments (when applicable). I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with my services.

I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:
1. where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. where the validity of a will of a former patient is contested
3. where such information is necessary for the practitioner to defend against a malpractice action brought by the client
4. where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the practitioner
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order or Workman's Comp.
I hold harmless for releasing information under the above conditions.

Client's Name: Date of birth:
Signature: Date:

PERMISSION TO RELEASE AND OBTAIN INFORMATION
I do hereby authorize to release and discuss the results of my
(BIA clinician)
____ Psychological Evaluation/Testing

____ Treatment/Therapy

with the following individuals. I also give those listed below my permission to discuss and release information regarding my care to Ann L. DeLucas, Ph.D.

This release of information is valid from _____(date) to _____ (date).

Individual Agency Phone Number

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____

Client name (print): Date of birth:

Signature: Date:

Ann L. DeLucas, Ph.D.
Clinical Psychologist
CA License PSY 18018

1146 San Marino Drive
Lake San Marcos, CA 92078
Cell: (858) 414-1299

DOCTOR'S LIEN ON PERSONAL INJURY RECOVERY

This agreement is entered into between Dr. Ann L. DeLucas (hereinafter, "Provider"), and _____ (hereinafter, "Patient"), in consideration of the obligations set forth herein and establishes certain obligations and responsibilities relating to Patient's accident of _____, 20____, (hereinafter, "claim").

1. I do hereby authorize Dr. Ann DeLucas, to furnish you, my attorney, with a full report of her examination, diagnosis, treatment plan, prognosis, etc. of myself in regards to the accident in which I was involved.
2. Dr. DeLucas' fee schedule is $200 per therapy hour (45-50 minutes face-to-face time). Home visits, upon request and approval by attorney, are billed at a higher cost (to be determined in advance). Any time spent beyond the therapy hour will be billed in 15 minute increments.
3. Patient hereby gives a lien to Provider against all proceeds derived from this claim (whether by settlement, judgment, or otherwise) to secure payment of all fees owed to Provider by Patient for

health care services and supplies arising out of injuries sustained, as of the time such proceeds are paid. This lien shall have priority over any subsequent lien or assignment of Patient's interest. Patient hereby directs Patient's attorney and all responsible parties to pay such sums as are secured hereby directly to Provider, as soon as possible after any proceeds are received.

4. Patient hereby expressly recognizes that even though this lien has been given, Patient still remains personally responsible for Provider's fees and that payment of such fees must be made by Patient regardless of whether any money is received through Patient's personal injury claim.
5. Patient hereby authorizes Provider to furnish Attorney, at reasonable intervals upon Attorney's request, complete reports of Patient's medical condition, care and cost of treatment. Provider agrees to furnish these reports within a reasonable time, and at a reasonable cost.
6. Provider hereby agrees to await Patient's payment of Provider's fees until this claim is concluded, except to the extent that payment is available from insurance which provides health care benefits for Patient. Provider agrees to be available to Patient's Attorney, upon reasonable notice and for reasonable compensation for consultations, depositions and court appearances. In the event Provider is requested or subpoenaed to testify, Provider shall be entitled to reasonable compensation as an expert witness.
7. In the event of any dispute between the Provider and the Patient concerning Provider's fees, Attorney shall hold in trust until such dispute is resolved, or to deposit with the Court, a sufficient amount of Patient's proceeds to satisfy Provider's claimed fee.
8. Patient hereby agrees to notify Provider, immediately, should Patient retain new legal counsel. Patient agrees to direct new legal counsel to execute another copy of this Claim Agreement and Lien when one is furnished by Provider. Should new legal counsel fail or refuse to execute another copy of this lien agreement, within ten days after being provided a copy, then Patient's bill shall become immediately due and payable in full.
9. Should any party seek judicial enforcement of this agreement, the prevailing party shall be entitled to reasonable attorney's fees.
10. This Claim Agreement and Lien cannot be modified, changed, or revoked by any party without the express written consent of all parties.
11. A faxed signature on this lien shall be as effective as an original signature.
12. The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor named above.

Patient's Signature: _____ Date: _____

Attorney's Signature: _____ Date: _____

The signed Attorney acknowledges receipt of a copy of this lien and agrees to be bound hereby. Please date, sign and return one copy to doctor's office at once. Keep copy for your records