Intake Paperwork (Adult)

PATIENT INFORMATION: **Is Treatment Court-Ordered? YES/ NO**

Last name: _____ First:_____ M.I. ____ Nickname:_____

SSN: _____-____-_____ Birth date: __/__/____ Allergies: _____ Sex:_____

Race:_____Patient's marital status: _____ Patient's Spouse:_____

Address: _____ City: _____ State: _____Zip: _____

Phone: H:_____ W:_____C:_____ Email: _____

Permission to leave voicemails? YES/ NO Permission to email? YES/ NO

Choose One Option for Appointment Reminder(s): _____ Email _____Text Message_____ Voicemail

Employer's Name: _____Referral Source: _____Primary Doctor: _____

Reason for Referral:_____

RESPONSIBLE PARTY (if other than patient)

(Shared Custody? Please provide name and phone number of other party)

Last name: _____First Name:_____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: home _____ work _____ cell _____

Employer's Name: _____ City: _____ State: _____

Other Party: Last name: _____First Name:_____ Phone Number:_____

EMERGENCY CONTACT **____Same as Responsible Party**

Last name: _____First Name:_____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: home _____ work _____ cell _____

Employer's Name: _____ City: _____ State: _____

INSURANCE INFORMATION: (Present Insurance Card to Office Staff Please)

Primary Insurance Company: _____ *Secondary Insurance Company:*_____

Card Holder _____Card Holder _____

Birth Date _____ Birth Date _____

SSN _____SSN_____

Address _____ Address _____

Phone # _____Phone # _____

Employer _____Employer _____

Policy ID #_____ Policy ID # _____

Group # _____-_____ Group # _____-_____

Please complete all information correctly and legibly.

266 Henrietta Ave. N., Park Rapids, MN, 56470
Phone: (218) 252-2785 Fax: (218) 732-4695

BILLING INFORMATION – Read and sign:

1. I authorize A Better Connection, Inc. to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, agency accountant(s), agency legal representatives, RPT-S Supervisor, and insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize A Better Connection, Inc. to release my medical records and billing information to my Primary Care and/or Referring Physician.
3. I authorize my insurance benefits to be paid to A Better Connection, Inc..
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.

Name of person completing this form (please print) _____
Signature of person completing this form_____ Date: _____
Relationship to Patient: _____

PERMISSION TO PROVIDE TREATMENT

I, _____, hereby authorize A Better Connection, Inc. to provide psychotherapy services. I attest to the fact that I have the legal authority to grant this permission.

Signature: _____ Date: _____

RESTRAINING ORDER/ ORDER OF PROTECTION

Is there currently a Restraining Order or Order of Protection on anyone? YES / NO

If so, what is the name of the individual(s)? _____

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Phone: (218) 252-2785 Fax: (218) 732-4695

NOTICE OF PRIVACY PRACTICES

Please read this notice and **sign and date** the attached acknowledgement.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act has given you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for you visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment activities and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified by removing all references to individually identifiable information.

We may contact you to provide appointment reminders and information about treatment alternative or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relaying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosers of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we much abide by it unless you agree in writing to remove it.
- The right to reasonable requests to review confidential communications of protected health information from us at alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosers of protected health information.
- The right to obtain and we have to obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of out legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy has been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights, 200 Independence Avenue, S. W., Washington, D.C. 20201 Phone: (2202) 619-0257 Toll Free: 1-877-696-6775

A Better Connection, Inc.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received a written copy of the **A Better Connection, Inc. Privacy Practices.** I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such a time as I may choose to revoke this acknowledgment. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____ _____

Date Signature of Client or Legal Guardian

Cancellation Policy/Agreement

Due to high demand for mental health services at A Better Connection Inc., clients and families are being asked to sign, and agree to, the cancellation policy terms and conditions. Text Message reminders 24 hours prior containing the appointment date and time are a courtesy provided by A Better Connection Inc. to ensure attendance. Please request this service if you do not currently receive text message reminders.

Late Cancel/No Shows: If patients arrive 15 or more minutes late to an appointment without calling to inform A Better Connection Inc. of the late arrival, they may be asked to reschedule as their appointment will be considered a Late Cancel/ No Show. Patients unable to attend a scheduled appointment or group session must cancel the appointment more than 24 hours prior to the appointment time. Reminder text messages are sent at this time. To cancel an appointment, please text or call 218-252-2785. In cases of extraordinary circumstances that arise less than 24 hours prior to the appointment time (e.g. physical illness), the clinic still appreciates to be informed about the missed appointment. There is a daily cancellation list of patients hoping to attend an open appointment time. It is appreciated by other clients and their families if you call with enough time to allow their attendance at that time. This also ensures the possibility of an appointment opening to reschedule your appointment at a later date. Failure to cancel an appointment less than 24 hours prior to an appointment will require:

- One late cancel/no show in a six month period= Client must call to confirm an appointment the following week. If no call is made, no appointment will be made for the following week.
- Two late cancels/no shows in a six month period= Client will lose their weekly/ biweekly session time and must schedule an appointment each week.
- Three late cancels/no shows in a six month period= Client will be required to call the morning of the day the client prefers to attend an appointment. A session will be scheduled if an appointment time is available. If no time is available, the client will need to call back at a later date.

I understand and agree to the above cancellation policy.

Signature:_____ Date: _____

Printed Name: _____

Adult History Questionnaire

Name:_____Birth Date:_____Age:_____

Has someone referred you to ABC?_____No _____Yes (If Yes, Who?)_____

Reason for seeking services?_____

On the chart below, please check what symptoms you have recently experienced. Check all that apply. Please feel free to ask ABC Staff questions if you do not understand.

☐	Withdrawing from family/friends	☐	Emotional highs	☐	Excessive worry	☐	Murderous thoughts or wishes
☐	Decrease in energy or fatigue	☐	Restlessness	☐	Anxiety	☐	Problems at work/school
☐	Irritability	☐	Hyperactivity	☐	Panic Attacks	☐	Breaking rules
☐	Reduced interest or enjoyment with life	☐	Impulsiveness	☐	Fear of abandonment	☐	Trouble with authority
☐	Depressed mood or lingering sadness	☐	Anger or hostility	☐	Nightmares	☐	Stealing or dishonesty
☐	Trouble with sleep (too much, too little, insomnia)	☐	Noticeable mood swings	☐	Phobias or excessive fears(of_____)	☐	Destructiveness
☐	Crying spells/easy to tears	☐	Difficulty making decisions	☐	Nervousness	☐	Over-aggressiveness
☐	Difficulty thinking or concentrating	☐	Disorganization	☐	Obsessions, having trouble getting thoughts out of mind	☐	Physical health concerns
☐	Easily distracted	☐	Impaired memory	☐	Flashbacks to distressing events	☐	Eat when not hungry or beyond fullness
☐	Feelings of rejection	☐	Racing thoughts or speech	☐	Feel like you are outside your body watching self	☐	Dissatisfied with body shape or weight
☐	Low self-esteem	☐	Difficulty speaking	☐	Unsure of what is real	☐	Muscle twitches
☐	Feelings of guilt or shame	☐	Persistent desire for alcohol or drugs	☐	Feel others are spying or trying to poison you	☐	Emotional eating
☐	Helplessness	☐	Concern over your use of tobacco	☐	Sometimes think you are hallucinating	☐	Eating behaviors of starving, binging, or purging
☐	Hopelessness	☐	Concern over your use of alcohol and/or drugs	☐	Suicidal thoughts or wishes	☐	Sexual problems or concerns
☐	Don't care about anything	☐	History of relapse	☐	Injuring self (cutting, burning, pulling hair)	☐	Chronic pain

How often do symptoms affect you? ___1-2 days per week ___ 3-4 days per week ___ 5-6 days per week ___Everyday

How long have you been dealing with these symptoms?_____

What makes the symptoms worse?_____

How much do symptoms interfere with work, housework, getting along with others?

On a scale of 1 (not at all) to 10 (all the time):_____

What improves symptoms?_____

When do you notice difficulty lessen or go away?_____

PLEASE COMPLETE THE FOLLOWING

Patient Health Questionnaire – 9	**(Circle one)**			
Over the *last 2 weeks,* how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Have you thought of suicide recently or in the past?_____

Have you attempted suicide recently or in the past?_____

Were you hospitalized? **NO/YES**, if yes when and where? _____

Have you made use of Crisis Services if feeling suicidal? _____

Do you harm yourself in a manner (for example: cutting, burning, drinking, smoking, etc.)?

NO/YES, if yes please explain:_____

Do you have any access to guns or weapons? YES/NO

Generalized Anxiety Disorder (GAD-7) Scale:

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several Days	More than half of the days	Nearly every day
Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
Not being able to stop or control worrying	**0**	**1**	**2**	**3**
Worrying too much about different things	**0**	**1**	**2**	**3**
Trouble relaxing	**0**	**1**	**2**	**3**
Being so restless that it's hard to sit still	**0**	**1**	**2**	**3**
Becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
Feeling afraid as if something awful might happen	**0**	**1**	**2**	**3**

How difficult have the above problems made it for you to do work, complete housework, or get along with other people? (Circle One) Not difficult at all - Somewhat difficult - Very difficult - Extremely difficult

<u>In the following chart, please identify what experiences you have had in your life?</u>

(Circle HX if you have a History and/or P if it is a Present event)

Life Experiences					
Abusive relationship	Hx P	Miscarriage	Hx P	Unhappy childhood	Hx P
Experienced physical abuse	Hx P	Abortion	Hx P	Poor academic progress	Hx P
Experienced emotional abuse	Hx P	Crime Victim	Hx P	Few Friends	Hx P
Experienced sexual abuse	Hx P	War	Hx P	Family Problems	Hx P
Witnessed physical abuse	Hx P	Poverty	Hx P	Rape	Hx P
Witnessed emotional abuse	Hx P	Natural Disaster	Hx P	Death of someone close	Hx P
Witnessed sexual abuse	Hx P	Death of a parent	Hx P	Traumatic Brain Injury	Hx P

<u>Please explain any details you wish to share about your life experiences</u>:_____

_____

_____

Below, please indicate if your functioning has been impacted in any of the following areas:

(Please circle and describe) Ratings: 1 (none) 2 (slight) 3 (moderate) 4 (severe) 5 (extreme)

		How has the problem made things worse?
Hobbies/Interests/Play Activities [Mental Health]	1 2 3 4 5	
Sleep Problems	1 2 3 4 5	
Abuse Issues	1 2 3 4 5	
Alcohol or Drug Use [Use of alcohol or drugs]	1 2 3 4 5	
Job Performance [Vocational Functioning]	1 2 3 4 5	
School Performance [Educational Functioning]	1 2 3 4 5	
Ability to Control Temper [Social Functioning]	1 2 3 4 5	
Friendship/Peer Relationships	1 2 3 4 5	
Marriage/Relationship Problems [Interpersonal Functioning]	1 2 3 4 5	
Family/Children Problems	1 2 3 4 5	
Activities of Daily Living[Self Care, Independent Living]	1 2 3 4 5	
Physical/Dental Health or Handicap [Medical/ Dental Health]	1 2 3 4 5	
Sexual Functioning	1 2 3 4 5	
Obtaining/maintaining Financial Assistance	1 2 3 4 5	
Obtaining/maintaining Housing	1 2 3 4 5	
Using Transportation	1 2 3 4 5	

What mental health services do you currently ***RECEIVE***? (examples: county assistance, case management, medication management)

What mental health services do you currently ***NEED***? (examples: county assistance, case management medication management)

Substance Use:

Past uses: ___alcohol____tobacco____caffeine____marijuana____meth____narcotics_____prescription drugs

Current uses:___alcohol____tobacco____caffeine____marijuana____meth____narcotics_____prescription drugs

Substance	When did you start	When/if you stopped	Amount used, Frequency	Negative effects or consequences

CageAid:

-Felt you ought to **cut** down on your drinking or drug use?	Yes No
-Had people **annoy** you by criticizing your drinking or drug use?	Yes No
-Felt bad or **guilty** about your drinking or drug use?	Yes No
-Had a drink or used drugs as an **eye-opener** first thing in the morning to steady your nerves, or get rid of a hangover or to get the day started?	Yes No

Legal issues as a result of substance use: ___No___Yes Describe:_____

_____

_____

Have you participated in a chemical dependency treatment program? ___No ___Yes (if yes, where and when?)_____

Do you feel you have a problem with substances or alcohol? ___No ___Yes (if yes, do you want help with this problem?)_____

Do you have family history of substance or alcohol abuse/dependence? ___No ___Yes (if yes, please describe) _____

Mental Health History:

Have you ever received outpatient mental health services? ___No ___Yes (if yes, describe below; where, when, for what reason and outcome) _____

_____

_____

Was a Psychiatrist Seen? ___No ___Yes **Physician's Name:**_____

Medication prescribed: _____

_____

_____

Was a Therapist Seen? ___No ___Yes **Therapist's Name:**_____

What did you find helpful in treatment?_____

What did you find not helpful in treatment?_____

Have you received inpatient mental health services or been hospitalized? ___No ___Yes (if yes, describe where, when, and why): _____

_____

_____

Was this a Voluntary Placement? ___Yes ___No (if No, describe) _____

_____

Any history of mental health commitment? ___No ___Yes (if yes, describe when, where, and length)

_____

_____

Family history of mental health issues: _____

_____

_____

Medical Health History:

Current physical health: ___Excellent ___Good ___Fair ___Poor

Date last seen by Primary Care Physician: _____

Name of Doctor and/or Primary Care Clinic: _____

Current Medical Conditions and their status: (example: Diabetes, childhood, current, special diet)

Condition	Started	Ended (or current)	Treatments	Status

Medication	Reason	Dosage (amount and frequency)	Prescriber	Effect (working or not)

Surgeries: ___No ___Yes (describe; on what and when) _____

_____

Medication allergies: ___No ___Yes (if yes, describe) _____

How has your current difficulty affected your physical and dental health? _____

_____

Family history of medical conditions (such as diabetes, heart disease, cancer, etc.) _____

_____

Social History:

Please describe your social history: _____

_____

Legal History:

Do you have any significant current or past legal problems: (such as arrests, probation, domestic violence, etc.) ___No ___Yes (describe below) _____

_____

_____

Educational History:

Level of education attained:

___Some High School ___High School ___GED ___Vocational ___Some College ___College Graduate ___Post Graduate

School currently attending: _____

Special Education as a Child? ___No ___Yes (specify) _____

_____

School Problems: ___Truancy ___Suspension ___Expulsion ___Poor Grades ___Conflict (peers) ___Conflict (Teachers) ___Other (Please Describe):_____

_____

Additional Comments about Educational History: _____

_____

_____

Military Service: ___No ___Yes (if yes, please answer below) _____

_____

Branch: _____ **Years of Service:** _____

Discharge Status: ___Honorable ___Dishonorable ___Medical

Most Recent Employment:

Place: _____
Position: _____
Date Started: _____ **Date Ended:** _____
Reason for Leaving: _____
Significant Job Stressors: _____

Current Economic or Financial Difficulties: _____

_____

_____

Are there other factors contributing to your current difficulties (such as recent divorce, death in family, natural disaster, job loss, economic downturn): _____

_____

Are you able to meet your living and self-care needs? ___Yes ___No (describe) _____

_____

Spirituality and Cultural Differences:

Is religion or spirituality important to you? ___No ___Yes (if yes, how so?) _____

_____

Are there cultural factors that influence your functioning? ___No ___Yes (how?) _____

_____

Hobbies/Activities: (What do you do for fun and enjoyment?) _____

_____

_____

Current Living Situation: (Apartment, house, residential facility, homeless) _____

_____

With whom do you live? (Please indicate number) ___Alone ___spouse ___parents ___children ___friends ___others

History of Relationship(s):

Marital Status: ___ Single (not looking) ___Single (looking) ___Married ___Separated ___Divorced ___Widowed

How many marriages/divorces/ deaths? _____

Current relationship: With whom? _____

Started: _____ Ended:_____ Ongoing: _____

Quality of Relationship: _____

Significant personal relationships: _____

_____

Do you have family or friends that support you emotionally or financially? ___No ___Yes (if yes, describe): _____

_____

Do you have children? ___No ___Yes: How many? _____ Gender/ages: _____

_____

Strengths and resources in social relationships or networks (what is going well in your life? Who is supportive of you? What support groups or community groups are helpful to you?) _____

_____

Family and Childhood History:

Describe your family growing up: (where born, where grew up, who lived with you, how you were treated by parents, safety of home, etc.) _____

_____

_____

What was your relationship like with your parents? _____

_____

Brief description of Child Development: (complications with pregnancy/delivery, significant development, educational, family, or social incidents in your life) _____

_____

What do you see as your personal strengths within your life at home, work, in your emotional wellbeing, in your physical wellbeing, and in your social life? _____

_____