ASSOCIATED CLINIC OF PSYCHOLOGY

# CLIENT PERSONAL HISTORY FORM

***Please complete both sides of this form and return it to the front desk.***

**Client Name:**_____ **Date of Birth:** _____ **Age:** _____

**What do you prefer to be called?**_____ **Gender:**_____

**Phone #:**_____ **Emergency Contact Name:**_____

**Emergency Contact Phone #:** _____

**Preferred Pharmacy** *(if applicable)*: _____

*Please be specific, e.g. "Walgreens on York in Edina"*

**What is your reason for seeking services today?** *(examples: depressed, difficulty sleeping, anxious, fighting with spouse, grieving ,etc.)*

_____

_____

**Have you previously been treated for mental health issues?** ☐ No ☐ Yes - therapy ☐ Yes - psychiatry/medication

If yes, who did you see? *(please complete a Release of Information form)*_____

**Do you currently have a mental health case manager?** ☐ No ☐ Yes - *please complete a Release of Information form*

**Who completed this form?** ☐ Self ☐ Parent/Guardian ☐ Case Worker ☐ Other:_____

◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆

**Current living situation**: ☐ Personal residence ☐ Foster home ☐ Group home ☐ Shelter/homeless
☐ Other: _____

**Marital status:** ☐ Single ☐ Married/Partnered ☐ Separated ☐ Divorced ☐ Widowed

**Employment status:** ☐ Employed full time ☐ Employed part time ☐ Unemployed (looking for work)
☐ Retired ☐ Disability/Applied for Disability ☐ Not in the work force (full-time student, homemaker, etc.)

**Are you a veteran?** ☐ Yes ☐ No If yes, currently **Active Duty**? ☐ Yes ☐ No

**Education Level:** ☐ Less than High School ☐ High School/GED ☐ Vocational/Trade
☐ Some College ☐ College (Bachelors) ☐ Masters or higher

**Race** (*check all that apply*): ☐ White ☐ African American/Black ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

**Ethnicity:** Hispanic/Latino? ☐ Yes ☐ No ☐ Decline to Answer

**Country of origin:** ☐ U.S. ☐ Other_____

**Primary language:** ☐ English ☐ Other _____

**How did you hear about ACP?** *(please choose <u>one</u>)* ☐ Family member ☐ Friend ☐ School ☐ Employer ☐ Insurance co.
☐ Internet Search ☐ Yellow Pages ☐ County/Social Services ☐ Probation Officer/Court ☐ Primary care provider
☐ Other medical facility/provider ☐ Other mental health provider ☐ Psychiatric hospital ☐ Chem dependence facility

**Referral name** *(and company/organization, if applicable)*: _____

Are there any **spiritual** considerations you would like your provider to be aware of? ☐ No ☐ Yes
Are there any **cultural** considerations you would like your provider to be aware of? ☐ No ☐ Yes
Are you currently or have you ever been involved in any **legal issues**? ☐ No ☐ Yes
Do you have any concerns about your **housing** or **financial** situation? ☐ No ☐ Yes

*Continued on other side*

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**Current Height:**_____ **Current Weight**:_____ **Date of Last Physical Exam** *(or mo/yr)*: _____

Do you have any current or past **medical conditions**? Please check all that apply:

**General**
- ☐ Cancer
- ☐ Weight Changes
- ☐ Currently/Possibly Pregnant
- ☐ Currently Breastfeeding

**Cardiovascular**
- ☐ Coronary Artery Disease
- ☐ Heart Surgery
- ☐ Hypertension
- ☐ Abnormal Blood Pressure
- ☐ High Cholesterol
- ☐ Fainting Spells

**Respiratory**
- ☐ Emphysema
- ☐ Asthma
- ☐ Sleep Apnea

**Endocrine**
- ☐ Diabetes
- ☐ Thyroid Problems

**Musculoskeletal**
- ☐ Broken Bones
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Arthritis
- ☐ Rheumatic disease

**Genitourinary**
- ☐ Kidney/Bladder Problems
- ☐ Sexually Transmitted Disease
- ☐ HIV/AIDS/ARC
- ☐ Urinary Incontinence

**Blood/Lymph**
- ☐ Cirrhosis
- ☐ Anemia
- ☐ Hepatitis

**Skin**
- ☐ Acne
- ☐ Skin Disorders
- ☐ Tuberculosis

**Neurological**
- ☐ Stroke
- ☐ Head Injury
- ☐ Headaches
- ☐ Epilepsy / Seizures
- ☐ Memory Loss

**Gastrointestinal**
- ☐ Ulcers
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation

**Allergies/Immune**
- ☐ Hay Fever
- ☐ Immunosuppressed

**Eyes/Ears**
- ☐ Visual Problems
- ☐ Hearing Impaired

**Previous hospitalizations (including psychiatric):** _____

**Previous surgeries:** _____

Are you **allergic** to any foods or medications? ☐ No ☐ Yes - please list:

Allergic to:_____ Reaction:_____

Allergic to:_____ Reaction:_____

Allergic to:_____ Reaction: _____

Are you currently taking any **prescription medications**? ☐ No ☐ Yes

If yes, please **attach a list** or list each medication **name** and **dosage** if known *(i.e. 20mg as needed or 5mg daily)*:

Medication:_____ Dosage:_____

Medication:_____ Dosage:_____

Medication:_____ Dosage:_____

Medication:_____ Dosage:_____

Medication:_____ Dosage: _____

***Thank you!***

# Authorization for Consent for Treatment and Acknowledgements

**Client Name _____ DOB _____**

**CONSENT FOR TREATMENT:** I consent to treatment and agree to abide by the policies and agreements with the Associated Clinic of Psychology (ACP), as stated herein.

**CONSENT FOR MINORS:** A guardian(s) must give consent for treatment of a minor. ACP requires copies of court documents related to custody and guardianship in order to validate consent.

**ACKNOWLEDGEMENTS**

- **CLIENT RIGHTS AND DATA PRIVACY:** I have received a copy of the document "Client Rights and Data Privacy" and a copy of the "HIPAA Notice of Privacy Practices" pamphlet.

- **FINANCIAL AGREEMENT:** I agree that in return for the services provided to me, I will pay my account at the time that service is rendered. If co-payments and/or other deductibles are a part of my insurance health plan, I agree to pay them at the time of service. I agree to pay all charges not covered by insurance. I understand and agree if my account is delinquent, I may be charged interest at the legal rate. If my account is sent to an attorney for collection, I agree to pay all collection expenses and reasonable attorney's fees as established by the court and not by jury in any court action.

- **ASSIGNMENT OF INSURANCE BENEFITS:** I authorize benefits of any type under my insurance plan or any party liable to me is hereby assigned to the Associated Clinic of Psychology. I authorize the Associated Clinic of Psychology to release health records to insurance carriers for purposes of processing claims for services rendered to me.

- **CANCELLATIONS:** I understand that I need to give at least a 24-hour notice when cancelling or rescheduling a scheduled appointment. If I fail to do so, I will be subject to a charge of $50.00 for the appointment, subject to the provider's discretion. ACP reserves the right to restrict scheduling due to no shows or cancellations.

- **COURT COSTS:** I understand that if a clinician or other member of the Associated Clinic of Psychology is required, by subpoena or other means of summoning, to appear in court on my behalf that I will be responsible for a fee for all time and costs associated, including but not limited to deposition time, attorney meetings and calls, travel time, preparation time, research, costs for copying records, time in court, etc. Therapy: $250/hour. Psychiatry: $500/hour.

- **CLINIC RIGHTS:** I understand that any verbal or physical aggression towards any person working for ACP or clients receiving services at ACP will be grounds for immediate termination of services.

- **TELEHEALTH POLICY:** I have received a copy and understand ACP's Telehealth Policy and Procedure.

**CONTINUED ON NEXT PAGE**

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- **AUTHORIZATION FOR COMMUNICATIONS VIA TEXT OR EMAIL AND ACKNOWLEDGMENT:** Per HIPAA regulations you have the right to receive communications via text message and/or non-secured email from ACP, if you choose. These messages will be used for scheduling, logistics, and administrative purposes only. ACP clinicians will not provide any services or other communications via text or email. Any protected health information (PHI) sent by ACP will be sent securely by alternative means or encrypted email. Before considering using non-secured email or text communication be advised that text messaging and nonsecure email messaging is an unencrypted conversation that has the potential to be read by a third party. Your cell service carrier rates will apply to communications via your cell phone. ACP is not responsible for any charges you may incur.

- **SUPERVISION PROGRAM**: I understand that at times my provider may be under the clinical supervision of another clinical provider based on licensing requirements or credentialing requirements. Your visit may be billed to your insurance under this Clinical Supervisor.

- **ACP SHADOWING PROGRAM**: I understand that occasionally there may be another provider or clinical student intern shadowing my group or individual session as part of their learning process. My provider will discuss this with me if this situation arises and I am always able to decline to have another provider/student shadow these sessions.

- **EMERGENCY CONTACT:** In case of emergency, ACP is authorized to contact the following person for the purpose of assessing client safety or whereabouts or obtaining other emergency information. Clinical information will not be released unless necessary to confirm or assess safety.

  Emergency Contact Name: _____

  Phone Number: _____ Relationship: _____

- **INSURANCE INFORMATION (only needed for Community-Based Services):**

  Insurance Company: _____ Member/Policy ID: _____

  Group #:_____ Policy Holder Name & Relationship to Client: _____

**By signing below, I consent to treatment and understand and agree to the policies and terms outlined above. This document is subject to regular updates.**

Client Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Relationship to client: _____

If Client is unable to sign, reason: _____

ACP ASSOCIATED CLINIC OF PSYCHOLOGY

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION TO PRIMARY CARE PROVIDER

## 1 Client Information

**First and Last Name** _____ **Client Date of Birth** _____

Previous Name(s) _____

Home Address _____

Phone_____ Secondary Phone: _____

## 2 This form when completed and signed by you, authorizes ACP to release protected personal health information to your primary care physician and/or clinic for continuity of care purposes, unless you choose to opt out below.

Check *one* of the boxes listed below.

☐ I **do not have OR do not authorize** ACP to contact my primary care physician or clinic.

☐ I **authorize** ACP to exchange information with my primary care physician and/or clinic.

Physician Name (if known): _____

Clinic Name: _____

Clinic Address: _____

Clinic Phone: _____ Clinic Fax: _____

## 3 Information to be released. IMPORTANT: Indicate only the information you are authorizing to be released. By checking any of the boxes below, you authorize mental health records to be released.

☐ Care Coordination Package (*includes Diagnostic Assessment, Treatment plan, last two progress notes, and discharge if applicable*)

☐ Intake/Diagnostic Assessment ☐ Progress Notes ☐ Treatment Plan ☐ Discharge Summary

☐ Psychiatric Notes ☐ Telephone Consultation ☐ Test Results/Evaluation ☐ Medication List

☐ Other (please specify): _____

**AND** please indicate date span below (if none indicated, intake and last two visit notes will be released):

☐ Specific Dates _____

**CONTINUE ON TO NEXT PAGE**

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**Patient's Name** _____ **Date of Birth** _____ 

## 4 Health information includes written and oral information

By indicating that you authorize ACP to contact your primary care physician or clinic in section 2, you are giving permission for written information to be released and for ACP to talk to a person in section 2 about your health information.

If you do not want to give your permission for ACP to talk with your primary care physician or clinic about your health information, indicate that here (check mark or initials) _____. If checked, only written records will be shared.

## 5

I understand this information will be disclosed to the above person, organization, or agency from records whose confidentiality is protected by Federal Laws (42 CFR Part 2) and by Minnesota Statutes. I also understand that I may revoke this authorization at any time by giving written notice to the Associated Clinic of Psychology, except to the extent that action has already been taken in reliance upon it. Unless revoked earlier or otherwise indicated, this authorization will expire three years from the date of signing. I understand that treatment by any party may not be conditioned upon my signing this authorization unless the psychological/psychiatric services are provided to me for the purpose of creating health information for a third party. Furthermore, I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. All records pertaining to chemical dependency/drug or alcohol abuse, or HIV related illnesses and treatment records will be released unless indicated here by your initials: _____

## 6 Client's Signature _____ Date _____

**OR** Parent/Guardian Signature _____ Date _____

Parent/Guardian (printed name): _____

Representative's relationship to client (parent, guardian, etc.) _____

**PLEASE NOTE: ACP requires supporting documentation in cases where guardianship or legal custody are involved, prior to release of protected health information.**

This authorization will expire in 3 years from the date of signature. Releases of Information signed by parent/guardian for a minor will expire in 3 years, or on client's 18th birthday, whichever date comes sooner.

**ACP Clinic Locations**

| | | |
|---|---|---|
| ☐ ACP Minneapolis: 4027 County Road 25, Minneapolis, MN 55416 | PH: 612-925-6033 | FAX: 612-925-8496 |
| ☐ ACP Apple Valley: 6950 West 146th Street, Suite 100, Apple Valley, MN 55124 | PH: 952-432-1484 | FAX: 952-432-2328 |
| ☐ ACP West St. Paul: 149 Thompson Avenue E, Suite 150, West St. Paul, MN 55118 | PH: 651-450-0860 | FAX: 651-450-0759 |
| ☐ ACP Brooklyn Center: 6200 Shingle Creek Parkway, Suite 350, Brooklyn Center, MN 55430 | PH: 763-503-8560 | FAX: 763-503-8563 |
| ☐ ACP West Metro: 1155 Ford Road, Suite B, St. Louis Park, MN 55426 | PH: 952-378-1800 | FAX: 952-378-1714 |
| ☐ ACP St. Paul Midway: 450 Syndicate Street N, Suite 385, St. Paul, MN 55104 | PH: 612-925-6033 | FAX: 612-925-8496 |
| ☐ ACP Hudson: 2501 Hanley Road, Suite 101, Hudson, WI 54016 | PH: 715-954-5300 | FAX: 612-925-8496 |

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ACCT#

**CLIENT NAME:** _____ **DATE:** _____

| **Over the last 2 weeks**, how often have you been bothered by any of the following problems? (please circle the number to indicate your answer) | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| **1. Little interest or pleasure in doing things** | 0 | 1 | 2 | 3 |
| **2. Feeling down, depressed, or hopeless** | 0 | 1 | 2 | 3 |
| **3. Trouble falling or staying asleep, or sleeping too much** | 0 | 1 | 2 | 3 |
| **4. Feeling tired or having little energy** | 0 | 1 | 2 | 3 |
| **5. Poor appetite or overeating** | 0 | 1 | 2 | 3 |
| **6. Feeling bad about yourself-- or that you are a failure or have let yourself or your family down.** | 0 | 1 | 2 | 3 |
| **7. Trouble concentrating on things, such as reading the newspaper or watching television** | 0 | 1 | 2 | 3 |
| **8. 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 |
| **9. Thoughts that you would be better off dead, or of hurting yourself** | 0 | 1 | 2 | 3 |
| **Add Columns** | | + | + | |
| **TOTAL:** | | | | |

**10. If you checked off any problems above**, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

**11. Do you or does anyone else have concern about your alcohol or drug use?** ☐ Yes ☐ No

**12. Do you use tobacco?** ☐ Yes ☐ No
If so, are you interested in quitting? ☐ Yes ☐ No

***This space for clinician use***

**CLINICIAN INTITALS:** _____
**C.R.**

REV. 11/13/12

 A2663B 10-04-2005

**Generalized Anxiety Disorder Screener (GAD-7)**

| Over the *last 2 weeks*, how often have you been bothered by the following problems? | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritated | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| | Add columns | | | |
| | Total Score | | | |
| 8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

When did the symptoms begin? _____