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:** _____

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 & Ethnicity *(check all that apply)*: ☐ White ☐ African American/Black ☐ Asian ☐ Hispanic/Latino
☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ 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

ACP
ASSOCIATED CLINIC OF PSYCHOLOGY

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
- ☐ Diarhhea
- ☐ 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!

ACCT # _____
PROVIDER # _____

ASSOCIATED CLINIC OF PSYCHOLOGY

☐3100 West Lake St. Suite #210 Minneapolis, MN 55416	Ph: 612-925-6033	Fax#: 612-925-8496
☐6950 West 146th St. Suite #100 Apple Valley, MN 55124	Ph: 952-432-1484	Fax#: 952-432-2328
☐1633 South Robert St. Suite A West St. Paul, MN 55118	Ph: 651-450-0860	Fax#: 651-450-0759
☐6200 Shingle Creek Parkway Suite #350 Brooklyn Center, MN 55430	Ph: 763-503-8560	Fax#: 763-503-8563
☐450 Syndicate St. N. Suite 385 St. Paul, MN 55104	Ph: 612-925-6033	Fax#: 612-925-8496
☐1155 Ford Road Suite B St. Louis Park, MN 55426	Ph: 952-378-1800	Fax#: 952-378-1714

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION TO A PRIMARY CARE PHYSICIAN

_____ ____/____/____

Client Name (please print) Date of Birth

THIS FORM WHEN COMPLETED AND SIGNED BY YOU, AUTHORIZES ACP TO RELEASE PROTECTED PERSONAL HEALTH INFORMATION TO YOUR PRIMARY CARE PHYSICIAN FOR CONTINUITY OF CARE PURPOSES.

*Check ***one*** of the boxes listed below.

☐ *I **do not have** a primary care physician.*

☐ *I **do not authorize** ACP to contact my primary care physician.*

☐ *I **authorize** ACP to exchange information with my primary care physician.*

PHYSICIAN NAME: _____

CLINIC NAME: _____

CLINIC ADDRESS: _____

_____

TELEPHONE: _____

FAX: _____

AT THE REQUEST OF THE INDIVIDUAL, THE FOLLOWING INFORMATION IS RELEASED:

Client Summary: This may include any of the following: Medication, Treatment Plan, Discharge Summary.

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 one year from the date of signing.

I understand that my clinician generally may not condition psychological/psychiatric services upon my signing an 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 HIPPA Privacy Rule.

SIGNATURE OF CLIENT: _____ *DATE:* _____

SIGNATURE OF PARENT OR GUARDIAN (IF APPLICABLE): _____ *RELATIONSHIP:* _____

IF PATIENT IS UNABLE TO SIGN, REASON: _____