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Internal: Case# ______________

Adult Intake Form

Client Name: ________________________________ **Date:** ________________

Legal Custodian (if applicable): ________________________________

Social Security #: ________________________________ *(SS# is a required identifier by insurance companies)*

Date of Birth: ________________ **Age:** ____________

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Other ☐ Choose not to respond

Sexual Orientation: ☐ Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Questioning ☐ Choose not to respond ☐ Other

Emergency Contact: ________________________________ **Phone Number:** ________________

Client Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐ Living Together

Partner/Spouse Name: ________________________________

Client Address: ________________________________

May we send mail to this address? ☐ Yes ☐ No

Email Address: ________________________ May we send email? ☐ Yes ☐ No

Client Phone 1: ________________________ OK to leave voice message? ☐ Yes ☐ No
May we send texts? ☐ Yes ☐ No

Client Phone 2: ________________________ OK to leave voice message? ☐ Yes ☐ No
May we send texts? ☐ Yes ☐ No

Reasons for seeking services/presenting issue(s) of client: ***(check all that apply)***

☐ Fears, phobias, worries
☐ Parent/child conflict
☐ Sibling conflict
☐ School difficulties
☐ Medication/med management
☐ Sleeping concerns
☐ Behavioral concerns
☐ Withdrawn
☐ Sexual behavior concerns
☐ Gender identity
☐ Peer conflicts
☐ Legal concerns
☐ Drug/alcohol use
☐ Eating concerns
☐ Death of close friend/family member
☐ Adjustment to divorce/separation
☐ Mandated by ______________
☐ Other ______________

Referral Source: ________________________________

When did this issue begin? ________________________________

What changes do you want to happen as a result of services? ________________________________

What strengths do you possess? ________________________________

Current living situation:
☐ Living independently in my residence ______________
☐ With parents
☐ With relative/guardian
☐ With foster family
☐ Friend's home
☐ Homeless
☐ Other ________________________

Residential Care/Treatment Facility:
☐ Hospital **
☐ Residential care **
☐ Temporary housing **
☐ Nursing home **
☐ Group home **
☐ Jail
** Identify facility ______________

Living situation during childhood/adolescence:

- ☐ Raised w/both parents
- ☐ Parents not married
- ☐ Parents split, raised by mother
- ☐ Parents split, raised by father
- ☐ Raised in foster/adoptive home
- ☐ Other ______________________________

Total number of people living in your household:__________

Primary Household (list all people living in the home – parents, step-parents, siblings, etc.)

Household member name	Relationship to client	Age

Additional family members or other support persons (not living in Primary Household, but relevant to the client (parents/caregivers, siblings, other relatives, etc.)

Family member of support person name	Relationship to client	Age

Quality of relationships between client and others

How well do you get along with:	**Poor**	**Good**	**Great**	**N/A**
Spouse/Partner				
Children/Step-children				
Parents				
Siblings				
Employer/Co-workers				
Your friends				

Developmental Issues

Are you aware of any problems during your mother's pregnancy with you? ☐ Yes ☐ No ☐ Unknown

Describe: ______________________________

____

Are you aware of any developmental concerns from birth to age 5 (eating, talking, walking) ☐ Yes ☐ No ☐ Unknown

Describe: ______________________________

____

Are you aware of any developmental concerns from age 6-18 (speech delay, learning delay) ☐ Yes ☐ No ☐ Unknown

Describe: ______________________________

____

Functioning

Have you ever had any concerns about your: *(check all that apply)*

☐ Mood ☐ Appetite ☐ Energy ☐ Falling asleep ☐ Staying asleep

For any of the items checked above, please indicate when you were first concerned and describe your concerns:

____

____

____

Family History

Is there any history of mental health issues on either side of your family? ☐ Yes ☐ No ☐ Unsure

If yes, describe: ______________________________

Is there any history of medical/physical health issues on either side of your family? ☐ Yes ☐ No ☐ Unsure

If yes, describe: ______________________________

Chemical/Substance History

Do you have any concerns about your use of alcohol or drugs?	☐ Yes	☐ No
CAGE assessment tool (required):		
Have you ever felt that you ought to cut down on your drinking or drug use?	☐ Yes	☐ No
Have people annoyed you by criticizing your drinking or drug use?	☐ Yes	☐ No
Have you ever felt bad or guilty about your drinking or drug use?	☐ Yes	☐ No
Have you ever had a drink or used drugs first thing in the morning (eye opener) to steady your nerves; e.g. get rid of a hangover or get the day started?	☐ Yes	☐ No

Do you use:	**Current**	**Past**	**Never**	**Additional Information**
Alcohol				
Street drugs				
Inhalants				
Prescription meds beyond				
Other				

Caffeine use (# of cups/cans per day and time of day): ______________________

Do you use tobacco/nicotine? ☐ Yes ☐ No If yes, amount per day: ______________

Does someone in your life (close friend or family member):	**Current**	**Past**	**Never**
Use alcohol in excess			
Use street drugs			
Use inhalants			
Use prescription meds beyond prescribed usage			
Have legal issues			
Other (describe):			

Legal History

Do you have a history of legal charges?	☐ Yes	☐ No
If yes, describe:		
Are you currently on probation?	☐ Yes	☐ No
Have you ever been on probation?	☐ Yes	☐ No
Have you ever been court-ordered into chemical health or mental health treatment?	☐ Yes	☐ No

Mental Health Treatment History (current or past)

(may include in-home services, outpatient, day treatment, psychiatric hospitalization, psychiatric partial-hospitalization, wraparound, case manager (partnership, rule 79, county), other supportive services (parent aide, PCA, guardian-ad-litem))

Agency/Provider	Dates

Trauma History

Have you ever experienced or witnessed any of the following:	During childhood (birth to age 17)	During adulthood (18 and older)
Physical abuse		
Domestic violence/abuse		
Neglect		
Emotional abuse		
Sexual abuse/molestation		
Community violence		
Been involved with child protective services (CPS)		
As a child, were you placed outside your home?		

Safety / Risk Issues

Do you have any of the following safety/risk concerns?

- ☐ Dangerous behaviors to self
- ☐ Dangerous behaviors to others
- ☐ Destruction of property
- ☐ Risk of wandering/running away
- ☐ Need for excessive supervision
- ☐ Other: ______________________________

Do you ever feel unsafe at home? ☐ Yes ☐ No

Spirituality/Religion

Is client/family currently engaged in any spiritual/religious activities? ☐ Yes ☐ No ☐ Unsure

Describe: ______________________________

Medical

Primary Care Physician: ______________________________

Name of Clinic: ______________________________

Psychiatrist/Medication-prescribing provider (if different than Primary Care Physician): ______________

Name of Clinic: ______________________________

Pharmacy: ______________________________

Do you consent to allow us to review your medication history *(enter initials):* ______________

Do you have an Advanced Health Care Directive? ☐ Yes ☐ No *(information can be found at www.caringinfo.org)*

Health Issues	Yes	No	Unkown	If yes, age first noted	If yes, still occurring?
Seizure (convulsions) or spells	☐	☐			☐
Head injury	☐	☐			☐
Chronic pain	☐	☐			☐
Trouble with hearing	☐	☐			☐
Trouble with vision	☐	☐			☐
Poisoning or overdose history	☐	☐			☐
Serious or chronic illness	☐	☐			☐
Hospitalizations	☐	☐			☐
Allergies Describe:	☐	☐			☐
Infectious/Contagious diseases Describe:	☐	☐			☐
Surgeries	☐	☐			☐

Medication	Start Date	End Date	Dosage	Frequency	Prescribed by	Notes

Family medical concerns that impact you: ______________________________

____

Other family concerns/stressors impacting you (financial concerns, parents' relationship stress, etc.):

____

____

Demographics

Your racial origin: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Native American
☐ Asian/Pacific ☐ Bi/multi-racial ☐ Other ____________________

Your primary language: ☐ English ☐ Spanish ☐ Other ____________________

Gross household income: ☐ $0-14,999 ☐ $15,000-19,999 ☐ $20,000-29,999
☐ $30,000-39,999 ☐ $40,000-59,999 ☐ $60,000+

Do you: ☐ Own your home ☐ Rent ☐ Other ____________________

Household military history: ☐ Active ☐ Past ☐ None ☐ Other ____________________

If active, who? ____________________

Describe impact on you: ____________________

Method of Payment for Services – For In-Office Services:

Fees vary depending on the service you are receiving. There are several options for a client to cover this cost - self-pay/ sliding fee, third-party reimbursement, or through reduced fee options in some service locations. In order to help us fairly and accurately assess your ability to pay and entitlement to benefits, please answer the following questions as accurately as possible. All information will be kept confidential. We reserve the right to request verification regarding the information provided.

☐ I have **Medical Assistance:** MA of MN MA of ND

Primary client Policy # ______________________ Primary client SS# ______________________

(SS# is a required identifier by your insurance)

☐ I have **Primary** insurance coverage:

Insurance Company: ______________________

Policy holder's name: ______________________

Policy holder's birthdate ______________________ Policy # ______________________

Group# ______________________ Primary client SS# ______________________

(SS# is a required identifier by your insurance)

__________ ***(please initial)*** I understand that I need to make my co-payment at the time of each visit.

☐ I have **Secondary** insurance coverage:

Insurance Company: ______________________

Policy holder's name: ______________________

Policy holder's birthdate ______________________ Policy # ______________________

Group# ______________________ Primary client SS# ______________________

(SS# is a required identifier by your insurance)

__________ ***(please initial)*** I understand that I need to make my co-payment at the time of each visit.

☐ I will be **Self-Paying** for my services. I understand that payment is to be made at the time of each session. Failure to do so will result in no future appointments being made.

☐ I have insurance coverage but I choose to Self-Pay.

Total Gross Household Income: Annual gross income before taxes. Include total of salaries, profits, government assistance, income from savings, investments, other interest, inheritance, student loans, etc. (listed on your IRS 1040 form).
Monthly income: ______________ x 12 = ______________Annual Gross Income

Extra income: (allowances, benefits, alimony or child support, bonuses, royalties, other) not reported above:
Monthly: ______________ x 12 = ______________ Total Extra Income

Total Income: ______________

If phone counseling is agreed upon between you and your counselor, the charge will be based on your annual income on our sliding fee scale: 15–30 minutes = 1/2 your established fee / 31–50 minutes = full session fee

______________________________ ______________

Client signature/Legal guardian signature if applicable Date

Please let us know at least 24 hours in advance if you need to cancel or reschedule your appointment.

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Confidentiality of Records

We take confidentiality of private information seriously. We want you to know the guidelines we follow to protect your information as outlined on the Client's Rights/Informed Consent and Notice of Privacy Practices. We also want to clarify what constitutes "your record" and how access to your record is controlled. Access to records varies depending on the type of service being delivered.

If you are Receiving Individual Services

- You/your legal custodian(s) sign a Client's Rights and Notice of Privacy Practices.
- You/your legal custodian(s) must sign an Authorization for Disclosure (release of information) form for information from your record to be released (except as we are required by law/court order to release information, or as allowed through the Notice of Privacy Practices).
- Other participants in your services:
    - Other non-custodial adults (18 and older) participating in service/sessions will be provided informed consent and will sign a Client's Rights and Notice of Privacy Practices form. Informed consent will be verbalized to participating minors as appropriate. These other participants cannot authorize the release of your information.

If you are Receiving Couples' Services

- Both members of the couple sign a Client's Rights and Notice of Privacy Practices.
- Both members of the couple must sign to authorize the release of information. If both signatures are not obtained, a redacted copy of the information may be provided.
- Other participants in your services:
    - Other adults (18 and older) participating in your service/sessions will be provided informed consent and will sign a Client's Rights and Notice of Privacy Practices form. Informed consent will be verbalized to participating minors as appropriate. These other participants cannot authorize the release of your information.

If you are Receiving Family Services

- All adult clients (18 and older) sign a Client's Rights and Notice of Privacy Practices.
- All adults must sign to authorize the release of information. If all signatures are not obtained, a redacted copy of the information may be provided.

- Other participants in your services:
  - Other adults (18 and older) participating in your service/sessions will be provided informed consent and will sign a Client's Rights and Notice of Privacy Practices form. Informed consent will be verbalized to participating minors as appropriate. These other participants cannot authorize the release of your information.

If Service is to a Minor

- The minor's legal custodian(s) who presents the minor for services signs the Client's Rights and Notice of Privacy Practices.
- Anyone with legal custody of the minor has rights to the information regarding treatment of/service to the minor.
- There are times when we are not required to release a minor's information if, in a provider's professional opinion, doing so could result in harm to the minor.
- Minor's records are maintained 7 years past the close of services or until the minor reaches age 21, whichever is longest. When a minor reaches the age of 18, they become the owner of their information and must sign for the release of information.

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? ____

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No-Show/Cancellation Policy

Mid Dakota Clinic believes that a healthy client/counselor relationship is based on good communication.

We understand that situations arise in which you must cancel your appointment. Mid Dakota requires at least 24-hour notice if you cannot keep your appointment to allow us to reschedule with another client. Appointments may be cancelled by calling 701.712.4521 or 701.712.4501.

Clients who do not show up for their appointment are considered a No-Show. All future appointments may be cancelled, and you will need to call to re-establish appointments.

Clients who No-Show (2) consecutive times or four (4) times within one year, will not be allowed to reschedule for 30 days.

Printed Client Name____

Client Signature Date____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" 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 in some way	0	1	2	3

FOR OFFICE CODING ___0___ + _______ + _______ + _______

=Total Score: _______

If you checked off <u>any</u> problems, how <u>difficult</u> 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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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Patient Notice and Assignment of Insurance Benefits

USE AND DISCLOSURE OF MEDICAL INFORMATION

Mid Dakota Clinic is authorized by law to release or receive a patient's medical information to or from healthcare providers (i.e. physician, clinic, hospital, pharmacy, etc.) involved in a patient's care; to release such information as may be necessary or required for statistical reporting or as required by applicable law; to obtain patient medication history information; and to release medical information necessary to process claims, insurance reviews, pre-authorizations and case management to any person or corporation which is or may be liable for the claims charges.

Mid Dakota Clinic sends immunization data to the North Dakota Immunization Information System (NDIIS) as part of your treatment. We are required by law to provide this for all children. Adult patients may elect to opt-out of submission of this data to the NDIIS by notifying their medical providers or the Clinic.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of any insurance benefits arising from policies insuring the patient, or any party liable to the patient, directly to Mid Dakota Clinic. I authorize application of any payment received by the Clinic for this period of care to any Clinic bill for which I am financially responsible that has not been paid in full at the time of the receipt of the insurance payment, subject to the rules of coordination of benefits. I understand that I am financially responsible for any charges not covered by this assignment of insurance benefits.

NOTICE OF PRIVACY PRACTICES

I acknowledge that the Mid Dakota Clinic has made a copy of its NOTICE OF PRIVACY PRACTICES available to me to read and to keep.

AUTOMATED HEALTHCARE REMINDERS

I hereby authorize Mid Dakota Clinic to deliver or cause to be delivered to me calls, messages, or text messages using an automatic telephone dialing system or an artificial or prerecorded voice, including but not limited to appointment reminders, health preventative reminders, test results, provider absences, billing and collection information, and weather-related events on my mobile phone, at the number I provided. I understand that I am not required to agree to receive such calls or messages as a condition of receiving any treatment, property, goods, or services. I also understand that my cell phone company may charge me for text messages.

I UNDERSTAND I MAY OPT-OUT OF RECEIVING SUCH MESSAGES AT ANY TIME BY INFORMING THE CLINIC, REPLYING AS DIRECTED IN THE MESSAGE TO DISCONTINUE SUCH MESSAGES, OR OPTING-OUT ON MY PATIENT PORTAL.

______________________________	______________________________
Patient or Authorized Signature	Relationship to Patient
______________________________	______________________________
Signature of Witness	Date