

CLIENT INFORMATION FORM

Today's Date _____

Client Legal Name _____
First MI Last Date of Birth Age

Spouse/Partner _____
First MI Last Date of Birth Age

Present Address _____

City, State, Zip _____

Client's Social Security # _____

Client's Place of Work _____ Work Phone (_____) _____

Home Phone (_____) _____ Cell Phone (_____) _____

Check contact number where we may leave a voice message? **Home** ___yes ___no **Cell** ___yes ___no **Work** ___yes ___no

To receive informational and personal helps from our office clearly print your E-Mail Address _____

How did you hear about our clinic? ___ Insurance Co. ___ Online Search ___ Personal Referral ___ Church ___ Our Website

IF WE ARE FILING FOR INSURANCE, THIS SECTION MUST BE COMPLETED EVEN IF WE HAVE YOUR INSURANCE CARD!

INSURANCE COMPANY _____

EMPLOYER ISSUING INSURANCE _____

EMPLOYEE HOLDING INSURANCE _____ Date of Birth _____

SOCIAL SECURITY OR I.D. NUMBER _____ GROUP NUMBER _____

RELATIONSHIP TO CLIENT _____

HAVE YOU BEEN IN THERAPY THIS CALENDAR YEAR? YES _____ NO _____ NUMBER OF VISITS _____

IF YOU ARE COVERED UNDER 2 POLICES WE MUST HAVE THE FOLLOWING INFORMATION

INSURANCE COMPANY _____

NAME OF POLICY HOLDER _____ ID# _____ GROUP# _____

Medical Information: I would like information about my counseling disclosed to my doctor. ___ Yes ___ No

Name of Doctor _____ Name of Clinic _____

Address of Clinic _____ Clinic Phone (_____) _____

Are you taking medication? YES _____ NO _____ Clinic Fax (_____) _____

List Medications

Dosage

An Authorization form must be completed and signed in order for Burnsville Counseling and Healing Center to disclose information. You may pick up an authorization form at the front desk. Please inform your therapist.

Have you ever been in counseling before? NO _____ YES _____ Dates _____

Reason _____

Have you ever been hospitalized for mental health reasons? ___ Yes ___ No Dates _____

Reason _____

Client Name _____

Date _____

Please indicate the **PRIMARY** cause for your visit today.

- Depressed feelings Grief or Loss Relationship/family Problems Occupational Problems General Stress
 Anxiety or Worry Abuse Issues Substance Abuse Issues Physical Health/Pain Self-esteem

Please rate the extent to which you have experienced the following symptoms over the past 7 days.

(Circle **only** the ratings that apply to you) Rating: 0 = not at all; 10= extreme)

- | | | | | | | | | | | | |
|--|---|---|---|---|---|---|---|---|---|---|----|
| Feeling sad or down | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Loss of interest in enjoyable activities | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Feelings of Worthlessness | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Inability to sleep/sleeping too much | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Low energy or fatigue | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Inability to concentrate | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Thoughts of suicide | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Poor appetite/overeating | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Weight gain/loss | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Racing thoughts | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Anxiety/worry | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Irritability | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Muscle Tension | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Impulsiveness | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Anger/temper | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Panic feelings | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Phobias/fears | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

How much has your life been affected by the problems that brought you here? 0 –Not at all 1-mildly 2-moderately 3 severely

RELATIONAL

- Fights/Arguments 0 1 2 3
 Withdrawal 0 1 2 3
 Aggressiveness 0 1 2 3
 Violence 0 1 2 3
 Financial 0 1 2 3
 Sexual 0 1 2 3
 Infidelity 0 1 2 3

BEHAVIORAL

- Normal exercise up/down 0 1 2 3
 Self injurious behavior 0 1 2 3
 Increase in alcohol/drug use 0 1 2 3
 Reckless driving 0 1 2 3
 Increased spending 0 1 2 3
 Poor compliance with medications 0 1 2 3
 Gambling 0 1 2 3
 Difficulty making decisions 0 1 2 3

OCCUPATIONAL

- Arriving late/leaving early 0 1 2 3
 Quality of work 0 1 2 3
 Missing work 0 1 2 3
 Excessive errors 0 1 2 3
 Poor judgment 0 1 2 3
 Fights/Arguments 0 1 2 3

ACTIVITIES OF DAILY LIVING

- Getting out of bed 0 1 2 3
 Personal hygiene 0 1 2 3
 Household chores 0 1 2 3
 Paying bills 0 1 2 3
 Opening mail 0 1 2 3
 Making meals 0 1 2 3

DRUG AND ALCOHOL USE

Place a by any substance that you currently use. Place an **X** by those you have used in the past.

- | | | | |
|------------------------------------|--|-------------------------------------|--------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Prescription Med. Abuse | <input type="checkbox"/> Narcotics | Other? |
| <input type="checkbox"/> LSD | <input type="checkbox"/> Speed/Stimulants | <input type="checkbox"/> Ecstasy | _____ |
| <input type="checkbox"/> Ephedrine | <input type="checkbox"/> Appetite Suppressants | <input type="checkbox"/> Cigarettes | |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Chewing tobacco | <input type="checkbox"/> Acid | |

SOCIAL

- Loss of relationships 0 1 2 3
 Isolation/withdrawal 0 1 2 3
 Discord with family/friends 0 1 2 3

IN THE PAST YEAR: Regarding your alcohol or drug use...

- Have you ever felt the need to cut down? yes no
- Have you ever felt annoyed by criticism of your usage? 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 as an eye opener first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started? yes no
- How much do you drink or consume per week on average? Please name what you are using.

Client Name _____

FAMILY OF ORIGIN

(Indicate step family members with *)

Names of Parents/Step-parents _____

Names of Siblings & ages _____

Did you spend most of your growing up years with ___ one parent; ___ both mother and father; ___ parent and step parent; ___ guardian?

Are your parents deceased? ___ yes ___ no If yes, who? _____

What was your relationship like with your parents when you were growing up? _____

What was your relationship like with your siblings when you were growing up? _____

Was there any other significant adult in your life growing up? ___ yes ___ no If yes, who? _____

CURRENT FAMILY

Are you currently ___ Single ___ Married ___ Divorced ___ Widowed ___ Significant relationship Partner's Name _____

Names of children Age Names of children Age

Are there any significant issues with which your family is coping? _____

Describe your relationship with your partner ___ very good ___ good ___ satisfactory ___ tense ___ many fights ___ distant ___ abusive

ABUSE HISTORY

Have you ever been abused? ___ yes ___ no If yes, ___ physically ___ verbally ___ emotionally ___ sexually

By whom? _____ At what age(s)? _____

SOCIAL RELATIONSHIPS AND SUPPORT SYSTEM

Do you have family member(s) that are supportive? ___ very supportive ___ somewhat supportive ___ not at all supportive

Do you have friendships that are supportive to you? ___ one or two good friends ___ many good friends ___ only casual relationships

___ no real supportive friendships

SPIRITUAL/RELIGIOUS

I do not believe in or practice any form of spirituality or religion ___ yes ___ no; I have a personal spiritual path ___ yes ___ no;

I participate in a church community ___ yes ___ no; I have participated in the past but have no current religious or spiritual practice ___ yes ___ no

EDUCATION

What level of education did you complete? ___ Did not complete High School ___ GED ___ High School Graduate ___ Some College

___ College Graduate ___ Post Graduate ___ Currently attending college.

MEDICAL/HEALTH

How would you describe your current health? ___ Excellent ___ Good ___ Fair ___ Poor

Are you currently dealing with any medical concerns? ___ yes ___ no If yes, please explain _____

PLEASE CHECK ANY PHYSICAL SYMPTOMS YOU CURRENTLY HAVE

___ Dizziness ___ Back pain ___ Frequent colds ___ Thyroid problems ___ Current/past head trauma

___ Headaches ___ Heart racing ___ Menopause ___ Allergies ___ Menstrual Problems

___ Ulcer ___ Swallowing ___ Stomach trouble ___ Chest pain ___ Indigestion/heartburn

EMPLOYMENT

Are you currently ___ employed ___ unemployed ___ on disability

What is your current job? _____ How long? _____

What is your level of satisfaction with your job? ___ very satisfied ___ satisfied ___ unsatisfied ___ actively seeking new employment

MILITARY

Are you currently in the military? ___ yes ___ no Have you ever been? ___ yes ___ no? If yes, when _____

Any significant information about your service? _____

LEGAL/CRIMINAL

Do you currently or have you in the past had legal or criminal issues that have significantly impacted your life? ___ yes ___ no If yes, briefly explain _____

What would you like to achieve as a result of therapy? _____

**INNERLIGHT HEALING CENTER
CLIENT PERMISSION and ACKNOWLEDGMENT FORM**

Client Name _____

ASSIGNMENT OF INSURANCE AND EAP

Private insurance companies, EAP's and governmental insurance programs such as Medicare and Medicaid, require you to sign an assignment of benefits in order for us to bill your insurance company or EAP directly. Minnesota State Law requires a signed patient consent to release medical information to your insurance company and any other parties cooperating in the delivery of your care.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. Information used or disclosed pursuant to this authorization may be subject to redisclosure and is no longer protected.
3. A photocopy or fax of this consent is as valid as this original.

Client/Guardian Signature _____ Date _____

NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received a copy of HIPAA notice of privacy practices

Client/Guardian Signature _____ Date _____

AUTHORIZATION FOR CLIENT INFORMATION TO BE DISCLOSED

While I am a client at InnerLight Healing Center, or until this permission is revoked through written request,

I hereby authorize _____

(name of designated person)

Please indicate this persons relationship to client _____

_____ to make or check on appointments

_____ to have access to financial information

Client/Guardian Signature _____ Date _____

Reason client did not sign (if applicable) _____

E-MAIL REMINDERS

We now have an email reminder system available for your convenience. At your request, we can send you a reminder via email to let you know of an upcoming appointment, however, it is important that you understand that the internet is not a secure delivery system.

_____ Yes, please send me email reminders. _____ No, thank you.

Initial Initial

Email address: _____