

Young Adult Intake Form
To Be Completed by Parent

InnerLight Healing Center
Lakeville, MN

Young Adult's Name _____ Date of Birth _____

Young Adult's S.S.# _____

Home Address _____

City _____ State _____ Zip _____

To receive information and personal helps from our office, clearly print your e-mail address:

How did you hear about our clinic? Friend/Relative Phone Book Internet (Which web site?) _____
 Our Web Site Church/Pastor Doctor's.(Name) _____ Insurance Co. Other _____

Phone Number where we may leave a message (_____) _____

Person responsible for bill _____

Parent Information

Father's Name _____

Address if different from above _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work (_____) _____

Mother's Name _____

Address if different from above _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work (_____) _____

Names of Step – Parents (If applicable)

Insurance Information

Insurance Carrier _____

Policy # _____

Group # _____

Policy Holder _____

Policy Holder Date of Birth _____

Client Relationship to Policy Holder _____

Secondary Insurance Information

Insurance Carrier _____

Policy # _____

Group # _____

Policy Holder _____

Client Relationship to Policy Holder _____

Physician Information

Who is your child's primary care physician? _____

What clinic do you go to for your child's care? _____

What is the clinic phone number? _____

May we provide information about your son/daughters care to their physician? ____ yes ____ no

Please indicate any medications being taken by your son or daughter.

Name _____ Dosage _____ Purpose _____

Name _____ Dosage _____ Purpose _____

Name _____ Dosage _____ Purpose _____

Primary Concerns

What are your primary concerns about your child that have brought you here today?

What do you see as your son or daughters greatest strengths?

What are you hoping will be accomplished through 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: _____

**Young Adult Intake Form
Center
To Be Completed by Young Adult**

**InnerLight Healing
Lakeville, MN 55044**

Today's Date _____ Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Phone (Where we can reach you or leave a message) _____

With whom do you currently live? (Include parents, step parents, siblings etc.) _____

Friendships (Check those that are true for you)

- ____ I have a lot of good friends
- ____ I have a few good friends
- ____ I have one close friend
- ____ I don't have any close friends
- ____ It is hard for me to make friends
- ____ I have a few friends but they are not close to me
- ____ I feel teased or bullied at school.

Work

Do you have a current job? ____ yes ____ no

If yes, where? _____

How many hours per week do you work? _____

Leisure Time

How many hours do you spend watching TV everyday? _____

How many hours do you spend on video games everyday? _____

How many hours do you spend on line everyday? _____

School Information

School Attending _____ Grade _____

City of School _____

Extra-Curricular Activities _____

Do you enjoy school? ____ yes ____ no

Check those things with which you have had problems: ____ grades ____ friends ____ teachers ____ administrators ____ attending classes ____ completing homework ____ other _____

What do you like best about school? _____

What is most difficult about school? _____

Have you ever been in therapy before? ____ yes ____ no If yes, when? _____

If yes, for what purpose? _____

Have you ever been hospitalized for mental health reasons? ____ yes ____ no If yes, when? _____

If yes, where and for what purpose? _____

Have you come to therapy at your own request? ____ yes ____ no

If no, who requested that you come? _____

Why did he/she suggest therapy? _____

If you are here at your own request, what is your reason for coming? _____

Substance Use Please check any substances that you currently use or have used in the past:

- | | | | |
|------------------------------------|------------------------------------|---|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Abuse of Prescription Meds | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> LSD | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Speed/Stimulants | <input type="checkbox"/> Ephedrine |
| <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Crack | <input type="checkbox"/> Chewing Tobacco | <input type="checkbox"/> Narcotics |
| <input type="checkbox"/> Inhalants | <input type="checkbox"/> Acid | <input type="checkbox"/> Appetite Suppressants | <input type="checkbox"/> Methamphetamine (Crank) |

Have you used more than one chemical at the same time in order to get high? yes no

Do you avoid family activities so you can use? yes no

Do you have a group of friends who also use? yes no

Abuse Issues

Have you ever been physically abused? yes no not sure

If yes, by whom? _____

Have you ever been emotionally abused? yes no not sure

If yes, by whom? _____

Have you ever been sexually abused? yes no not sure

If yes, by whom? _____

Legal Issues

Have you ever had a DUI? yes no

If yes, when? _____

Have you ever been arrested? yes no

If yes when? _____

For what reason? _____

Physical Concerns (Check how much you are bothered by the following:)

	Not at all	A little	Quite a bit	All the time
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Backaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shakiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling Tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Mutilation (Cutting, hair pulling, picking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gaining or loosing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Emotional Concerns (Check how much you are bothered by the following:)	Not at all	A little	Quite a bit	All the time
Feeling sad or depressed	_____	_____	_____	_____
Feeling worried or nervous	_____	_____	_____	_____
Feeling empty inside	_____	_____	_____	_____
Feeling angry	_____	_____	_____	_____
Feeling lonely	_____	_____	_____	_____
Feeling panicky	_____	_____	_____	_____
Feeling afraid	_____	_____	_____	_____
Feeling irritable	_____	_____	_____	_____
Low energy	_____	_____	_____	_____
Feeling on edge/fidgety	_____	_____	_____	_____
Difficulty concentrating	_____	_____	_____	_____
Not able to complete things	_____	_____	_____	_____
Low interest in things you used to enjoy	_____	_____	_____	_____
Thoughts of suicide	_____	_____	_____	_____
Bad or negative thoughts	_____	_____	_____	_____
Withdrawing from friends/family	_____	_____	_____	_____
Problems with parents	_____	_____	_____	_____
Problems with friends	_____	_____	_____	_____
Problems with school	_____	_____	_____	_____
Chemical Use	_____	_____	_____	_____
Sexual Concerns	_____	_____	_____	_____
Gender Concerns	_____	_____	_____	_____

What are your greatest strengths? _____

What do you think are your weaknesses? _____

What else would be helpful for your therapist to know about? _____