CLIENT #____________

TO BE COMPLETED BY THERAPIST

THERAPIST CODE: ____________
DSM IV CODE: ______________
DATE OF 1ST APPT: __________
☐New Client
☐Returning/Existing Client

CONFIDENTIAL PERSONAL DATA SHEET

Client Information (PLEASE PRINT CLEARLY)

NAME: ____ **GENDER:** ☐ Male ☐ Female
FULL FIRST MIDDLE INITIAL LAST

DOB: ___/___/_____ **AGE:** __________ **GUARDIAN:** ____________________________

ADDRESS: STREET ________________________________ CITY ____________________

STATE __________ ZIP __________ COUNTY __________________

HOME PHONE: (_____)________________________ **MPR can leave message:** ☐ YES ☐ NO

CELL PHONE: (_____)________________________ **MPR can leave message:** ☐ YES ☐ NO

EMAIL ADDRESS: ___________________________ **MPR can leave message:** ☐ YES ☐ NO

EMPLOYER:______________________________

EMPLOYMENT: ☐Full time ☐Part time ☐Unemployed

WORK PHONE: (_____)________________________ **MPR can leave message:** ☐ YES ☐ NO

MARITAL STATUS: ☐S ☐M ☐Sep ☐Div ☐W **STUDENT:** ☐Full time ☐Part time ☐Not a student

IN CASE OF EMERGENCY CONTACT: ____________________ **PHONE:** ______________________

HOW DID YOU HEAR ABOUT MPR?: ____

FAMILY PHYSICIAN: __________________ **RELIGIOUS AFILIATION:** ______________________

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY:____

CUSTOMER SERVICE NUMBER: (on back of card) (_____)_________________________

NAME OF POLICY HOLDER: ___________________________________ **DOB:**______________

PATIENTS RELATIONSHIP TO POLICY HOLDER: __________________________

****** PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD TO MAKE A COPY FOR OUR RECORDS******

CLIENT INFORMATION

The purpose of this form is to provide you with information about your rights at Minnesota Psychological Resources. We are committed to providing quality professional services to all our clients. In order to do so, we need your informed participation. As you read this form, please feel free to discuss any questions you may have with your therapist.

1. The information which is requested about you is used by us to determine your eligibility for services, to evaluate your needs and to develop a plan to address those needs.

2. It is necessary to keep records on all services provided to you. The records must include diagnosis, treatment plans, and specific treatment given.

3. As a client of this Center, you have a right to privacy and a right to see your records. You have a right to a copy of your records (There is a charge for this service). Your therapist can make a clinical decision to deny you access to part or all of your private records if it is determined that your psychological and/or physical well-being or that of another person would be jeopardized.

4. You have the right to challenge your records and to insert your own explanation about that which you object to in your records.

5. You have the right to appeal the content of your records. To file an appeal, you can contact your therapist, the Director of Minnesota Psychological Resources, or you can write directly to the Department of Human Services, Licensing Division, Human Services Building, 444 Lafayette Road North, St. Paul, Minnesota, 55155.

6. If you are a minor, your parents or legal guardians have the right to request access to information related to your assessment and treatment at Minnesota Psychological Resources. You are encouraged to discuss your concerns related to this with your therapist.

7. Your Minnesota Psychological Resources records are kept confidential and ONLY with your written authorization can your records be released to another person or agency EXCEPT when such release is specifically required by law.

8. It is required by law for therapists to disclose confidential information in some specific situations to prevent harm from occurring (for example, child abuse, injury to yourself or others, etc.). In some circumstances a court might be able to obtain your records or subpoena your therapist.

9. You have the right to know the specifics of your treatment plan including treatment options and possible treatment side effects. You also have the right to discuss the outcomes of your treatment.

10. You have the right to know the professional qualifications of your therapist. You are encouraged to ask your therapist about his/her professional background and training.

11. You have the right to request corrective action be taken if your rights are violated. You may present your concern or complaint to your therapist or to the Director of Minnesota Psychological Resources. You may also file a complaint if your concern is not resolved in a satisfactory manner by writing the Department of Human Services, Licensing Division, Human Services Building, 444 Lafayette Road North, St. Paul, Minnesota, 55155.

12. You have a right to a copy of the *Minnesota Psychological Resources Notice of Privacy Practices* brochure which describes how mental health information about you may be used and disclosed, and how you can get access to this information.

A copy of the Minnesota Psychological Resources Notice of Privacy Practices brochure has been provided or made available to me. ________ Please Initial

Again, if you have any questions regarding the information in this form, please direct your questions to your therapist.

______________________________ Client Signature

______________________________ Date

PATIENT HEALTH QUESTIONNAIRE

Name: ____ Date: _________________

Over the *last 2 weeks,* 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 of 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 asleep 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
				+	+

TOTAL:

10.	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 _______

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at http://www.pfizer.com. Copyright © 1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

NAME: ____________________________________ DATE: _____/______/______

DO YOU SMOKE? YES _____ NO ______

DO YOU USE TOBACCO PRODUCTS? YES _____ NO ______

DO YOU WANT TO STOP SMOKING OR USING TOBACCO PRODUCTS? YES _____ NO ______

WOULD YOU LIKE INFORMATION OR ASSISTANCE IN STOPPING SMOKING OR USING TOBACCO PRODUCTS? YES _____ NO ______

If you smoke, please answer the following six (6) questions.

For each statement, circle the most appropriate number that best describes you.

1. How many cigarettes do you smoke per day?
   a) 10 or less
   b) 11-20
   c) 21-30
   d) 31 or more

2. How soon after you wake up do you smoke your first cigarette?
   a) 0-5 min
   b) 30 min
   c) 31-60 min
   d) After 60 min

3. Do you find it difficult to refrain from smoking in places where smoking is NOT allowed (e.g. hospitals, government offices, cinemas, libraries etc)?
   a) Yes
   b) No

4. Do you smoke more during the first hours after waking than during the rest of the day?
   a) Yes
   b) No

5. Which cigarette would you be the most unwilling to give up
   a) First in the morning
   b) Any of the others

6. Do you smoke even when you are very ill?
   a) Yes
   b) No

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