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 AFFILIATION:** _____

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 _____

Medical History Form

Directions: Please answer the following questions to the best of your knowledge

Your records are considered confidential. Your records will not be released to any party without your written consent.

Patient Information		
First Name	**Last Name**	**Date of Birth**
Primary Physician(s)		
Name	**Name**	**Name**
Address	**Address**	**Address**
Phone:	**Phone:**	**Phone:**

Medication Allergies? ❑ Yes ❑ No

Substance or Food Allergies? ❑ Yes ❑ No

If yes, what medication(s) _____

If yes, what substance(s) _____

Family History: Please ✓ if your family has a history of the following

❑ Diabetes ❑ High Blood Pressure ❑ Heart Attack, Heart Disease ❑ Blood Clots or Stroke ❑ Tuberculosis

❑ Cancer ❑ Alzheimer's ❑ Family History Unknown ❑ Mental Illness ❑ Epilepsy/Seizure

Any other major conditions? _____

If you have answered YES to any of the above, please explain:_____

_____

Are you currently being treated for medical conditions? ❑ Yes ❑ No If YES, please list:_____

_____

Medications (List more on separate page if necessary)

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

Past Medications / For what condition? (list sedatives, pain medications, sleeping pills, antidepressants, etc.)

History

❑ Yes ❑ No	Do you smoke? If yes, how many cigarettes per day?
❑ Yes ❑ No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
❑ Yes ❑ No	Have you ever had or would you like help now with an alcohol or drug problem?
❑ Yes ❑ No	Would you like to discuss problems related to a rape or emotional / physical / sexual abuse?
❑ Yes ❑ No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

AUDIT-C : Please circle your response	**0**	**1**	**2**	**3**	**4**	**Score**
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
How often do you have more than five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL	

Medical History Form **Directions: Please answer the following questions to the best of your knowledge**

Your records are considered confidential. Your records will not be released to any party without your written consent.

Review of Systems: Please ✓ if you currently have or have ever had the following

1. General

Productive cough (3 weeks or more) ❑ Current ❑ Past
Dry, unproductive cough (3 weeks or more) ❑ Current ❑ Past
Shortness of breath ❑ Current ❑ Past
Chest pain ❑ Current ❑ Past
Recurrent night sweats, chills, fevers ❑ Current ❑ Past
Swollen glands (neck, armpits or groin) ❑ Current ❑ Past
Persistent weight loss without dieting ❑ Current ❑ Past
Weight problem / eating disorder ❑ Current ❑ Past

Unusual discharge (vaginal or from penis) ❑ Current ❑ Past
Bloody or painful urination ❑ Current ❑ Past
Dark, bloody or painful bowel movements ❑ Current ❑ Past
Hepatitis A ❑ Current ❑ Past
Hepatitis B ❑ Current ❑ Past
Hepatitis C ❑ Current ❑ Past
Chronic Fatigue ❑ Current ❑ Past
Cancer ❑ Current ❑ Past

Tuberculosis: Ever tested? ❑ Yes ❑ No Date and result of last test: _____ If Positive, did you have a chest x-ray? _____

Ever treated? ❑ Yes ❑ No Date(s) and type(s) of treatment: _____

HIV: Ever tested? ❑ Yes ❑ No Would you like information regarding HIV / AIDS or testing sites? ❑ Yes ❑ No

2. Skin

Allergies / Rash / Itching ❑ Current ❑ Past
Psoriasis / Eczema ❑ Current ❑ Past

3. Eyes

Vision problems ❑ Current ❑ Past
Eye infections ❑ Current ❑ Past

4. Ears, Nose, Throat, Lungs

Hearing problems ❑ Current ❑ Past
Teeth / gum problems or disease ❑ Current ❑ Past
Frequent nosebleeds ❑ Current ❑ Past
Recurrent sinusitis ❑ Current ❑ Past
Frequent sore throats ❑ Current ❑ Past
Recurrent Pneumonia ❑ Current ❑ Past
Asthma ❑ Current ❑ Past

5. Cardiac

Palpitations / arrhythmia ❑ Current ❑ Past
Heart disease / murmur ❑ Current ❑ Past
High blood pressure / Low blood pressure ❑ Current ❑ Past
High cholesterol ❑ Current ❑ Past
Thrombophlebitis / blood clots ❑ Current ❑ Past

6. Neurologic

Stroke ❑ Current ❑ Past
Frequent headaches or migraines ❑ Current ❑ Past
Seizures / Epilepsy ❑ Current ❑ Past
Weakness / paralysis / unsteady walking ❑ Current ❑ Past
Dizziness / confusion / wandering ❑ Current ❑ Past
Forgetfulness / memory lapse / memory loss ❑ Current ❑ Past

Other conditions / problems not listed: _____

7. Gastrointestinal

Recurrent nausea / vomiting / diarrhea ❑ Current ❑ Past
Stomach / bowel problems ❑ Current ❑ Past
Gall bladder disease ❑ Current ❑ Past
Pancreatitis ❑ Current ❑ Past
Diabetes / hyperglycemia / hypoglycemia ❑ Current ❑ Past
Encopresis (incontinent of feces) ❑ Current ❑ Past

8. Genitourinary

Bladder / kidney problems or infection ❑ Current ❑ Past
Incontinence (unable to control bladder) ❑ Current ❑ Past
Enuresis (bedwetting) ❑ Current ❑ Past
Sexually transmitted disease:
❑ Gonorrhea ❑ Syphilis ❑ Herpes
❑ Chlamydia ❑ Trichomonas
❑ HPV or genital warts

Females:

Menstrual Difficulties ❑ Current ❑ Past
Cycle: ❑ Regular ❑ Irregular
❑ Pre-Menopause ❑ Menopause
Problems / infection of tubes / ovaries / uterus ❑ Current ❑ Past
Abnormal Pap Smear(s) ❑ Current ❑ Past
Number of pregnancies: _____
Number of births: _____
Problems with pregnancies / births (explain) _____
_____
Breast disease / tumor / surgery (explain) _____
_____

Miscellaneous:

Anemia / blood disorder ❑ Current ❑ Past
Arthritis ❑ Current ❑ Past
Sleep disturbance ❑ Current ❑ Past

I certify that I have answered these questions to the best of my knowledge

Patient Signature: _____ Date: _____

Clinician's Notes

Reviewed by (Clinician): Date:

0111

Developmental and Medical History

(For Child/Adolescent Clients: 18 years and under only)

Name: _____

Complete all items as accurately as possible.

1. Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.) _____
2. Length of delivery (number of hours from initial labor to birth) _____
3. Mother's age when child was born _____
4. Child's birth weight _____
5. **Did any of the following conditions occur during the pregnancy/delivery?**
    a. Bleeding ..... NO YES
    b. Excessive weight gain ..... NO YES
    c. Toxemia/Preclampsia ..... NO YES
    d. RH factor incompatibility ..... NO YES
    e. Frequent nausea or vomiting ..... NO YES
    f. Serious illness or injury ..... NO YES
    g. Used prescription medications during pregnancy ..... NO YES
        i. If yes, name of meds taken _____
    h. Took illegal drugs ..... NO YES
    i. Used alcoholic beverages ..... NO YES
        i. If yes, approximate number of drinks per week _____
    j. Smoked Cigarettes ..... NO YES
        i. If yes, approximate number of cigarettes per day _____
    k. Used Caffeine ..... NO YES
        i. If yes, approximate number of cans or cups per day _____
    l. Was given medication to ease labor pains ..... NO YES
    m. Delivery was induced ..... NO YES
    n. Forceps were used during delivery ..... NO YES
    o. Had a breech delivery ..... NO YES
    p. Had a cesarean section delivery ..... NO YES
    q. Other problems ..... NO YES
        i. Describe: _____
6. **Did any of the following conditions affect your child during delivery or within the first few days after birth?**
    a. Injured during delivery ..... NO YES
    b. Cardiopulmonary distress during delivery ..... NO YES
    c. Delivered with cord around neck ..... NO YES
    d. Had trouble breathing following delivery ..... NO YES
    e. Needed oxygen ..... NO YES
    f. Was cyanotic, turned blue ..... NO YES
    g. Was jaundiced, turned yellow ..... NO YES
    h. Had an infection ..... NO YES
    i. Had seizure(s) ..... NO YES
    j. Was given medication ..... NO YES
    k. Born with a congenital defect ..... NO YES
    l. Was hospitalized more than seven days ..... NO YES
7. **During the first 12 months, was your child:**
    a. Difficult to feed ..... NO YES
    b. Difficult to get to sleep ..... NO YES
    c. Colicky ..... NO YES
    d. Difficult to put on a schedule ..... NO YES

e. Alert ..... NO YES
f. Cheerful ..... NO YES
g. Affectionate ..... NO YES
h. Sociable ..... NO YES
i. Easy to comfort ..... NO YES
j. Difficult to keep busy ..... NO YES
k. Overactive, in constant motion ..... NO YES
l. Very stubborn, challenging ..... NO YES

8. At what age did your child first accomplish the following:

a. Sitting up without help ..... _____
b. Crawling ..... _____
c. Walking alone, without assistance ..... _____
d. Using single words (i.e. mama, dada, etc.) ..... _____
e. Putting two or more words together (i.e. mama up) ..... _____
f. Bowel training, day and night ..... _____
g. Bladder training, day and night ..... _____

9. Date of child's last physical exam ..... _____

10. At any time, has your child had the following:

a. Asthma ..... Never Past Present
b. Allergies ..... Never Past Present
c. Diabetes, arthritis, or other chronic illnesses ..... Never Past Present
d. Epilepsy or seizure disorder ..... Never Past Present
e. Febrile seizures ..... Never Past Present
f. Chicken pox or common childhood illnesses ..... Never Past Present
g. Heart of blood pressure problems ..... Never Past Present
h. High fever (over 103) ..... Never Past Present
i. Broken bones ..... Never Past Present
j. Severe cuts requiring stitches ..... Never Past Present
k. Head injury with loss of consciousness ..... Never Past Present
l. Lead poisoning ..... Never Past Present
m. Surgery ..... Never Past Present
n. Lengthy hospitalization ..... Never Past Present
o. Speech or language problems ..... Never Past Present
p. Chronic ear infections ..... Never Past Present
q. Hearing difficulties ..... Never Past Present
r. Eye or vision problems ..... Never Past Present
s. Fine motor/handwriting problems ..... Never Past Present
t. Gross motor difficulties, clumsiness ..... Never Past Present
u. Appetite problems (overeating or under-eating) ..... Never Past Present
v. Sleep problems (falling asleep, staying asleep) ..... Never Past Present
w. Soiling problems ..... Never Past Present
x. Wetting problems ..... Never Past Present

y. Other health difficulties- please describe _____

_____

_____

_____

_____

_____

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

_____