Client Registration Form

Last Name:_____First Name:_____MI:___

Address:_____

Home #:_____ Work #:_____ Cell #:_____

Gender: M F Date of Birth:_____

Marital Status: Single Married Other Religion:_____

Occupation/Employer:_____Emergency Contact:_____

Preferred Emergency Room/Hospital:_____

Have you had previous psychological consultations/treatments? Y N

Treating Physician/Clinic_____

Terms and Conditions of Service

Notice of Privacy Practice and Disclosure of Information:
I have received a copy of the Notice of Privacy Practices for Protected Health Information.

I understand that my health information (including mental health information) may be disclosed for the purposes of treatment, for obtaining payment from my insurance carriers, and/or to other qualified health care professionals, with my written authorization, within limits of the law.

I understand that according to Minnesota law, I may choose to pay for services if I do not wish my health information to be given to my insurance company. I agree to notify this office about my wishes regarding payment and I understand that if I fail to pay for the services, the information will be sent to my insurance carrier.

Nondiscrimination Policy:
This facility will treat clients within its capabilities, regardless of race, national origin, religious belief, gender, sexual orientation, marital status, age, veteran's status, political beliefs, or disability.

Communications:
In an effort to facilitate prompt communication of information related to your care, and in an effort to respect your privacy, we ask you to respond to the following. Check ALL items that apply to you. Non-urgent results, confirmation, reminder calls and general information/instructions regarding your health care can be left on:

____A message at my home number
____My work voicemail
____My cell phone voicemail/text message
____Do NOT leave any messages on my home, work or cell phone

Information regarding non-urgent results confirmation, reminder calls and general information/instructions regarding my health care can be shared with:

____Spouse/Significant Other (Name of party)_____
____Other, Specify name(s)_____

_____ _____
Client or if under 18 Parent's Signature Relationship to Client (if app.)

_____ _____
Print Name Date/Time

New Client Questionnaire

Please complete the following questions as fully and as honestly as possible in order to help me better understand your reasons for seeking therapy and to get to know you.

Name_____ Date_____

May I ask how you heard of me?_____

Have you received any mental health services before?_____

If yes, what type of services?_____

When and where did you receive the above service(s)?_____

How many different Therapists have you seen?_____

Therapist's name (optional)_____

What did you find **most helpful** in therapy?_____

What did you find **least helpful** in therapy?_____

As you see it, what is bothering you most right now?_____

_____

Has anything like this happened before?_____ When?_____

What led you to seek help at this time?_____

_____

How would you like to change things?_____

_____

What do you do to help you feel better?_____

What was the happiest time in you life?_____

What was the **worst** time of your life?_____

Ideally, what would you like to get from therapy?_____

_____

Please add any additional information which you feel may be important for me to know.____

_____

Thank you for taking the time to complete this questionnaire.

Symptom Checklist

Client:_____ Date:_____

Circle Yes or No if you have noticed any of the following symptoms, then please check the duration of the symptoms.

		2 weeks or longer	2 years or longer
A sad or blue or depressed mood or loss of interest or pleasure in all or most of your usual activities?	YES or NO		
Sad mood is worse in the mornings?	YES or NO		
Wake at least two hours before your usual time of waking?	YES or NO		
Decreased effectiveness or productivity at school, work, or home?	YES or NO		
Social withdrawal (less involvement with friends and activities)?	YES or NO		
Loss of interest in sex or decrease in sexual drive?	YES or NO		
A loss of interest or pleasure in usual activities?	YES or NO		
Feelings of worthlessness or low self-esteem?	YES or NO		

Sluggish feeling (slowing down)?	YES or NO		
Feelings of self-reproach or guilt?	YES or NO		
Recurrent thoughts of death, suicidal thoughts, wishes to be dead?	YES or NO		
Suicide attempts?	YES or NO		
Feeling nervous or anxious or on edge? Any sudden feeling of fear or panic attack?	YES or NO		
Diminished ability to think or concentrate, having a lot on your mind?	YES or NO		
Irritability or excessive anger?	YES or NO		
Difficulty with sleeping or sleeping too much?	YES or NO		
Poor appetite or weight loss when not dieting or increased appetite or weight gain?	YES or NO		
Making self vomit or taking laxatives?	YES or NO		

<u>Explain if necessary:</u>

Have you experienced episodes of violence with destruction of property or assaults on

other people or have you ever been arrested for this type of behavior? Yes or No

Have you been seriously troubled by impulses to gamble, steal, set fires, or behave in any way that is harmful to yourself or others? Yes or No

If yes, have you been arrested for any of these behaviors? Please describe.

_____

_____

Have you had or do you have thoughts of hurting someone else (homicidal thoughts? Yes or No

Are you aware of any problem with your sexual functioning? Yes or No

Are you troubled by fear or avoidance of any situation or object that seems excessive or unreasonable to you or that interferes with normal functioning? (Examples: Fear of flying, crowds, etc.) Yes or No

Check all of the following which have troubles you in the past month:

Shakiness	
Jitters	
Trembling	
Jumpiness	
Tension	
Muscle Aches	
Fatigue	
Unable to Relax	
Eye Twitch	
Furrowed Brow	
Strained Face	
Fidgeting	
Restlessness	
Startled Easily	
Sweats	
Agitated	

Heart Pounding or Racing	
Cold Clammy Hands	
Dry Mouth	
Dizziness	
Light Headedness	
Tingling Hands or Feet	
Upset Stomach	
Hot or Cold Spells	
Frequent Urination	
Diarrhea	
Discomfort in Pit of Stomach	
Lump in the Throat	
Flushing	
Rapid Breathing	
Excessive Worries, Fears, or Thoughts	
Nightmares	
Being Too Alert and Causes:	
- Difficulty in Concentration	
- Not Sleeping Well	
- Feeling on Edge, Irritable, Impatience	
Back Pain	
Chest Pain	
Headaches	
Migraines	
Hormonal Symptoms	

<u>Have you been troubled significantly enough to interfere with your relationship with others, with work, with enjoyment of life in any of the following situations:</u>

Recurrent, persistent ideas or thoughts, impulses or images that intrude on your mind and are difficult to get rid of and keep popping back in despite attempts to ignore them or make them go away? Yes or No

By repetitive behaviors that have to be performed according to certain ideas or rules, that if not done would result in an increase in tension? Yes or No

Do you now or have you in the past noted any experience of voices talking about you or to you even though there are no people around? Yes or No

Have you noted any ideas that seem bizarre, strange or unusual to you that persisted or interfered with your functioning Yes or No

Do you feel that people or organizations are monitoring you, tapping your telephone or following you? Yes or No

Do you think you have a problem or have had a problem with alcohol or other chemicals prescribed or not? Yes or No

Do you think that others can read your mind or control your thoughts? Yes or No

Guidelines for Therapy

Therapy is a process that allows you the freedom and privacy to discuss issues that may be painful or difficult to discuss with family and/or friends.

The following are a few suggestions to help make your counseling experience most effective:

1. When questions, topics or issues arise that you would like to focus on in your sessions, write them down and bring them to your next scheduled appointment.

2. Communicate your expectations to me so that we are working together toward your goals.

3. Provide ongoing feedback to me so that I know how you are doing (example, "I want to focus on my anger more" or "I like doing relaxation exercises").

4. If you feel a need to increase or decrease the frequency of your sessions, or to end counseling, feel free to communicate that to me.

5. If you feel the need to bring a partner, relative, or friend in with you for your sessions in order to work on interpersonal issues, feel free to do so. Please discuss it with me prior to their arrival.

6. If you have another professional involved in your care (i.e., physician, chiropractor, attorney, etc.), I would be happy to coordinate with him/her if you wish. It is not advisable to have more than one mental health counselor involved in your treatment at one time.

7. Try to make a commitment to yourself to remain in therapy and attend regular sessions for as long as you feel necessary. If you wait until you have a crisis, it will be more difficult to build long-lasting coping skills.

8. If for any reason you would like to see a different therapist, please feel free to tell me. I can provide you with names of other therapists.