Adult Intake Form

Northwoods Counseling Services
481 Mag Seven Court SW, Suite #3; Bemidji, MN 56601
Phone: 218-444-2821 Fax: 218-333-9445

Name of Client: _____Former or Maiden name: _____

Date of Birth: _____ Age: _____ SSN# _____Gender: ☐ Male ☐ Female

Mail Address: _____Physical Address: _____

City: _____ State: ____ Zip: _____ County: _____ Referral Source: _____

Indicate the best way to reach you: ☐Home #_____ ☐Cell #_____Text OK? ☐Yes ☐ No

Email Address: _____Name of person completing form:_____

Do you have difficulty with reading or writing? ☐ Yes ☐ No

Employment: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Employer: _____ Occupation: _____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

Education: 1 2 3 4 5 6 7 8 9 10 11 12 ☐ Diploma ☐ GED ☐ College/Vocational 1 2 3 4 5 6
Degree:_____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ Alaskan/Native American Tribe:
_____

Client Lives: ☐ Alone ☐ With immediate family ☐ With extended family ☐ With non-related

Client Lives in: ☐ Private Residence (home/apartment) ☐ Shelter/Homeless ☐ Other Residential Setting
☐ Correctional Facility ☐ Other institution setting ☐ Other: _____

Are you a Veteran? ☐ Yes ☐ No If yes, date of discharge: _____

Is the reason you are wishing to be seen military related? ☐ Yes ☐ No

Have you had a diagnostic assessment completed within the past year at another mental health agency? ☐
Yes ☐ No If yes, please tell us the agency: _____

Does a copy of your assessment need to be forwarded to someone outside of this office? ☐ Yes ☐ No
If yes, please tell us: Who: _____ Office: _____

People Living in the same household:

Name	Age	Relationship	M/F	Employer	Phone

In case of emergency, who may we contact?

Name	Relationship to You	Phone

**I authorize Northwoods Counseling Services Ltd. to release necessary information to my emergency contact in the event of emergency* Initial: _____

Order for protection and restraining order policy (Please read and sign):
In order to ensure the safety of our clients and clinicians, it is mandatory that we be informed and provided copies of any current or future Orders for Protection and/or Restraining Orders concerning our clients. We are further bound to comply with existing OFP's and Restraining Orders. I understand and will comply with the Northwoods Counseling Services policy concerning disclosure of restraining orders.

_____ _____
Signature of Client (or client's guardian) **Date**

Is there currently an Order of Protection (OFP) or Harassment Order in place from any state regarding a member of your household?
☐ Yes ☐ No If yes, name of family member: _____
Name of other party involved: _____
Expiration Date of Order: _____

INSURANCE INFORMATION: (Present Insurance Card(s) to Office Staff Please)

Primary Insurance Company: _____

Card Holder: _____ Birth date:_____

Phone #: _____ Employer: _____

Address _____

Employer _____

Policy ID #_____ Group # _____

Secondary Insurance Company:_____

Card Holder: _____ Birth date:_____

Phone #: _____ Employer: _____

Address _____

Employer _____

Policy ID #_____ Group # _____

BILLING INFORMATION – Please read and sign:

1. I authorize Northwoods Counseling Services Ltd to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, agency accountant(s), agency legal representatives, RPT-S Supervisor, and insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize Northwoods Counseling Services to release my medical records and billing information to my Primary Care and/or Referring Physician.
3. I authorize my insurance benefits to be paid to Northwoods Counseling Services
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.

Name of person completing this form (please print) _____

Signature of person completing this form_____ Date: _____

Relationship to Patient: _____

Checklist of Concerns

Describe what changes in your life you are seeking by coming to Northwoods Counseling:

Please mark all of the items below that apply to you. Circle the one that is the most important.

- ☐ Marital/family Problems
- ☐ Abuse/assault victim
- ☐ Social/interpersonal (not family) problems
- ☐ Sexual abuse/rape victim
- ☐ Coping with daily roles
- ☐ Child behavior problems
- ☐ Medical Physical symptoms
- ☐ Major mental illness
- ☐ Depression
- ☐ Psychiatric medication
- ☐ Attempt, threat, danger of suicide
- ☐ Other: _____
- ☐ Alcohol/drugs
- ☐ Perpetrator of sexual abuse
- ☐ Court Evaluation Referral
- ☐ Anger Management
- ☐ Program entrance Evaluation
- ☐ Gambling
- ☐ Eating disorder
- ☐ Stress
- ☐ Anxiety
- ☐ ADD/ADHD

Please continue checking all items that apply to you:

- ☐ Aggression, violence
- ☐ Headaches, other kinds of pain
- ☐ Career concerns, goals and choices
- ☐ Inferior feelings
- ☐ Childhood issues (your own childhood)
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Children, child management, child care, parenting
- ☐ Irresponsibility
- ☐ Concentration
- ☐ Judgement problems, risk taking
- ☐ Compulsions (actions that are repeated)
- ☐ Legal matters, charges, suits
- ☐ Custody of children
- ☐ Loneliness
- ☐ Decision making, indecision, putting off decision
- ☐ Memory problems
- ☐ Delusions (false ideas)
- ☐ Menstrual problems, PMS, menopause
- ☐ Dependence
- ☐ Mood swings
- ☐ Emptiness
- ☐ Motivation, laziness
- ☐ Failure
- ☐ Nervousness, tension
- ☐ Fatigue, tiredness, low energy
- ☐ Obsessions (thoughts that are repeated)
- ☐ Fears, phobias
- ☐ Overly sensitive to rejection
- ☐ Financial or money worries
- ☐ Panic or anxiety attacks
- ☐ Work problems, workaholic, can't keep a job
- ☐ Perfectionism
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Pessimism
- ☐ Guilt
- ☐ Procrastination, work inhibitions
- ☐ Relationship problems
- ☐ School problems
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Sexual issues (dysfunction, conflicts, etc)
- ☐ Self-neglect, poor self-care
- ☐ Shyness, over sensitivity to criticism
- ☐ Suspiciousness
- ☐ Sleep problems
- ☐ Smoking and tobacco use
- ☐ Thought disorganization and/or confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Other concerns or issues: _____
- ☐ Recreation/hobbies

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In order to provide high quality care, please complete the following. This information will become part of the Diagnostic Assessment.

Are you allergic to any drugs? ☐ Yes ☐ No
If yes, please list: _____

Do you have any other allergies? ☐ Yes ☐ No
For example: foods, air borne, etc. If yes, please list: _____

Are you pregnant? ☐ Yes ☐ No

Who is your medical Doctor? _____

Name of Clinic and location: _____

When was your last physical examination? _____ Results: _____

Have you experienced a recent weight loss or weight gain? ☐ Yes ☐ No

Do you have any problems that might interfere with your receiving services at here? ☐ Yes ☐ No
If yes, please list: _____

Have you received services for alcohol and/or drug problems in the past? ☐ Yes ☐ No
If yes, where? _____

Have you ever been treated for any of the following?

☐ Birth or developmental problems in childhood
☐ Chronic illness
☐ ADHD
☐ Hepatitis
☐ Alcohol issue
☐ Heart disease
☐ Anemia
☐ High blood pressure (hypertension)
☐ Anxiety
☐ Chest pain, palpitations
☐ Cancer
☐ Kidney disease
☐ Chronic pain
☐ Lung disease, pneumonia
☐ Diabetes ☐ Type I ☐ Type II
☐ PTSD
☐ Depression
☐ Serious injury or accident
☐ Head injury (epilepsy, seizures, convulsions, confusion)
☐ Sexual performance problems
☐ Headaches, migraines
☐ Stroke
☐ Constipation
☐ Thyroid problems
☐ Urinary incontinence
☐ Tuberculosis
☐ Vision problems
☐ Ulcer
☐ Hearing problems
☐ Sexually transmitted disease
☐ Low energy
☐ Problems with appetite
☐ Skin problems
☐ Gastrointestinal problems
☐ Past surgeries
☐ Ongoing pain or discomfort
☐ Gastric bypass
☐ Other: _____

If any of the boxes are checks, please comment on length and duration of problem: _____
_____

Client Initial: _____ DOB: _____ Today's Date: _____

Medical Information Supplement – page 2

Have you had any past suicide thoughts or attempts? ☐ Yes ☐ No
How long ago: _____

Have you had any visits to the Emergency Room in the last year? ☐ Yes ☐ No

If yes, what symptoms were you were experiencing when you went to the ER? _____

Have you had any hospitalizations related to mental health? ☐ Yes ☐ No
If yes, when: _____

Where: _____

What symptoms were you experiencing when you were hospitalized? _____

Are you currently or have you been treated for any mental health conditions? ☐ Yes ☐ No

If yes, when: _____

Where: _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list below:

Medication Name:	Dosage:	How Often:	Prescribed by:

Past medications: _____

Do you take vitamins, herbal medications, diet supplements or over the counter medications? ☐ Yes ☐ No

If yes, what type, how much, and for how long? _____

PERMISSION TO PROVIDE TREATMENT

I, _____, hereby authorize Northwoods Counseling

Services Ltd to provide psychotherapy services. I attest to the fact that I have the legal authority to grant this permission.

Signature: _____ Date: _____

Cancellation Policy/Agreement

Due to high demand for mental health services at Northwoods Counseling Services Ltd., clients and families are being asked to sign, and agree to, the cancellation policy terms and conditions. Text Message reminders 24 hours prior containing the appointment date and time are a courtesy provided by Northwoods Counseling Services Ltd. to ensure attendance. Please request this service if you do not currently receive text message reminders.
Late Cancel/No Shows: If patients arrive 15 or more minutes late to an appointment without calling to inform Northwoods Counseling Services Ltd. of the late arrival, they may be asked to reschedule as their appointment will be considered a Late Cancel/ No Show. Patients unable to attend a scheduled appointment or group session must cancel the appointment more than 24 hours prior to the appointment time. Reminder text messages are sent at this time. To cancel an appointment, please text or call 218-252-2785. In cases of extraordinary circumstances that arise less than 24 hours prior to the appointment time (e.g. physical illness), the clinic still appreciates to be informed about the missed appointment. There is a daily cancellation list of patients hoping to attend an open appointment time. It is appreciated by other clients and their families if you call with enough time to allow their attendance at that time. This also ensures the possibility of an appointment opening to reschedule your appointment at a later date. Failure to cancel an appointment less than 24 hours prior to an appointment will require:

- One late cancel/no show in a six month period= Client must call to confirm an appointment the following week. If no call is made, no appointment will be made for the following week.
- Two late cancels/no shows in a six month period= Client will lose their weekly/ biweekly session time and must schedule an appointment each week.
- Three late cancels/no shows in a six month period= Client will be required to call the morning of the day the client prefers to attend an appointment. A session will be scheduled if an appointment time is available. If no time is available, the client will need to call back at a later date.

I understand and agree to the above cancellation policy.

Signature:_____ Date: _____

Printed Name: _____

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