

2356 University Ave W, Suite 280
 Saint Paul, MN 55114
 651-646-1488 phone
 651-646-2285 fax



Family Circle Counseling

Therapist:
 Date:
 Diagnosis:

Client Insurance Information and Financial Agreement

Client Name:	Date of Birth:
Responsible Party Name:	Relationship to Client:
Address:	Email:
Phone - Home: <small>OK to leave message Y/N</small>	Work: <small>OK to leave message Y/N</small>
	Cell: <small>OK to leave message Y/N</small>
<p>IMPORTANT: It is essential that you fill out the rest of the form very carefully with all the necessary information regarding ALL of your insurances. If you do not give us accurate information you will then be responsible for payment, or will be charged for re-submission of claims.</p> <p>I HAVE ONLY ONE INSURANCE and understand that if I have another one at any time and do not communicate the information to FCC, I might be responsible for payment in full. <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, make sure you fill in all the information in the form below)</p>	
Insurance - Primary ID-Number:	Group Number:
Insurance Company Name:	Phone Number:
Insurance Claim Address:	
We get insurance through MEDICARE , the Military , or employment with a Federal Government Agency <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Policy Holder:	Relationship to client:
Address (if different from above):	
Policy Holder's/Insurance Parent's ID Number:	Social Security No:
Date of Birth:	
If insurance is through employer, Employer Name:	
Employer's Address:	
Co-Pay:	Deductible:
Pre-authorization required: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, number to call:	
Important: To bill your insurance, we must have a copy of your insurance card on file.	
Other Insurances - ID-Number:	Group Number:
Insurance Company Name:	Phone Number:
Insurance Claim Address:	
Name of Policy Holder:	Relationship to client:
Address (if different from above):	
Policy Holder's Social Security Number:	
Date of Birth:	
If insurance is through employer, Employer Name:	
Employer's Address:	
Co-Pay:	Deductible:
Pre-authorization required: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, number to call:	



Adult Intake Questionnaire

Name:

Preferred Name:

Pronouns:

Referred by:

Why are you seeking therapy at this time?

Current Family Information

Partner's Name:

Years married/involved:

Please list children (whether or not they are living with you) and other household

Name	Age	Sex	Relationship to Client

Other significant information about your/your partner's family that would be helpful to know? Family history of medical and/or mental problems? Please explain:

Medical/Mental Health History

Do you currently have any medical problems (include chronic health problems such as asthma, diabetes, etc.)? If so, please list:

Current medications:



Have you ever had surgery?
.....

Have you had accidents that resulted in serious injury?
.....

Physical Symptoms

- | | |
|--|--|
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> poor memory |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> overweight |
| <input type="checkbox"/> poor appetite | <input type="checkbox"/> underweight |
| <input type="checkbox"/> back pain | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> can't sleep | <input type="checkbox"/> always hungry |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> other (specify) |
-

Have you ever had an outpatient/inpatient mental health treatment? Yes No

Dates of Service:
.....

Location:
.....

Therapist(s):
.....

Psychiatrist(s):
.....

Medications prescribed? Yes No

Name:

Dose:
.....

Name:

Dose:
.....

Name:

Dose:
.....

Have you ever had thoughts of harming yourself? No Yes:

When was the last time you have had these thoughts?
.....

Are you currently experiencing any of the following symptoms? When did these problems begin? Check all that apply.

- depressed or irritable mood most of the day, nearly every day
- diminished pleasure in activities
- decrease or increase in appetite
- insomnia (too little sleep) or hypersomnia (too much sleep)
- fatigue or loss of energy
- having excessive thoughts of worthlessness or inappropriate guilt
- difficulty concentrating/thinking
- suicidal thoughts or thoughts about dying
- more talkative than usual or pressure to keep talking
- racing thoughts



- distractibility
- agitation, anger outbursts
- excessive involvement in pleasurable activities that have a potential for painful consequences (buying sprees, sexual activity, etc....) feeling the need to be a perfectionist
- feeling anxious
- feeling irritable
- experiencing lack of self confidence
- experiencing temper outbursts
- feeling over active
- feeling not active enough
- having upsetting and /or persistent thoughts
- feeling nervous most of the time
- experiencing poor self-control
- unable to make decisions
- feeling easily confused
- having too high expectations of self
- feeling unhappy
- having too high expectations of others
- not able to trust others
- feeling isolated
- experiencing school problems
- experiencing work problems
- experiencing feelings of loss and grief around:
 - death
 - divorce
 - suicide

Have you ever been treated for alcohol or drug dependence? Yes No

CAGE-AID Questions - Please check Yes or No for each question:

Have you ever felt you ought to cut down on your drinking or drug use? Yes No

Have people annoyed you by criticizing your drinking or drug use? Yes No

Have you felt bad or guilty about your drinking or drug use? Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? Yes No



Has anyone in your family/extended family had drug/alcohol problems or been treated for alcohol/drug dependence? Yes No If Yes, please explain:

.....
.....

Have you ever been sexually abused, physically abused, emotionally abused?
 No Yes - By whom?

.....

Is there abuse in your present relationships/family? Yes No
Do you worry about being abusive? Yes No

Family/Relationship

Are you experiencing any of the following difficulties?

- difficulty with partner/spouse
- staying away from home too much
- difficulty with children
- excessive arguing
- difficulty with relatives
- poor communication
- sexual/intimacy problems
- lack of understanding other
- other (specify)

.....

Social Problems

Is your daily functioning impacted by stressors such as

- racism sexism
- discrimination due to sexual preference
- discrimination due to physical and/or mental disability fear of crowds
- problems with your religion or faith
- not being liked by others
- experiencing loneliness lacking companionship
- experiencing dating problems
- experiencing job problems having panic attacks
- dealing with financial difficulties
- other (specify)

.....
.....
.....

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How would you describe your ethnicity / cultural heritage?

.....
.....
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.....

What are you most concerned about?

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What are some of your goals for therapy?

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.....
.....

Where do you turn for support? Family? Friends? Faith / spirituality? Work relationships?

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.....
.....

What personal strengths have helped you in the past to deal with difficulties similar to those of concern today?

.....
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.....
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