Therapist:
Date:
Diagnosis:

2356 University Ave W, Suite 280
Saint Paul, MN 55114
651-646-1488 phone
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Family Circle Counseling

Client Insurance Information and Financial Agreement

Client Name:	
Date of Birth:	
Responsible Party Name:	Relationship to Client:
Address:	
Phone - Home:	OK to leave message ❑ Yes ❑ No
Phone - Work:	OK to leave message ❑ Yes ❑ No
Phone - Cell:	OK to leave message ❑ Yes ❑ No

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.
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. ❑Yes ❑No (If No, make sure you fill in all the information in the form below)

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** ❑ Yes ❑ No	
Name of Policy Holder:	
Relationship to Client:	
Address (if different from above):	
Policy Holder's/Insurance Parent's ID Number:	
Date of Birth:	Social Security Number:
If insurance is through employer, Employer Name:	
Employer's Address:	
Co-Pay:	Deductible:
Policy Holder's Social Security Number:	
Date of Birth:	
If insurance is through employer, Employer Name:	
Employer's Address:	
Co-Pay:	**Deductible:**

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Pre-authorization required: ❑ No ❑ 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 Address:	
Co-Pay:	**Deductible:**
Pre-authorization required: ❑ No ❑ Yes If Yes, number to call:	

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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:

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Have you ever had surgery?

Have you had accidents that resulted in serious injury?

Physical Symptoms

❑ shortness of breath
❑ fatigue
❑ poor appetite
❑ back pain
❑ can't sleep
❑ panic attacks
❑ poor memory
❑ overweight
❑ underweight
❑ chest pain
❑ always hungry
❑ 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

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❑ 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

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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?

What are you most concerned about?

What are some of your goals for therapy?

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

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