Northland Counseling Center, Inc.
Adult Registration Form

Client Name: ______________________________ **Client Number:** __________

I. ADMISSION INFORMATION

Client Address: ______________________________

City ______________________ State __________ Zip __________

Phone #: (home) ______________ (work) ______________ (cell) ______________

I authorize Northland staff to contact me at the above address and phone number: Yes No

May we leave a message if you are not at home? Yes No

Birthdate: ______________ **Social Security #:** ______________ **Sex:** Male Female

Client's primary physician: ______________________________

II. POWER OF ATTORNEY/GUARDIANSHIP INFORMATION *(Signature on reverse authorizes treatment of above client)*

Your Name ______________________________ Phone #______________

Address ______________________________

_____ I have Power of Attorney on behalf of client above and am attaching supporting documentation of said Power of Attorney.

_____ I have Guardianship of client above and am attaching supporting documentation from the Court giving me said guardianship.

III. INSURANCE INFORMATION *(check and complete all that apply)*

_____ Primary insurance ***(attach copy of card)*** ID# ______________ Group#______________

Insurance Company Name ______________________________

Address ______________________________

Phone Number ______________________________

Subscriber Name ______________________ DOB: ______________

Address ______________________________

Relationship ______________________________

_____ Secondary Insurance ***(attach copy of card)*** ID# ______________ Group#______________

Insurance Company Name ______________________________

Address ______________________________

Phone Number ______________________________

Subscriber Name ______________________ DOB: ______________

Address ______________________________

Relationship ______________________________

_____ No insurance Have you applied for Medical Assistance? Yes No Pending or denied?

****PLEASE READ AND SIGN REVERSE****

IV. RELEASE OF INFORMATION

I authorize Northland Counseling Center, Inc. to release information to my insurance company regarding my treatment and I permit a facsimile or photographic reproduction of this authorization in place of the original. This could include my Social Security number, diagnosis, prognosis, dates of treatment, narrative notes, and types of treatment. This is for the purpose of validating claims submitted to stated insurance carrier. I also authorize stated insurance carrier to make payments to Northland Counseling Center, Inc. for all insurance benefits to which I or my dependents are entitled for services received. I understand that this consent will terminate one year from signature date unless I choose to revoke it earlier.

V. STATEMENT OF UNDERSTANDING

I understand that I am responsible for the charges in full if I do not maintain coverage for which I am eligible or fail to provide insurance information and/or income verification (if interested in fee reduction).

I recognize that Northland Counseling Center, Inc. cannot guarantee payment of charges by any particular insurance carrier. **If I have questions regarding coverage, I will contact my insurance company.**

In the event Northland Counseling Center, Inc. has been unable to collect payment from me for services within a reasonable period of time, the Center then reserves the right to turn the account over for collection of my bill. A 15% processing fee will be added to any account sent to collections.

I affirm that the information on reverse is accurate. I am aware of my financial responsibilities and agree to the payment terms. I authorize the release of information to my insurance carrier(s). **If my address, phone number, financial status, or insurance coverage changes, I will notify Northland Counseling Center, Inc.**, and an update of this agreement may be renegotiated.

____ ________________

Client signature Date

____ ________________

Parent/Guardian signature Date

NORTHLAND COUNSELING CENTER

ADULT HEALTH QUESTIONNAIRE

Name: ______________________________ Date of Birth: __________ Age: ______

Height: __________ Weight: __________ Do you have a Health Care Directive (assumed no if blank)? ________

In an emergency notify: ____________________ relationship: __________ phone: __________

Primary care physician/clinic: ____________________ Pharmacy: ____________________

Brief reason for contacting NCC: ______________________________

Referred by: ____________________ Current therapist: ____________________

MEDICAL

Date of last physical examination ______________________________

Yes No Medication allergies -List if yes ______________________________

Yes No Other allergies - List if yes ______________________________

Yes No Medication side effects -Explain if yes ______________________________

Yes No Supplemental medicinal treatment (St. John's Wort, herbs, vitamins)

Types if yes ______________________________

Yes No Family history of thyroid problems - Explain if yes ______________________________

Yes No Head/brain injuries, seizure, stroke, concussion or loss of consciousness

Explain if yes ______________________________

Yes No Current treatment for medical condition/infection

Explain if yes ______________________________

Yes No Past medical problems

List if yes ______________________________

Yes No Pain which interferes with daily activities - Explain if yes ______________________________

Yes No Recent significant weight gain/loss? (how much) ______________________________

Yes No Caffeine consumption - Type & daily quantity ______________________________

Yes No Tobacco (smoke/chew) - Daily quantity ______________________________

Yes No Do you eat regular meals? Describe meal if yes ______________________________

Yes No Exercise - List type & how often ______________________________

WOMEN

Yes No Currently pregnant – Due date ______________________________

Yes No Regular periods - Explain if no ______________________________

MEDICATION			
Brand	**Dose**	**Brand**	**Dose**
1		6	
2		7	
3		8	
4		9	
5		10	

Yes No Mental Health Assessment within past year (date) ______________________________

MENTAL HEALTH			
Type	**Facility**	**Date**	**Reason**
In-patient			
Out-patient			
Medication management			
Other (i.e., day treatment, partial hospitalization)			

CHEMICAL DEPENDENCY (CD) TREATMENT			
Type	**Facility**	**Date**	**Reason**
In-patient			
Out-patient			

Comments: ____

____

____

____

______________________________________ Date: ____________________

Client/Guardian signature

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GAIN-Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS 2.0.3

What is your name? a.________________________ b. ____ c. ________________________
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) ____/____/________

The following questions are about common psychological, behavioral, and personal problems. These problems are considered <u>significant</u> when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0
IDScr 1. <u>When was the last time</u> that you had <u>significant</u> problems…				
a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	3	2	1	0
b. with sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	3	2	1	0
c. with feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	3	2	1	0
d. with becoming very distressed and upset when something reminded you of the past?	3	2	1	0
e. with thinking about ending your life or committing suicide?	3	2	1	0
EDScr 2. <u>When was the last time</u> that you did the following things <u>two or more times</u>?				
a. Lied or conned to get things you wanted or to avoid having to do something?	3	2	1	0
b. Had a hard time paying attention at school, work, or home?	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home?	3	2	1	0
d. Were a bully or threatened other people?	3	2	1	0
e. Started physical fights with other people?	3	2	1	0
SDScr 3. <u>When was the last time</u> that…				
a. you used alcohol or other drugs weekly or more often?	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs?	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	3	2	1	0
d. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events?	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	3	2	1	0

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(Continued) After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0

CVScr 4. When was the last time that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	3	2	1	0
b. took something from a store without paying for it?	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	3	2	1	0

5. Do you have other significant psychological, behavioral, or personal problems that you want treatment for or help with? (If yes, please describe below) .... Yes 1 No 0

v1. ______________________________

v2. ______________________________

v3. ______________________________

6. What is your gender? (If other, please describe below) ………… 1-Male 2-Female 99-Other

v1. ______________________________

7. How old are you today? |__|__| years

For Staff Use Only

8. Site ID: ____________ Site Name v. ____________
9. Staff ID: ____________ Staff Name v. ____________
10. Client ID: ____________ Comment v. ____________
11. Mode: 1) Administered by staff 2) Administered by other 3) Self-administered
12. Number of 2s and 3s: IDSscr: ____ EDScr: ____ SDScr: ____ CVScr: ____ TDScr: ____
13. Referral: MH____ SA ____ ANG ____ Other ____ 14. Referral Code: ________
15. Referral comments:

v1. ______________________________

v2. ______________________________

v3.

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Patient Health Questionnaire (PHQ-9)

Patient name: ________________________________ Date: __________________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy.	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	☐	☐	☐	☐
h. 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 more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, 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

TOTAL SCORE ____________

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WHODAS 2.0
World Health Organization
Disability Assessment Schedule 2.0

Name:______________________________ Date: ____________________

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please check only one response.

		None (1)	Mild (2)	Moderate (3)	Severe (4)	Extreme or cannot do (5)
1	Standing for long periods such as 30 minutes?					
2	Taking care of your household responsibilities?					
3	Learning a new task, for example, learning how to get to a new place?					
4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?					
5	How much have you been emotionally affected by your health problems?					
6	Concentrating on doing something for ten minutes?					
7	Walking a long distance such as a mile (or equivalent)?					
8	Washing your whole body?					
9	Getting dressed?					
10	Dealing with people you do not know?					
11	Maintaining a friendship?					
12	Your day-to-day work?					

1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days ____
2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days ____
3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days ____

This completes the questionnaire. Thank you.

Northland Counseling Center, 215 SE Second Avenue, Grand Rapids, MN 55744
218-326-1274 1-800-450-1274 Fax: 218-326-9787

Authorization for the Release of Medical Information

I, ____ **authorize**
(Name) (DOB)

Northland Counseling Center to:
(Check one or both)

__x__ **Give information to**
__x__ **Receive information from**

____
(Outside Agency or Individual's Name)

Dates or Type of service to be released by mail, telephone, or facsimile as follows:

X Diagnostic Assessment/Psychological Evaluation
X Treatment Plan
X Narratives/Progress Notes
X Educational Information
X Other (specify) Verbal

X Psychological Testing Results
X Medical Report and Medication Regimen
X Discharge Summary

Records related to chemical dependency, mental health, sickle cell anemia, tuberculosis, and/or HIV/AIDS will be released, unless otherwise indicated by initialing here: ________

Approximate Dates of information requested: Current or most recent episode of care.

Purpose of Disclosure:

X Coordination of Care and Services
X Future Referrals/References
____ Other (specify) ______________________

____ Legal
____ Disability Claims

I understand that my authorization terminates one year from the date of my signature. I understand that I have the right to revoke this authorization in writing at any time prior to the termination date. I understand that NCC cannot release information disclosed by this authorization to anyone other than listed above, and that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient only upon my written consent. I further understand that the information disclosed as a result of this authorization may no longer be protected and could be redisclosed by the recipient without my permission. NCC will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original.

______________________ ____________
Client/Guardian Signature **Date**

______________________ ____________
Witness **Date**

If signing as the authorized representative of the patient, I am: (please check one)
____ Court appointed guardian
____ Custodial parent of a minor
____ Other, explain______________

This information will be disclosed from your records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical, or other information, is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.