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

INITIAL CONTACT SUMMARY

CLIENT LEGAL NAME _____

DOB _____ SS# _____

MAILING ADDRESS _____

_____

HOME # _____ WORK # _____

CELL # _____ MESS OK: YES NO TEXT OK: YES NO

PARENT/SPOUSE _____

PERSON RETAINING LEGAL CUSTODY IF NOT PARENT (NAME, PHONE, ADDRESS)

_____

_____

PRESENTING ISSUE _____

PRIMARY CARE PHYSICIAN/FACILITY _____

CURRENT MH THERAPIST/PSYCHIATRIST _____

TYPE OF INSURANCE _____

ID # _____ GROUP # _____

SUBSCRIBER NAME, DOB & EMPLOYER _____

PHYSICIANS, HOSPITALS, MENTAL HEALTH PROVIDERS SEEN IN THE LAST 3 YEARS (Name, Facility Name, City, State)

1. _____
2. _____
3. _____
4. _____
5. _____

OFFICE USE ONLY

ICS DATE _____ NEW _____ CLOSED _____ CHART # _____

APPT DATE & TIME _____ CLINICIAN _____

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

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 significant 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. When was the last time that you had significant 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. When was the last time that you did the following things two or more times?

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. When was the last time 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

(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.

NAME: _____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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 a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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**
☐	☐	☐	☐

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/CD Evaluation	X	Psychological Evaluation
X	Treatment Plan	X	Medical Report and Medication Regimen
X	Narratives/Progress Notes		
X	Educational Information	X	Discharge Summary
X	Labs		
X	Other (specify) Verbal		

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: _____

Purpose of Disclosure:

X	Coordination of Care and Services	_____	Legal
X	Future Referrals/References	_____	Disability Claims
X	Other (specify) _____		

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**

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

_____ _____
Witness **Date**

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.