

Dynelle Helgeson, RN, MA, LMFT

3209 West 76th Street Suite 202A

Edina, MN 55435

Phone: 612-568-8038 Fax: 612-314-8501

**Client Identification Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ClientName | (Last) | (First) | (Middle) | Age | Birthday | Sex |
| Address | City | State | Zip |
| Cell phone | Home phone | Work phone |
| **Ok to call? Yes NO** | **Ok to call? Yes NO** | **Ok to call? Yes NO** |
| **Ok to leave message? Yes NO** | **Ok to leave message? Yes NO** | **Ok to leave message? Yes NO** |
| **Marital Status**Single □ Married □ Divorced □ Separated □ Widowed □ | Email address(s) |
| Education (Highest degree/grade completed) | Health Insurance Company name | Health Insurance Member ID# |
| Health Insurance Group # | Employer/Occupation | Secondary Insurance Information |

**Family History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Names of Family Members** | **Age** | **Emotional Problems** | **Living?** | **Occupation** |
| **Yes** | **No** | **Yes** | **No** |
| Spouse |  |  |  |  |  |  |
| Child |  |  |  |  |  |  |
| Child |  |  |  |  |  |  |
| Child |  |  |  |  |  |  |
| Child |  |  |  |  |  |  |
| Other significantperson(s) in yourhousehold |  |  |  |  |  |  |

**Emergency Contact**

|  |  |  |  |
| --- | --- | --- | --- |
| Name  | Relationship | ContactNumber(s) |  |
|  |
|  |

**Responsible Party Information**

|  |  |
| --- | --- |
| **Printed name of client** | **Printed Name of Legal Guardian (if applicable)** |
| **Signature of client or legal guardian** | **Date** |

**Insurance Provider Statement**

inSession is a provider of Blue Cross and Blue Shield, Preferred 1, United and Tricare. All other insurance companies are out of network and may or may not cover services. We will not know your exact benefits and coverage until we receive an explanation of benefits from your information company after first billing. It is recommended that you call your insurance company to verify your mental health coverage and see what prior authorizations may be necessary. If you are not covered by insurance, my hourly rate is $240.00 for the initial intake assessment and $170.00 for regular sessions and payment will be asked at the start of the appointment.

Please sign this form indicating that you understand this statement and either mail or bring this form into office prior to the beginning of therapy.

Policy Holder Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FOR OFFICE USE ONLY:**

Authorization Number (If Required): \_\_\_\_\_\_\_\_\_\_\_\_Number of Visits Allowed (12 or 24 months):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Copay:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective date of Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**inSession**

Edina Executive Plaza5200 Willson Road, Suite 290

Edina, MN 55424

Phone: 612-568-8038 Fax: 952-236-7129

**Current Symptom Checklist (rate the intensity of the symptoms present in the last 4 weeks)**

**None:** This symptom not present at this time

**Mild:** Impacts quality of daily life, but no significant impairment of day-to-day functioning

 **Moderate:** Significant impact on quality of life and/or day-to-day functioning

**Severe:** Profound impact on quality of life and/or day-to-day functioning

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Symptoms** | **None** | **Mild** | **Moderate** | **Severe** | **Symptoms** | **None**  | **Mild**  | **Moderate** | **Severe** |
| Depressed mood |  |  |  |  | Increased/decreased appetite |  |  |  |  |
| Low energy |  |  |  |  | Unplanned weight gain |  |  |  |  |
| Sleep disturbance |  |  |  |  | Unplanned weight loss |  |  |  |  |
| Dissociation |  |  |  |  | Paranoid thoughts |  |  |  |  |
| Hyperactivity |  |  |  |  | Poor Concentration or Indecisive |  |  |  |  |
| Binging |  |  |  |  | Purging/Over exercising |  |  |  |  |
| Decreased sex drive |  |  |  |  | Excessive worrying |  |  |  |  |
| Unresolved guilt |  |  |  |  | Impulsive actions/speech |  |  |  |  |
| Irritability |  |  |  |  | Anger management problems |  |  |  |  |
| Nausea/Acid reflux |  |  |  |  | Daily stress level |  |  |  |  |
| Social anxiety |  |  |  |  | Hallucinations |  |  |  |  |
| Self-mutilation/Cutting |  |  |  |  | Racing thoughts |  |  |  |  |
| Low self worth |  |  |  |  | Restlessness |  |  |  |  |
| Nightmares |  |  |  |  | Loss of interest in normal activity |  |  |  |  |
| Negative voices inside |  |  |  |  | Decreased creativity/productivity |  |  |  |  |
| Losing train of thought |  |  |  |  | Unresolved anger |  |  |  |  |
| Mood swings |  |  |  |  | Easily distracted |  |  |  |  |
| Disorganized |  |  |  |  | Memories of trauma |  |  |  |  |
| Anorexia |  |  |  |  | Hopelessness |  |  |  |  |
| Social isolation |  |  |  |  | Marital problems |  |  |  |  |
| Grief |  |  |  |  | Panic attacks |  |  |  |  |
| Phobias |  |  |  |  | Suicidal thoughts |  |  |  |  |
| Headaches |  |  |  |  | Feel panicky/anxious |  |  |  |  |
| Loneliness |  |  |  |  | Work problems |  |  |  |  |
| Viewing pornography |  |  |  |  | Alcohol/drug intake |  |  |  |  |
| Problems at home |  |  |  |  | Attempted suicide in the past |  |  |  |  |

**Briefly describe how the above symptoms impair your ability to function**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Situation**

**(Include reason for making appointment, precipitating events, course of symptoms)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you could change anything about your life, what would it be?**

**What can I help you work on?**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What would be different? How would you know that things are better?**

**What would your life look like when you achieve it?**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Psychiatric Treatment? YES NO**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date(s) | Psychiatrist Name/Clinic Name | Issues addressed | Was it helpful? | What worked? What didn’t work? |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Previous Hospitalizations? YES NO**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date(s) | Psychiatrist Name/Clinic Name | Issues addressed | Was it helpful? | What worked? What didn’t work? |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Previous Counseling? YES NO**

(List any and all counselors you have seen previously and include clinic name and dates)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date(s) | Psychiatrist Name/Clinic Name | Issues addressed | Was it helpful? | What worked? What didn’t work? |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

**Health Data**

Your Physician (Full Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic City, State and Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any current medical issues (including any infectious diseases)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your medical problems being treated?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a drug allergy or sensitivity?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | What was it prescribed for? | Dosage | When do you take it each day? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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**Socio Economic Status/Ethnic Background/Religion/Marital Status**

|  |  |  |  |
| --- | --- | --- | --- |
| **Socio Economic Status** | **Ethnic Background** | **Religion** | **Marital Status** |
| □ White/Non-Hispanic | □ Lower Class | □ Christian | □ Married |
| □ Hispanic | □ Middle Class | □ Judaism | □ Divorced |
| □ African American | □ Upper-Middle Class | □ Islam | □ Separated – Still living in home |
| □ Asian American | □ Upper Class | □ Buddhism | □ Separated – Living separately |
| □ European American | □  | □ New Age | □ Single |
| □ Pacific Islander | □ | □ No Religion | □ Widowed |
| □ Native American | □ | □ | □ |
|  |  |  |  |

**Developmental History**

Normal Full-Term Birth? \_\_\_\_\_ Yes \_\_\_\_\_ No (if No, please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did you walk? \_\_\_\_\_ - months \_\_\_\_\_ Early \_\_\_\_\_ Delayed \_\_\_\_\_ Normal

At what age did you talk? \_\_\_\_\_ - months \_\_\_\_\_\_ Early \_\_\_\_\_ Delayed \_\_\_\_\_ Normal

At what age were you toilet trained? \_\_\_\_\_ - months \_\_\_\_\_ Early \_\_\_\_\_\_ Delayed \_\_\_\_\_ Normal

Any significant childhood losses or trauma? \_\_\_\_\_ Yes \_\_\_\_\_ No (if Yes, please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any History of Physical / Emotional / Sexual Abuse? YES NO**

If Yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chemical Use History**

Do you drink any alcoholic beverages? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what do you drink? \_\_\_\_\_ Beer \_\_\_\_\_\_Wine \_\_\_\_\_ Hard Liquor - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you drink? \_\_\_\_\_ Daily \_\_\_\_\_3-5 times/week \_\_\_\_\_\_ 1-2 times/week \_\_\_\_\_ Less frequently

Do you sometimes drink more than you had planned? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have family and friends ever expressed concern about your drinking? \_\_\_\_\_ Yes \_\_\_\_\_\_ No

Have you ever been arrested for alcohol related charges (DWI, Public Intoxication, etc.) \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever been treated for drinking, chemical dependency or gone to AA? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had periods where you were unable to remember what happened when you were drinking? \_\_\_\_\_Yes \_\_\_\_\_ No

Have you ever overdosed? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you use nicotine? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how much and how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use marijuana? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how much and how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Street Drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how much and how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use prescription drugs NOT prescribed to you? \_\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how much and how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Educational History**

Please describe if and when you graduated from high school, list college attendance, any special services received, any difficulties you may have had while in school, any excessive absences, etc.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Classroom type** | **Special services** | **Area(s) of Learning Disability** | **Behavior Issues I** | **Behavior Issues II** |
| **□** Mainstream | **□** Learning Disabilities | **□** Reading | **□** Aggression | **□** Withdrawal |
| **□** Special Ed/ Mainstream  %/ % | **□** Educational Development | **□** Math | **□** Refuses to do work | **□** Truancy |
| **□** All Special Ed | **□** Behavioral Development | **□** Writing | **□** Poor Social Skills | **□** In-school Suspension |
| **□** Day Treatment | **□** Developmental Delays | **□** | **□** | **□** Out-school suspension |
| **□** | **□** | **□** | **□** | **□** Expelled |
| **□** | **□** | **□** | **□** | **□** |

**Occupational History**

(Please describe your past and current occupational experiences)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational concerns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Military History? YES NO**

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**inSesssion** Edina Executive Plaza5200 Willson Road, Suite 290 Edina, MN 55424