Heartland Psychological Services

A South Dakota Nonprofit Corporation - Client Information Questionnaire

Adult Form

Welcome! Please fill out this questionnaire, as it will be useful in getting to know you and help us plan our services for you. Please fill in all pages as completely as possible. If an item is unclear, feel free to ask your therapist for clarification. We are so glad you are here and look forward to working with you.

The Mission of Heartland

To help people in distress relieve their suffering, restore their hope, and reach their potential in an environment of encouragement, compassion, and respect with highly qualified staff committed to effective services

General Client Information

_____

Legal First Name **M.I.** **Legal Last Name** **Maiden**

What name do you prefer we call you? _____ **Preferred Pronouns:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone**: _____

Email: _____

*Please check the boxes to indicate **yes**:*

May we call Home? ☐ **Work?** ☐ **Cell?** ☐

May we leave a message at Home? ☐ **Work?** ☐ **Cell?** ☐

Would you like to receive appointment reminders via text message? ☐

Date of Birth (mm/dd/yyyy): _____ **Age:** _____ **Preferred Gender:** _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Date_____

Race/Ethnicity: _____ **Is Spirituality or Religion important to you?** ☐

Veteran ☐ **Active-Duty** ☐ Dates of Service: _____

Were you referred by a healthcare professional? ☐ If yes, which one? _____

May your therapist contact them? ☐ Yes ☐ No

Spouse or Significant Other (if applicable)

_____

Legal First Name **M.I.** **Legal Last Name** **Maiden**

Preferred Name: _____Preferred Pronouns: _____

Address: _____

City: _____State: _____ Zip: _____

Spouse Home Phone: _____ Work Phone: _____ Cell Phone:

_____

Date of Birth: _____ Age: _____ Preferred Gender: _____

If necessary, may we:

call them at Home? ☐ **May we leave them a message at Home?** ☐

Work? ☐ **Work?** ☐

Cell? ☐ **Cell?** ☐

May we list them as your <u>emergency contact</u>? Yes ☐ No ☐

If not, please list who you would like contacted in the event of an emergency:

_____

Name **Phone** **Relation**

Children Information (if applicable)

Name **Date of Birth** **Age**

_____

_____

_____

_____

_____

_____

What brings you to Heartland at this time? _____

_____

List personal goals you have for treatment: _____

_____

Symptom Screening Checklist

Please rate any of the following symptoms that you are <u>currently</u> experiencing or have experienced in the <u>past</u> and list the duration of the symptom.

Symptom	Never	Often	Always	Duration
Marriage	☐	☐	☐	_____
Separation/Divorce	☐	☐	☐	_____
Children	☐	☐	☐	_____
Parenting	☐	☐	☐	_____
Grief	☐	☐	☐	_____
Sexual Problems	☐	☐	☐	_____
Nervous	☐	☐	☐	_____
Social Anxiety	☐	☐	☐	_____
Fears	☐	☐	☐	_____
Stress	☐	☐	☐	_____
Difficulty Relaxing	☐	☐	☐	_____
Worry	☐	☐	☐	_____
Drug Use	☐	☐	☐	_____
Alcohol Use	☐	☐	☐	_____
Legal Matters	☐	☐	☐	_____
Finances	☐	☐	☐	_____
Gambling	☐	☐	☐	_____
Nightmares	☐	☐	☐	_____
Tiredness	☐	☐	☐	_____
Ambition	☐	☐	☐	_____
Loneliness	☐	☐	☐	_____
Sadness	☐	☐	☐	_____
Tearfulness	☐	☐	☐	_____
Low Self-Esteem	☐	☐	☐	_____
School	☐	☐	☐	_____
Physical Pain	☐	☐	☐	_____

Symptom	Never	Often	Always	Duration
Work	☐	☐	☐	_____
Career Choices	☐	☐	☐	_____
Anger	☐	☐	☐	_____
Agitation/Irritability	☐	☐	☐	_____
Self-Control	☐	☐	☐	_____
Aggression	☐	☐	☐	_____
My Thoughts	☐	☐	☐	_____
Making Decisions	☐	☐	☐	_____
Memory	☐	☐	☐	_____
Attention/Focus	☐	☐	☐	_____
Confusion	☐	☐	☐	_____
Homicidal Thoughts	☐	☐	☐	_____
Suicidal Thoughts	☐	☐	☐	_____
Self-Harm	☐	☐	☐	_____
Headaches	☐	☐	☐	_____
Stomach Troubles	☐	☐	☐	_____
Bowel Troubles	☐	☐	☐	_____
Internet	☐	☐	☐	_____
Computer Games	☐	☐	☐	_____
Pornography	☐	☐	☐	_____
Food Binging	☐	☐	☐	_____
Food Purging	☐	☐	☐	_____
Food Restricting	☐	☐	☐	_____
Exercise	☐	☐	☐	_____
Gender Issues	☐	☐	☐	_____
Times of Increased Energy	☐	☐	☐	_____

My Appetite: ☐ Normal ☐ Less than usual ☐ Much less than usual ☐ No appetite at all ☐ More than usual ☐ Much more than usual ☐ Crave food all the time

My Sleep Pattern: ☐ Normal ☐ Difficulty falling asleep ☐ Excessive sleep ☐ Diminished sleep ☐ Frequent awakening ☐ Nightmares ☐ Sleepwalking ☐ Early morning awakening

Have the above symptoms ever caused concerns in any of the following areas: Personally☐ Socially☐ Occupationally☐ Academically☐ If yes, please explain: _____

_____

_____

Please describe recent stressors in your environment (e.g., moves or relocations, losses, changes in environment): _____

_____

_____

Client History

Academic History

*Please check the boxes to indicate **Yes**:*

Highest level of education: High School ☐ GED ☐ No Diploma ☐ Some College ☐ Trade School ☐
Associates ☐ Bachelors ☐ Masters ☐ Doctoral ☐ Graduation Year_____ Major/Degree_____
Please describe your academic experience, past grades, or other school difficulties: _____

_____

_____

Have you completed any of the following?
Psychological testing ☐ Placement in special education programs ☐ Learning disabilities ☐
Been placed on an: IEP ☐ 504 ☐ Special Education Plan ☐
If so, please describe: _____

_____

Vocational History

*Please check the boxes to indicate **Yes**:*

Employment: Full Time ☐ Part Time ☐ Self-Employed ☐ Homemaker ☐ Student ☐
Retired ☐ Disabled ☐ Unemployed ☐ Internship ☐ Volunteer ☐ Other ☐ _____
Employer (if applicable) _____ **Length of Employment**_____
What type of work do you do? _____
Any additional education, training, or certifications you have received:

_____

Previous jobs (Please give approximate length of employment):

_____

_____

_____

_____

_____

Legal History

*Please check the boxes to indicate **Yes**:*

Has anyone committed a crime against you? ☐ If so, what was the crime and its current legal status:

_____

_____

Have you ever committed a crime? ☐ **Have you been placed on:** Probation ☐ Parole ☐
Have you ever been placed in a correctional facility? ☐ Time Served: _____
If yes to any of the above, please describe: _____

Abuse History

*Please check the boxes to indicate **Yes**:*

Have you ever experienced abuse? Physically☐ Emotionally☐ Sexually☐ Mentally☐
If yes, please describe: _____
_____
_____
_____

Have you ever experienced bullying?☐ If yes, please describe: _____
_____
_____

Psychological History

*Please check the boxes to indicate **Yes**:*

Have you ever received counseling or psychiatric help before? Yes☐ No☐
If yes, please describe: _____
_____

Location: _____ **Clinician/Provider:** _____
_____

What was liked/disliked while receiving previous help? _____
_____
_____

Are you currently seeing a psychiatrist? ☐ **Date of last visit:** _____
If yes, please list their name and location: _____
_____

Please list any Psychiatric Hospitalizations:

Year	Hospital	Purpose of Hospitalization	Admitting Physician	Length of Stay

Medical History

Primary Physician: _____ Phone Number: _____
Clinic Name & Location: _____
Last Exam: _____
Reason for visit? _____
_____

Please list any major health problems for which you have or are currently receiving treatment:

_____
_____
_____
_____

Please list chronologically all medications (from oldest to most recent) that you have used in the *past year*:

Medication	Purpose of Medication	Prescribing Physician	Date Started	Date Stopped

Please list any known allergies to medication, food, or products: _____
_____
_____

Please list any Medical Hospitalizations or Treatment:

Date	Hospital	Purpose for Hospitalization	Admitting Physician	Length of Stay

Family History

Please list any other family members or individuals that reside in the same household as you (if different from previously stated):

_____
_____
_____

Please describe any recent family stressors and/or changes (e.g., illness, deaths, separations, incarceration, loss of job, moves, etc.):

_____
_____
_____

Please describe strengths and weaknesses in the relationships between family members:

_____
_____
_____

Please indicate any family history of Psychological Problems:

Name	Relationship to You	What was the Problem?	Treatment Given

Developmental History

Please describe any difficulties or complications with your mother's pregnancy or birth with you:

_____

Did you meet general milestones on time, such as walking and talking? Yes ☐ No ☐
If no, please describe: _____
_____

Early or delayed: Menstruation? ☐ **Physical development?** ☐ **Sexual development?** ☐
Please explain: _____

Social History

What leisure activities or hobbies do you enjoy? _____
_____
_____

Do you prefer to do activities alone or with others? Alone ☐ With Others ☐ Both ☐

How many friends do you have? Few ☐ Several ☐ Many ☐

What clubs, organizations, or social activities do you participate in on a regular basis?
Please list if applicable: _____
_____
_____

Alcohol/Drug Use/Other Addictive Behavior Profile:

*Please check the boxes to indicate **Yes**:*

Have the following behaviors ever caused problems for you?

Alcohol ☐ Frequency_____
Drugs/Substances ☐ Frequency_____
Medications ☐ Frequency_____
Gambling ☐ Frequency_____
Eating ☐ Frequency_____
Sex ☐ Frequency_____
Internet/Computer Usage ☐ Frequency_____
Smoking ☐ Frequency_____
Other ☐ Frequency_____

If you answered yes to any listed above, please explain: _____
_____
_____

Have the above behaviors caused concerns in any of the following areas:
Personally ☐ Socially ☐ Occupationally ☐ Academically ☐

If answered yes to any listed above, please explain: _____
_____
_____

Have you ever received treatment for alcohol/other drug misuse/other addictive behaviors, (i.e., gambling, sex, internet, eating, smoking, etc.)? Yes ☐ No ☐ If yes, please complete the following:

Year	Place	Length of Stay/Number of sessions	Did you complete the program?

Please indicate any family history of addictive behaviors (alcohol, drugs, prescription or over-the-counter medications, gambling, smoking, eating disorders, etc.):_____
_____
_____
_____

Client Assets

Please check and list the strengths that you hold:

- ☐ Good communication skills
- ☐ Intelligent
- ☐ Assertive
- ☐ Confident
- ☐ Motivated
- ☐ Medication compliant
- ☐ Coordinated
- ☐ Other _____

- ☐ Healthy
- ☐ Outgoing
- ☐ Careful, good judgment
- ☐ Mature
- ☐ Good support system
- ☐ Self-sufficient
- ☐ Friendly
- ☐ Other _____

- ☐ Creative
- ☐ Optimistic
- ☐ Good knowledge of parenting
- ☐ Expresses thoughts and feelings well
- ☐ Healthy friends and relationships
- ☐ Trustworthy/Loyal
- ☐ Reliable
- ☐ Other_____

Client Limitations

Please check the weaknesses or limitations you have dealt with:

- ☐ Low self-esteem
- ☐ Dependent
- ☐ Insecure
- ☐ Impulsive
- ☐ Struggle to following directions
- ☐ Pessimistic

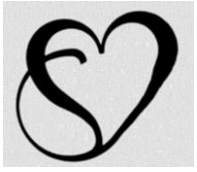
- ☐ Difficulty with judgment
- ☐ Problems with anger management
- ☐ Trouble communicating
- ☐ Difficulty making friends
- ☐ Difficulty with emotional controls
- ☐ Challenges with boundaries

- ☐ Need help with social skills
- ☐ Poor Memory
- ☐ Anxious
- ☐ Lack of motivation
- ☐ Lack of patience
- ☐ Other _____

Please share any additional information that you feel is important for your therapist to know to best help you: _____

_____

_____



Thank you for taking the time to complete this form,

we look forward to meeting with you!

Heartland Psychological Services

Insurance Information

Primary Coverage:

NAME OF INSURANCE COMPANY POLICY HOLDER'S NAME INSURANCE PHONE NUMBER

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ID #: _____POLICY #: _____GROUP #: _____

Supplemental Coverage:

NAME OF INSURANCE COMPANY POLICY HOLDER'S NAME INSURANCE PHONE NUMBER

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ID #: _____POLICY #: _____GROUP #: _____

INSURANCE SIGNATURE AUTHORIZATION

TO PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER:

I, _____ authorize the release to my insurance company of medical information or other information necessary to process claims, determine benefits, or respond to my insurance company's audit of records. I also request that payment of authorized insurance benefits be made on my behalf to Heartland Psychological Services for any services furnished me by Heartland Psychological Services employees.

NOTE: If I am a SD Medicaid recipient, I understand that it is my responsibility to provide a referral card according to the Managed Card instructions. If I am a SD Medicaid recipient, I will allow the South Dakota Medicaid Program, Medical Services, to access any and all material which may be deemed confidential by any regulatory or licensing agency, board or commission as required by Title XIX. If I am a NE Medicaid recipient, I will allow the Nebraska Medicaid Program and Magellan Behavioral Health to access any and all material which may be deemed confidential by any regulatory or licensing agency, board or commission as required by Nebraska Medicaid or Magellan Behavioral Health.

FOR YOUR INFORMATION: In certain cases, some therapy services are not covered by insurance, i.e., marital therapy, collateral therapy. We will be glad to assist you in checking on coverage for your therapy. Please let us know if you want help with this. **Also please note:** If you have more than one insurance carrier, it is extremely important that you provide the correct information to us regarding which insurance is primary. If Heartland is required to reimburse an insurance company because of an error regarding primary coverage or change in insurance coverage, you may be asked to reimburse Heartland for such payments.

Signature _____ Date _____
(If minor, signature of parent or guardian)

Witness Signature _____ Date _____