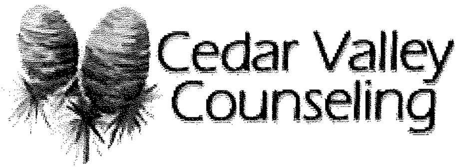


Insurance Information Form

Date:________________

Client Name:_________________________________ Date of Birth_____________

Sex: ___M ___F Place of Employment/School ___________________________

Home Street Address: ____

City/State _____________________________ Zip Code_____________________

Telephone Number (home) ____________________________ Message ok? _______

Telephone Number (cell) _____________________________ Message ok?_______

Health Insurance: ______________________________Relationship to Insured:__________

Member ID: ___________________________ Group Number _______________

Policy Holder: Name _________________________ Date of Birth ___________

Address of the Policy Holder/Insured:

____

Secondary Insurance: Yes/No Secondary Health Insurance:_________________

Secondary Policy Holder:_______________________Date of Birth_____________

Secondary Insurance ID:________________________Group Number_________________

Local Contact in case of emergency: _______________________________________

Phone number of emergency contact: __________________________________

Relationship to the client: ____

How did you hear about my services? Family ______ Friend______ Doctor________
Internet search ________ Insurance Company _______ Other _____________

The above information is true to the best of my knowledge. I authorize my insurance benefits paid directly to the therapist. I understand my therapist bills electronically using a secure internet connection. I understand I am financially responsible for any balance unpaid by my insurance company. I authorize Angela Olson, MA, LMHC to release information required to process my claim.

Signature: ____

Insurance Intake Addendum – for non-Medicaid clients only

Do you have a "deductible" on your health insurance plan? Yes No

My insurance deductible is____.

A deductible is the amount you and or your family need to pay in medical expenses prior to your insurance company paying the allowed rate they have agreed to pay for your visits. When our office receives an 'explanation of benefits' (note: these are also sent out to you – the insured member) we can let you know the exact amount that was applied to your deductible by your insurance company. You are expected to pay this amount to your counselor.

Do you pay a co-pay when you see your medical doctor? Yes No

If you answered "Yes" you are more than likely expected to pay a co-pay to your counselor. Please plan to pay your co-pay at the time of service by Cash Check Debit Credit

Do you pay a co-insurance when you see your medical doctor? Yes No

A co-insurance is a percentage of the allowed amount your insurance company has agreed to pay for the session. You can pay your co-insurance regularly at the time you see your therapist as soon as we know the actual amount. For the first session(s) you can pay a reasonable amount determined between you and your therapist to be adjusted when the actual statement is received.

Do you have a health spending account? Yes No

Health spending accounts are managed in various ways depending on the company that is administering the service. Some clients have HSA cards that can be ran as debit cards to pay for the portion of service the client has incurred. Some insurance companies automatically draw money from an HSA account to pay as the billing is received. Some clients need to notify their HSA account to approve or authorize the payments. We will work with you on navigating this process but in the end you are responsible for the cost of your sessions based on what your insurance plan allows as payment.

Who will be responsible for money owed through receiving counseling services?

Name:____

Address:____

____

Email of responsible party:____

Phone number of responsible party:______________________________________

CAGE Questionnaire

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

Scoring:

Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

....

Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Cahpel Hill, CAGE is an internationally used assessment instrument for identifying alcoholics. It is particularly popular with primary care givers. CAGE has been translated into several languages.

Burns Anxiety Inventory*

Name: ______________________________ Date of Test: ________________________

DOB: ______________________________

INSTRUCTIONS: **Mark the appropriate box with an X to answer each question.** **Please be honest and be sure to answer all questions on the page.** **Indicate how much each of the following symptoms has been bothering you in the past several days.**		**0- Not at all**	**1- Somewhat**	**2- Moderately**	**3- A lot**
CATEGORY I: ANXIOUS FEELINGS					
1	Anxiety, nervousness, worry or fear				
2	Feeling things around you are strange or foggy				
3	Feeling detached from all or part of your body				
4	Sudden unexpected panic spells				
5	Apprehension or a sense of impending doom				
6	Feeling tense, stress, "uptight" or on edge				
CATEGORY II: ANXIOUS THOUGHTS					
7	Difficulty concentrating				
8	Racing thoughts				
9	Frightening fantasies or daydreams				
10	Feeling on the verge of losing control				
11	Fears of cracking up or going crazy				
12	Fears of fainting or passing out				
13	Fears of illnesses, heart attacks, or dying				
14	Fears of looking foolish in front of others				
15	Fears of being alone, isolated or abandoned				
16	Fears of criticism or disapproval				
17	Fears that something terrible will happen				
CATEGORY II: PHYSICAL SYMPTOMS					
18	Skipping, racing or pounding of the heart				
19	Pain, pressure or tightness of the chest				
20	Tingling or numbness in the toes or fingers				
21	Butterflies or discomfort in the stomach				
22	Constipation or diarrhea				
23	Restlessness or jumpiness				
24	Tight, tense muscles				
25	Sweating not brought on by heat				
26	A lump in the throat				
27	Trembling or shaking				
28	Rubbery or "jelly" legs				
29	Feeling dizzy, lightheaded, or off balance				
30	Choking or smothering sensations or difficulty breathing				
31	Headaches or pains in the neck or back				
32	Hot flashes or cold chills				
33	Feeling tired, weak, or easily exhausted				

Office Use Only:
Score: ______________
Test #: ______________

*Copyright © 1984 by David D. Burns, MD (from *The Feeling Good Handbook*, Plume, 1990)

Burn's Depression Checklist

Name: Date:

Instructions: Put a check ☑ to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.		0 = Not At All	1 = Somewhat	2 = Moderately	3 = A Lot	4 = Extremely
Thoughts and Feelings						
1	Feeling sad or down in the dumps					
2	Feeling unhappy or blue					
3	Crying spells or tearfulness					
4	Feeling discouraged					
5	Feeling hopeless					
6	Low self-esteem					
7	Feeling worthless or inadequate					
8	Guilt or shame					
9	Criticizing yourself or blaming others					
10	Difficulty making decisions					
Activities and Personal Relationships						
11	Loss of interest in family, friends or colleagues					
12	Loneliness					
13	Spending less time with family or friends					
14	Loss of motivation					
15	Loss of interest in work or other activities					
16	Avoiding work or other activities					
17	Loss of pleasure or satisfaction in life					
Physical Symptoms						
18	Feeling tired					
19	Difficulty sleeping or sleeping too much					
20	Decreased or increased appetite					
21	Loss of interest in sex					
22	Worrying about your health					
Suicidal Urges						
23	Do you have any suicidal thoughts?					
24	Would you like to end your life?					
25	Do you have a plan for harming yourself?					
	Please Total Your Score on Items 1-25 Here:					

Total Score	Level of Depression
No Depression	0-5
Normal but unhappy	6-10
Mild depression	11-25
Moderate depression	26-50
Severe depression	51-75
Extreme depression	76-100

Mood Disorders Questionnaire

This is a test for bipolar disorder developed by a team of leading bipolar researchers. The MDQ is widely known and used. You'll learn how to score this test when you're done, but remember, even a "positive" test result does not mean you have bipolar disorder. You'll see why when we come to scoring your results.

Here are the 3 sections. For sections 1 & 2 answer each question by circling yes or no. Then choose the answer in section 3 that best fits your situation.

1	**Has there ever been a period of time when you were not your usual self (while not on drugs or alcohol) and -**	**Yes**	**No**
	- you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	**Yes**	**No**
	- you were so irritable that you shouted at people or started fights or arguments?	**Yes**	**No**
	- you felt much more self-confident than usual?	**Yes**	**No**
	- you got much less sleep than usual and found you didn't really miss it?	**Yes**	**No**
	- you were much more talkative or spoke faster than usual?	**Yes**	**No**
	- thoughts raced through your head or you couldn't slow your mind down?	**Yes**	**No**
	- you were so easily distracted by things around you that you had trouble concentration or staying on track?	**Yes**	**No**
	- you had much more energy than usual?	**Yes**	**No**
	- you were much more active or did many more things than usual?	**Yes**	**No**
	- you were much more social or outgoing than usual? For example, you telephoned friends in the middle of the night.	**Yes**	**No**
	- you were much more interested in sex than usual?	**Yes**	**No**
	- you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	**Yes**	**No**
2	If you checked YES to more than one of the above, have several of these ever happened during the *same period of time*?	**Yes**	**No**
3	How much of a problem did any of these cause you – like being unable to work; having family, money, or legal troubles; or getting into arguments or fights? No Problem Minor Problem Moderate Problem Serious Problem		

Scoring the Mood Disorders Questionnaire

The following scores are the most indicative of having bipolar disorder, though be careful: a positive test *does not mean you have bipolar disorder* (read on to understand that). The authors found these scores include the most individuals who do have bipolar disorder, and "rule out" the most individuals who don't have it.

Section 1	7 yes responses
Section 2	Yes
Section 3	Yes/must cause some problems in life

Don't go away yet, though. How do you know whether the test was "right"? All tests like this have a built-in rate of being wrong. If you'll stick with me, I think I can help you understand more about this.

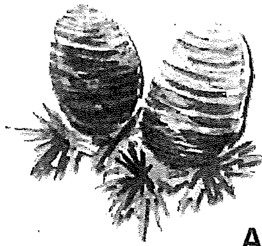
Think about it: they had to have a way of saying who *definitely* "has" bipolar disorder, as a way of "testing the test". If the test says yes, but their "gold standard", their definite authority – whatever that was – says no, then that means the test is not working perfectly. They tried using 6 yes's, and 8 yes's. But the test performed best, compared to their experts gold standard, when 7 was used as the official "cut-off".

You need to know this. When somebody offers you a "test", which says whether you have some diagnosis or not, this is how it is done. The test is compared to some "gold standard" way of knowing.

You see the problem? In bipolar disorder, we have no gold standard way of knowing! There is no "lab test" that measures some chemical only bipolar people have. (Hopefully in the next 5 years or so we'll have something like that). The "gold standard" used in testing the test you just took was some experts using a list of diagnostic criteria, and talking with the patient for an hour. Not a really great standard, but the best we now have.

What's the point of all this? You just took a test, and the scoring system says: seven items = "yes", and less than that = "no". Just be careful and understand: the test you took is not magic. Even using "7 yes's" as the cut-off, one person in 10 will be missed that their *gold standard* thought "had bipolar disorder". Similarly, getting 7 yes answers doesn't prove you have bipolar disorder, because there can be "false positives" too, with this or any such test (how many false positives? that gets pretty complicated). When you put all this together, I hope you can see that taking a test like this doesn't offer "the answer". It is a shorthand version of deciding something that would otherwise take you hours to learn about.

Hirschfeld RM et al. (2000) Am J Psychiatry 157 (11):1873-5



Cedar Valley Counseling

Adult Intake Form

Please provide the following Information and answer the questions below. *Please note*: information you provide here is protected as confidential information.

Therapist: ______________________________

Please fill out this form at or prior to your first session.

Name: ____________________________________ **Date:** ____________
(Last) (First) (Middle Initial)

Birth Date: ____________________ **Age:** ______ **Gender:** M F Trans Other: __________

Name of Parent or Guardian if under 18 years of age: ______________________________
(Last) (First) (Middle Initial)

Address: ____

Home Phone: __________________ May we leave a message? Yes No

Mobile: ________________ Message? Yes No **Work:** ______________ Message? Yes No
Please note: messages left on mobile devices or answering machines may not be secure

Email: ________________________________ May we email you? Yes No
Please note: email is not a secure form of communication

Preferred Contact Method: ____________________

Marital/Relationship Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Dating

If you are currently in a relationship how would you rate your relationship?
On a scale of 1-10, 1 being poor and 10 being fantastic __________

Please list any children with their ages: ______________________________________

____

____

How did you learn of our services? ______________________________________

Who is your Primary Care Physician? ____________________

When was your last physical? ____________________

Are you currently experiencing any medical issues? Yes No ____________________

____

____

Do you take any prescription medication? Yes No

Please list: ____________________

____

____

Have you faced any specific physical or developmental challenges in your life? Yes No

Please describe: ____________________

____

____

Have you ever been given a mental health diagnosis? Yes No

Have you been prescribed psychiatric medications? Yes No

Please list current psychiatric medications: ____________________

____

____

Family Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, sister, etc)

Please Check		List Family Member
☐ Alcohol Abuse	☐ none	____________
☐ Substance Abuse	☐ none	____________
☐ Anxiety	☐ none	____________
☐ Depression	☐ none	____________
☐ Mood Disorder	☐ none	____________

☐ **Obsessive Compulsive Behavior** ☐ **none** ____________

☐ **Eating Disorders** ☐ **none** ____________

☐ **Obesity** ☐ **none** ____________

☐ **Domestic Violence** ☐ **none** ____________

☐ **Suicide** ☐ **none** ____________

☐ **Self-Harming** ☐ **none** ____________

Are you experiencing legal issues? Yes No

Please describe:____________________________

Do you use tobacco/nicotine products? Yes No ____________________

Do you drink alcohol more than once a week? Yes No ____________________

Do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Sometimes ☐ Never

Do you have a drug of choice? Yes: ____________ No

Please list any difficulties you experience with your appetite or eating patterns:____________

____

____

Are you currently experiencing overwhelming sadness or grief? Yes No

What have been your recent losses?____________________________

____

____

Some losses are from years past that still may cause emotional pain. In your life have you experienced:

☐ **Traumatic experience:** ____________________________

____

Domestic Violence:

☐ Physical ☐ Verbal ☐ Sexual ☐ Emotional

Sexual Abuse:

☐ Incest ☐ Rape ☐ Molestation ☐ Other: ___________

Sometimes people lose hope and seek to hurt themselves or end their lives. Have you ever:

Made effort to end your life? **Yes** **No** When: ___________________________

Harm yourself through cutting, burning etc: ___________________________

Are you experiencing suicidal thoughts at this time? Yes No

If you experience suicidal thoughts what has kept you alive? ___________________________

____

____

Note: Thank you for sharing such difficult information. Trust that we hold you in high regard as you seek to build your own set of supports to aid you in finding health and peace.

Are you currently experiencing anxiety, panic attacks or have any phobias? Yes No

Please describe: ___________________________

____

Are you currently experiencing chronic pain? Yes No

Please describe: ___________________________

____

Additional Information:

Are you currently employed? Yes No

If yes, what is your current employment situation? ___________________________

____

Do you enjoy your work? Is there anything stressful about your current work? ___________

____

____

Do you consider yourself to be spiritual or religious? Yes No

If yes, describe your faith or belief:_______________

Are you part of a spiritual community? Yes No _______________

____

Are you part of a specific cultural community? Yes No _______________

Are you participating in any community activities? (gym, school, volunteering...) Yes No

____

____

What do you consider to be some of your weaknesses?

____

____

____

What do you consider to be some of your strengths?

____

____

____

What would you like to accomplish out of your time in therapy?

____

____

____

____

____

Signature: _______________ **Date:** _______________

Thank you for your patience in completing this intake.