Cedar Valley Counseling

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 (cell) _____ Message ok? _____ Text ok? _____

Telephone Number (home) _____ 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 our 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

Date: _____ Name: _____ DOB: _____

- Have you ever felt you should cut down on your drinking? Yes ___ No ___
- Have people annoyed you by criticizing your drinking? Yes ___ No ___
- Have you ever felt bad or guilty about your drinking? Yes ___ No ___
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes ___ No ___

Total: _____

Scoring: Item responses on the CAGE are scored 0 for no and 1 for yes, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

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Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Chapel 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.

Name:_____ DOB:_____ Date:_____

Burns Depression Checklist

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 and inadequate					
8. Guilt or shame					
9. Criticizing yourself or blaming yourself					
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 to 25 here: _____

Burns Anxiety Inventory

Date: _____ **Name:** _____ **DOB:** _____

Instructions: The following is a list of symptoms that people sometimes have. Check the box that best describes how much that symptom or problem has bothered you during the past week.	0 – Not At All	1 - Somewhat	2 – Moderately	3 – A Lot
CATEGORY I: ANXIOUS FEELINGS				
1. Anxiety, nervousness, worry, or fear				
2. Feeling that things around you are strange, unreal, 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, stressed, "uptight", or on edge.				
CATEGORY II: ANXIOUS THOUGHTS				
7. Difficulty concentrating				
8. Racing thoughts or having your mind jump from one thing to the next.				
9. Frightening fantasies or daydreams.				
10. Feeling that you're on the verge of losing control.				
11. Fears of cracking up or going crazy.				
12. Fears of fainting or passing out.				
13. Fears of physical illnesses or heart attacks, or dying.				
14. Concerns about looking foolish or inadequate in front of others.				
15. Fears of being alone, isolated, or abandoned.				
16. Fears of criticism or disapproval.				
17. Fears that something terrible is about to happen.				
CATEGORY III: PHYSICAL SYMPTOMS				
18. Skipping, racing or pounding of the heart (palpitations).				
19. Pain, pressure, or tightness in 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.				

Total: _____

Mood Disorders Questionnaire

Date: _____ Name: _____ DOB: _____

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 concentrating or staying on track?	**Yes**	**No**
	- you had much more energy 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		

PTSD Checklist (PCL-5) Name: _____ DOB:_____

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then select one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at All	A Little Bit	Moderately	Quite a Bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were happening again (as if you were back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example: heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example: people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example: being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4

17. Being “super alert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Total Score:_____

Test Date:_____

Name:_____ DOB:_____ Date:_____

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...

   Swear at you, insult you, put you down, or humiliate you?

   or

   Act in a way that made you afraid that you might be physically hurt?

   Yes No If yes, enter 1 ___

2. Did a parent or other adult in the household **often or very often**...

   Push, grab, slap, or throw something at you?

   or

   Ever hit you so hard that you had marks or were injured?

   Yes No If yes, enter 1 ___

3. Did an adult or person at least 5 years older than you **ever**...

   Touch or fondle you or have you touch their body in a sexual way?

   or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   Yes No If yes, enter 1 ___

4. Did you **often or very often** feel that...

   No one in your family loved you or thought you were important or special?

   or

   Your family didn't look out for each other, feel close to each other, or support each other?

   Yes No If yes, enter 1 ___

5. Did you **often or very often** feel that...

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes, enter 1 ___

6. Were your parents **ever** separated or divorced?

   Yes No If yes, enter 1 ___

7. Was your mother or stepmother:

   Often or very often pushed, grabbed, slapped, or had something thrown at her?

   or

   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

   or

   Ever repeatedly hit for at least a few minutes or threatened with a gun or knife?

   Yes No If yes, enter 1 ___

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

   Yes No If yes, enter 1 ___

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   Yes No If yes, enter 1 ___

10. Did a household member go to prison?

    Yes No If yes, enter 1 ___

Now add up your "Yes" answers: _____This is your ACE Score.

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: _____ **Birth Date:**_____
(Last) (First) (Middle Initial)

Gender:_____ **Pronouns**:_____

Race:_____ **Ethnicity**:_____ **Primary Language**:_____

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

Address:_____

Home Phone: _____Message ok? Yes No

Mobile: _____ Message ok? Yes No Text ok? 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:_____

Relationship/Household Information

Relationship status (please describe):_____

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? _____

Are you a parent, step parent, or guardian? Please describe:_____
_____
_____

Please list children with their names and ages:_____
_____
_____

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Do the children live in your household? Please Describe:_____

_____

Health Information

Who is your Primary Care Physician? _____

When was your last physical? _____

Are you currently experiencing any medical issues? Yes No Please Describe:_____

_____

_____

Are you currently experiencing chronic pain? Yes No

Please describe: _____

_____

Do you take any prescription medication for medical issues? Yes No

Please list: _____

_____

_____

Mental Health Information

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

What was the diagnosis/diagnoses? (Please list)_____

_____

Who provided this diagnosis (PCP, psychiatrist, previous therapist, etc.) and when?

_____

Have you been prescribed psychiatric medications? Yes No

Please list: _____

_____

_____

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Have you ever been hospitalized or received inpatient or intensive outpatient treatment related to a mental health diagnosis? Please describe:_____

_____

_____

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**	_____
□ **Schizophrenia**	□ **none**	_____
□ **Obsessive Compulsive Behavior**	□ **none**	_____
□ **Schizophrenia**	□ **none**	_____
□ **Eating Disorders**	□ **none**	_____
□ **Obesity**	□ **none**	_____
□ **Domestic Violence**	□ **none**	_____
□ **Suicide**	□ **none**	_____
□ **Self-Harming**	□ **none**	_____

Substance Use History

Do you use tobacco/nicotine products? Yes No

Please Describe:_____

Do you drink alcohol? Yes No

Please Describe:_____

Do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Sometimes ☐ Never

If yes, what substances do you use?_____

Have you ever been diagnosed with a substance use disorder? Yes No

Please list:_____

Have you received inpatient or intensive outpatient treatment for substance use? Yes No

If yes, please describe:_____

_____

Are you currently, or have you been in the past, a member of a substance use support group? Yes No

If yes, please describe:_____

Grief, Loss, and Trauma History

Please Note: If you feel uncomfortable answering any of the questions in this section, feel free to refrain and discuss the incidents with your clinician when you feel ready.

Are you currently experiencing overwhelming sadness or grief? Yes No

What losses have you experienced that still impact you?_____

_____

_____

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

☐ **Traumatic experience:**_____

_____

☐ **Difficult childhood (Please explain):** _____

_____

☐ **Domestic Violence (please check all that apply):**

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☐ Physical ☐ Verbal ☐ Sexual ☐ Emotional

☐ **Sexual Abuse:**_____

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

Made an effort to end your life? _____

Harm yourself through cutting, burning etc: _____

Are you experiencing suicidal thoughts at this time? Yes No

If you experience suicidal thoughts what keeps 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.

Additional Information

Are you experiencing legal issues? Yes No

Please describe:_____

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 primary beliefs:_____

_____

Are you part of a spiritual community? Yes No _____

_____

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

_____

_____

Goals for Therapy

What do you consider to be some of your strengths?

_____

_____

_____

What do you believe to be your weaknesses?

_____

_____

_____

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

_____

_____

_____

Signature: _____ **Date:** _____

Thank you for your patience in completing this form. CVC is here to support you and your goals for growth and change.