MERLE MULLINS COUNSELING

REGISTRATION FORM

(Please Print)

	Today's date:	/ /

CLIENT INFORMATION

Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.: -- --	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No AUTHORIZATION NUMBER:

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name of Primary Insurance:	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of insurance for Behavioral Health (if applicable):	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Behavioral Health Insurance Phone Number:	( )	

Behavioral Health Claims Mailing Address:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Merle Mullins Counseling or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

MERLE MULLINS COUNSELING Date:___________

INTAKE QUESTIONNAIRE

	SELF	**SPOUSE/PARTNER**
Name:	______________________________	______________________________
Email:	______________________________	

TELEPHONE NUMBERS

Home:	____________________ _____*	____________________ _____*
Work:	____________________ _____*	____________________ _____*
Cell:	____________________ _____*	____________________ _____*

** Please indicate Y or N if we may leave a message for you at this number.*

Education Level:	____________________	____________________
Military service:	___ yes ___ no	___ yes ___ no
Religion: as child:	____________________	____________________
as adult:	____________________	____________________
Have you been married before (Y,N) ?	_____	_____
How many times?	_____	_____

Children's Names *	Sex	Age	Birth date	Grade	In home?

** Please indicate next to name if any children are your (S) or spouse/partner's (P) from a previous relationship, adopted (A) or foster children (F).*

MEDICAL INFORMATION:

Name of Physician: ______________________________ Phone:__________________

Approximate date of last appointment: ________

Have you ever been hospitalized for surgeries or major health, psychological, drug, or alcohol problems? ___ yes ___ no. If yes, please describe:

Have there been any pregnancies that have not gone full term? ___ yes ___ no
(For children up to 18 years of age) Problems during pregnancy or at time of birth:

____

____

Please check all of the health problems that you have experienced or are experiencing now. Mark **"C"** if you are currently experiencing the problem, **"P"** if you have experienced the problem in the past, and **"B"** if both are true:

___ Arthritis
___ Cancer
___ High Blood Pressure
___ PMS
___ Diabetes
___ Allergies
___ Other health problems
___ Asthma
___ Fainting/Blackouts
___ Heart trouble
___ Frequent colds/flu
___ Lung disease
___ Chronic pain
___ Chronic pain
___ Epilepsy/Seizures
___ Thyroid problems
___ Headaches
___ Back pain

Have you been on any medication during the past six months? ___ yes ___ no

Prescribing Physician:____

Medication	Illness	Dose	Frequency	Date began/ended

Have you ever attempted suicide? ___ yes ___ no

PRESENTING PROBLEM

Please state in your own words the nature of your main problem(s)/reasons for therapy. How upsetting is your situation to you (on a scale of 1 to 10)?

When did your problem(s) begin? What important events occurred at that time or since then, which may have contributed to the problem?

What is your primary goal for therapy?

Please check all of the symptoms that you have experienced or are experiencing now. Mark **"C"** if you are currently experiencing the symptom, **"P"** if you have experienced the symptom in the past, and **"B"** if both are true:

___ Depression
___ Decreased Energy
___ Grief
___ Hopelessness
___ Worthlessness
___ Guilt
___ Anxiousness
___ Panic Attacks
___ Irritability
___ Learning Difficulty
___ Recent Trauma
___ Self-Injury
___ Hyperactivity
___ Other ___________________________
___ Difficulty Concentrating
___ Memory Problems
___ Loneliness
___ Social Withdrawal
___ Sleep Disturbance
___ Appetite Disturbance
___ Sexual Difficulties
___ Infidelity
___ Physical Violence
___ Compulsive eating/ Not eating
___ Legal problems
___ Recent Weight Gain/Loss
___ Suicidal Thoughts
___ Marital Difficulties
___ Parent-Child Problems
___ Child or Adolescent Problems
___ Extended Family Problems
___ Financial Difficulties
___ Alcohol Use
___ Drug Use
___ Angry Outbursts
___ Repetitive thoughts or behaviors
___ Thoughts of harming someone
___ Difficulty Functioning at Work, School, or Home
___ Compulsive behaviors : CIRCLE: gambling, food, internet, pornography, shopping, other

Have you participated in mental health or substance treatment before or received any prior professional assistance for your problems? ___ yes ___ no. If yes, please give Clinician(s)' name and title, and approximate dates of service. Was there relevant family history related to that treatment? How did you respond to that treatment?

Approximate date Clinician's name

Are any of the following events impacting your life? Mark **"C"** if you are currently experiencing the symptom, **"P"** if you have experienced the symptom in the past, and **"B"** if both are true:

___ Moved to a new place
___ Inadequate housing
___ Divorce/separation
___ Conflicts with children
___ Significant communication problems with spouse or partner
___ Are you or have you abused or controlled anyone?
___ Contact with Human Services/Community Resources
___ Change in financial status or problems with debt
___ Have you been controlled and/or abused by anyone in any way?
___ Death of a loved one
___ Difficulties/problems with the law
___ Alcohol or drug problems in family
___ Serious illness or injury in family
___ Questioning religious faith
___ Academic problems
___ Work injury
___ Job problems

FAMILY BACKGROUND

Have any members of your family of origin had any of the following? Please check all that apply.

___ Major health problem(s)	___ Severe anxiety
___ Drinking problem	___ Obsessive-compulsive disorder
___ Drug problem	___ Suicide attempt(s)
___ Severe depression	___ Serious problems with the law
___ Schizophrenia	___ Borderline personality

To what extent do you think your family background is contributing to your current challenges?
Circle one: Not at all A little Somewhat Quite a bit Very Much. Please describe.

What do you feel are your strengths and challenges in the following areas?

	Strengths	**Challenges**
Physical	________________________________	________________________________
	________________________________	________________________________
Psychological	________________________________	________________________________
	________________________________	________________________________
Social	________________________________	________________________________
	________________________________	________________________________
Intellectual	________________________________	________________________________
	________________________________	________________________________
Academic	________________________________	________________________________
	________________________________	________________________________

Please add any other information that would help me understand your situation, including the place of religion or spirituality in your life, hobbies, or leisure activities. Use the reverse side of the page if you need additional space.

Date Physician Contacted: ________

Specialist Name: ________________________________ Phone number: ________________

Date Contacted: __________

ALERT®

Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name ____ , First Name ____ Date of Birth: (mm/dd/yy) __ / __ / __

Subscriber ID ____ Authorization # ____

Clinician Last Name ____ , First Name ____ Today's Date: (mm/dd/yy) __ / __ / __

Clinician ID/Tax ID ____ Clinician Phone ___ ___ - ____ State __ *MRef* ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? __ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* __ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* __ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No