Christina Kress, MSW, LICSW, LLC
12301 Whitewater Dr Suite 30
Minnetonka, MN 55343
P: 952.223.1300 ext. 3

Adult Initial Paperwork

What brings you in to therapy? What are you wanting help with?

How are your mental health symptoms interfering with your life?

Race (check all that apply):
[] American Indian/Alaska Native Tribe:_____
[] Asian ([] Chinese [] Hmong [] Japanese [] Korean [] Laotian [] Vietnamese [] Other_____)
[] Black/African American [] Ethiopian [] Somali []
Other_____)
[] Native Hawaiian or Other Pacific Islander
[] White [] Other _____

Ethnicity:
[] Hispanic/Latino/a
[] Not Hispanic/Latino/a

Primary Language:
[] English [] Other:

Religion:

Marital Status:

Sexual Preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender Other_____

Gender Identity:

Do you have children?	**Do you have legal custody of your children?**
☐ No ☐ Yes ☐ **Ages**_____	☐ No ☐ Full ☐ Joint ☐ N/A

Current Employment Status:

☐ **Not working** ☐ **Employed (FT PT)** ☐ **Disability** ☐

Current Employer:	**Position:**	**Length of time at job:**	**Avg. # of hours worked per week:**

Highest level of school completed?

Are you currently enrolled in school?

Family History

List any medical/psychological history important to your visit:

List any family mental health history (parents/siblings):

Circle YES or NO for next questions, just in last 12 months.

- Have you ever felt you ought to cut down on your drinking or drug use? **Y/N**
- Have people annoyed you by criticizing your drinking or drug use? **Y/N**
- Have you ever felt bad or guilty about your drinking or drug use? **Y/N**
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? **Y/N**

DRUG/ALCOHOL USE/ABUSE HISTORY

please check all appropriate boxes

Alcohol	☐ Never Used	☐ Currently Use	☐ Used in Past
Benzodiazepines	☐ Never Used	☐ Currently Use	☐ Used in Past
Crack Cocaine	☐ Never Used	☐ Currently Use	☐ Used in Past
Cocaine	☐ Never Used	☐ Currently Use	☐ Used in Past
Hallucinogens (i.e., LSD)	☐ Never Used	☐ Currently Use	☐ Used in Past
Heroin	☐ Never Used	☐ Currently Use	☐ Used in Past
Inhalants	☐ Never Used	☐ Currently Use	☐ Used in Past
Marijuana	☐ Never Used	☐ Currently Use	☐ Used in Past
Methadone	☐ Never Used	☐ Currently Use	☐ Used in Past
Opiates	☐ Never Used	☐ Currently Use	☐ Used in Past
Prescription Drugs	☐ Never Used	☐ Currently Use	☐ Used in Past
Methamphetamine	☐ Never Used	☐ Currently Use	☐ Used in Past
Other:_____		☐ Currently Use	☐ Used in Past
Other:_____		☐ Currently Use	☐ Used in Past

Medication Allergies/Reactions to medications:

Please list dates of other services you are currently receiving, or have received in the last year:					
Dates of service:	**FROM**	**TO**	**Dates of service:**	**FROM**	**TO**
ACT			Crisis Response Services		
ARMHS			Medication Management		
IRTS			Psychotherapy- Family		
Day Treatment			Psychotherapy- Group		
DBT (other provider)			Psychotherapy- Individual		
Emergency Services			Other MH: _____		
Partial Hospitalization			Substance Abuse		

CURRENT MEDICATIONS

Prescribed by:

Current Medication	For What Condition?	Dose	Frequency	Comments	
1)					
2)					
3)					
4)					
5)					
6)					
7)					

Answer YES or NO to the following questions	
☐ Yes ☐ No	Do you smoke? If yes, how many cigarettes per day: _____
☐ Yes ☐ No	Do you drink caffeine? If yes, how often and how much per day: _____
☐ Yes ☐ No	Have you ever received help for a drug or alcohol problem? (treatment program, AA/NA)
☐ Yes ☐ No	In the last 6 months, have you been in inpatient or residential treatment for substance abuse?
☐ Yes ☐ No	Would you like help now for a drug or alcohol problem?
☐ Yes ☐ No	Have you been hospitalized for a mental issue? If YES: When?_____ # of times in the last year? _____
☐ Yes ☐ No	In the last 6 months, have you been admitted to a hospital for a self-harm injury? If YES, please list dates:_____
☐ Yes ☐ No	Would you like to discuss problems related to a rape or sexual/emotional/physical abuse?
☐ Yes ☐ No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?
☐ Yes ☐ No	Did you receive special education services in school? What kind?
☐ Yes ☐ No	Have you ever been in the military?
☐ Yes ☐ No	Have you ever been arrested?
☐ Yes ☐ No	Are you currently on probation?
☐ Yes ☐ No	Has your mental health treatment been court ordered?
☐ Yes ☐ No	Have you been homeless within the last 6 months? If YES, please list how long/ # of occurrences:_____
☐ Yes ☐ No	Are there cultural/spiritual issues that you would like to discuss that would be important in counseling?
☐ Yes ☐ No	Do you have an infectious disease?
☐ Yes ☐ No	Have you received psychological Testing? Where?
☐ Yes ☐ No	Do you have your own transportation?

YOUR CURRENT PROVIDERS

THERAPIST	PSYCHIATRIST	CASE MANAGER
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
PRIMARY PHYSICIAN	**PROBATION OFFICER**	**ARMHS WORKER**
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
OTHER	**OTHER**	**OTHER**
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax

I certify that I have answered these questions myself and to the best of my knowledge.

_____ _____

Patient Signature **Date**

WHODAS 2.0 12-Item version, self-administered

(required by MN Dept. of Human Services as of 10/1/2014)

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
S6	Concentrating on doing something for 10 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometer (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, how many days were these difficulties present?	**Record number of days** ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities of work because of any health condition?	**Record number of days** ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	**Record number of days** ____

Christina Kress, MSW, LICSW, LLC
12301 Whitewater Drive Suite 30
Minnetonka, MN 55343
P: 952-223-1300 ext.3

Legal Name:_____

Preferred Name: _____

Date of Birth: _____ Sex: ☐ Male ☐Female

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ ☐ Cell ☐Home ☐Other Email:_____

Emergency Contact: _____Emergency Contact Phone Number: _____

Primary Insurance Information

Primary Insurance Company: _____Phone Number: _____

Member ID Number: _____Group or Account Number: _____

*You are responsible for understanding your insurance benefit information and can obtain this information by calling your insurance company directly.

POLICY HOLDER INFORMATION (If the patient is not the policy holder):

Name: _____Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Phone Number: _____ ☐ Cell ☐Home ☐Other Sex: ☐ Male ☐Female ☐Other

Secondary Insurance Information (If Applicable)

Secondary Insurance Company: _____Phone Number: _____

Member ID Number: _____Group or Account Number: _____

*You are responsible for understanding your insurance benefit information and can obtain this information by calling your insurance company directly.

POLICY HOLDER INFORMATION (If the patient is not the policy holder):

Name: _____Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Phone Number: _____ ☐ Cell ☐Home ☐Other Sex: ☐ Male ☐Female ☐Other

Responsible Party: If Patient is Under 18

Name: _____Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Phone Number: _____ ☐ Cell ☐Home ☐Other Sex: ☐ Male ☐Female ☐Other

Signature and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Patient or Responsible Party Signature (if under 18) Relationship Date

Release of Information

PATIENT'S FULL NAME:	Other names used (if any):
Date of Birth:	Social Security Number (voluntary):
I Authorize: Christina Kress, MSW, LICSW 12301 Whitewater Dr # 30 Minnetonka, MN 55343	Phone: 952-223-1300 ext 3 Fax: 202-546-4025
To release information to and receive information to and from: Name: Address:	My relation to this person: _____
Agency Phone/Fax:	Agency Phone/Fax:

Information which may be released includes (check appropriate boxes):

[] ALL
[] Phone Contacts
[] Discharge Summaries
[] Medication Information
[] History and Physical Exams
[] Psychological Tests / MMPI
[] Two-way communication between physicians and therapists [] Other _____

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: DO NOT release records regarding: ↄ mental health ↄ chemical dependency ↄ HIV/AIDS

Dates of information to be released:

[] ALL ↄ Other _____

This information may be released for the purposes of:

[] Planning or continuing my care and treatment [] Determining eligibility for insurance benefits
[] Sharing information about my stay and treatment [] Determining eligibility for Social Security Benefits
[] Other (specify) _____

Your signature indicates that you know what information will be given and what it will be used for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our *Notice of Privacy Practices*. You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal healthcare privacy protections.

REVOCATION CLAUSES:

I understand that I may withdraw my authorization by written notice. My authorization will expire one year from the date signed if I do not revoke my consent earlier. Date of Expiration (not to exceed one year): _____

Patient Signature:	Date:	Parent or guardian signature (if applicable)	Date:
Phone Number:		Relationship to patient:	

This notice describes how mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Notice of privacy practices In this notice, the words "We" and "Us" mean Christina Kress, MSW, LICSW, LLC.(CK)

"You" means anyone who receives mental health services from us. "Health information" means any information that we create or receive relating to your health or health care payment, whether oral, written or recorded in any form.

How we may use and disclose your health information The law requires us to inform you that we use and disclose your health information for the following purposes.

Treatment We will use your health information to provide you with mental health services. We may share your health information with other mental health care providers who are involved in your care and who are a part of CK. With your consent, we may disclose certain health information specified by you to your family, others involved in your care or organizations outside of CK providing health care to you.

Payment
We may use and disclose health information to bill:
• your insurer
• Medicare
• any other payer or programs
• your health plan
• Medical Assistance
• you
If your insurer or health plan requires prior approval to determine whether they will pay for those services, we may disclose parts of your health information to them, unless you have asked that we not bill your insurer or plan.

Health Care Operations

1. We may use and disclose information about you within Christina Kress, MSW, LICSW, LLC to manage and improve our mental health services. This includes:

• quality assessment
• licensing and accreditation
• business planning and management
• evaluating health professionals
• legal and accounting services. We may provide services with the help of people who are not our employees, and companies that are not our affiliates. This includes equipment technologists, computer hardware and software providers or maintenance personnel. We call these people or companies our "business associates." We may give our business associates some access to your health information so they can perform their job duties. We minimize their access as much as possible. They are required to safeguard your information.

Appointment reminders, treatment alternatives
We may use and disclose your health information to provide you with: • appointment reminders
• information about treatment options and services
• other health-related services

People involved in your care At your request, we may release health information to a family member or friend. We may disclose information about you to a disaster relief organization if there is a disaster, so that your family can be notified.

Research We will not use or disclose health information that can be used to identify you for research purposes without first obtaining your written authorization or following state law procedures for trying to notify you. When you register with us, we will ask you to use and disclose your health information within Christina Kress, MSW, LICSW, LLC for medical or scientific research. You will be asked to sign additional authorizations for clinical research trials involving treatment

Required disclosures permitted without your authorization We will release health information about you as required to comply with Minnesota law.

In addition, we may need to use or disclose your health information without your authorization: • to the government for public health activities as permitted or required by law to report abuse or neglect
• to a health oversight agency for audits, investigations, inspections and licensure activities
• to prevent a serious and imminent threat to your health or safety • to prevent a serious and imminent threat to a person or the public, or to help the police apprehend a person involved with a violent crime that may have seriously harmed someone • to law enforcement official in response to a court or administrative order, subpoena, warrant, summons or similar process; to identify or locate a suspect, witness or missing person; to identify a victim of crime if, under certain limited circumstances, we are unable to obtain the victim's agreement; or in emergency circumstances to report the locations and perpetrator or a crime • to a private party in litigation in response to a valid court order or administrative order
• to a correctional institution if you are an inmate, as necessary for your heath and the health and safety of other people
• for military, national security or lawful intelligence activities • otherwise as permitted or required by law
• to your parent(s)/ legal guardian(s) if you are a non emancipated minor

Other uses and disclosures of your health information will be made only with your written authorization. You may revoke that authorization at any time for future uses and disclosures by writing to Christina Kress, MSW, LICSW, LLC at the address at the end of this notice.

Your rights to your health information You have the following rights regarding the health information we maintain about you.

Rights to inspect and copy With some exceptions, you have the right to see and request a copy of records that include your health information and are maintained or used by us (the designated record set). To request a copy, write to Christina Kress, MSW, LICSW, LLC at the address listed at the end of this notice. We charge a fee for copying or mailing costs. In some cases, we may deny your request. If you are denied access to records, you may request that another licensed health care professional chosen by us review the denial. We will comply with the outcome of the review.

Right to amend You may ask us to amend a record containing your health information if you feel it is incorrect or incomplete. Your request must be submitted in writing to Christina Kress, MSW, LICSW, LLC at the address listed at the end of this notice. You must provide a reason for your request. We may deny your request if, among other reasons, the information was not created by us; is not included in your clinical, billing or other records; or is otherwise accurate and complete.

Right to an accounting of disclosures You have the right to request a written report of where we sent your health information for up to a six-year period. This does not include disclosures to or authorized by you or disclosures for treatment, payment and health care operations as described in this notice. You must submit your request in writing to Christina Kress, MSW, LICSW at the address listed at the end of this notice. Your request must state a time period of six years or less, and may not include dates before August 1, 2017 report you request within a 12-month period will be free. After that, we may charge you for the cost of providing the report.

Right to request restrictions You may request that we restrict or limit the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree with your request. If we agree, we will honor your request unless the information is needed to provide emergency treatment. You must make your request in writing to Christina Kress, MSW, LICSW, LLC at the address listed at the end of this notice. In your request, you must tell us (1) what information you want to limit; (2) how you want to limit our use or disclosure; (3) to whom you want the limits to apply. Right to request confidential communications

You have the right to request that we communicate your health information in a certain method or place (such as at work or by mail). You must make your request in writing when you register with us, or to Christina Kress, MSW, LICSW, LLC at the address listed at the end of this notice. We will try to meet all reasonable requests. Our legal duties and rights The law requires us to protect the privacy of your health information and to provide this notice of our practices. We reserve the right to change our health information practices and the terms of this notice. We reserve the right to make the changed notice effective for health information we already have about you and for new information. The notice will contain an effective date on the first page, in the top right-hand corner. The notice will be placed in a prominent place at each of our clinic sites. We will replace the notice with updated notices as they become available. In addition, you may request a paper copy of this notice by contacting Christina Kress, MSW,LICSW, LLC at the address shown on the back of this brochure. Notices will be available whenever we provide you with health care. Complaints If you have any questions or complaints, or would like to obtain a copy of your medical records, contact:

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