Christina Kress MSW, LICSW, LLC

12301 Whitewater Drive suite 30
Minnetonka, MN 55345
P:952.223.1300 F:202.546.4025

Name of Client: _____

DOB: _____

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

Sex: ☐ Male ☐Female ☐Other Age: _____ Emergency Contact: _____

Emergency Contact Phone Number: _____Email:_____

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: _____ Sex: ☐ Male ☐Female ☐Other

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

Relationship to Patient: _____ Phone Number: _____ ☐ Cell ☐Home ☐Other Email:_____

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.

_____ _____

Signature Date

CLIENTS FAMILY INFORMATION

Name and Address of Parent #1:	**Name and Address of Parent #2:**
Primary Phone Number: **Alternate Phone Number:** **OK to leave message?** ☐ Yes ☐ No **Email:**	**Primary Phone Number:** **Alternate Phone Number:** **OK to leave message?** ☐ Yes ☐ No **Email:**

Child Lives With (primarily):

☐ Bio Mom ☐ Stepmother ☐ Grandparents
☐ Bio Dad ☐ Stepfather ☐ Siblings
☐ Group Home ☐ Adoptive Mother ☐Other_____
☐ Foster Parent ☐ Adoptive Father

Parents Relationship Status:

☐ Married ☐ Never Married
☐ Widowed ☐ Mother Remarried
☐ Partnered ☐ Separated
☐ Divorced ☐ Father Remarried

Legal Custody

Both Parents: ☐ Joint Physical/Legal
Mother: ☐ Sole Physical/Legal ☐Sole Physical/Joint Legal ☐ Visitation
Father: ☐ Sole Physical/Legal ☐ Sole Physical/Joint Legal ☐ Visitation
Custody Issues: ☐No ☐Yes (specify:_____)
CPS Involvement: ☐No ☐ Yes Caseworker:_____

Race (√ 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:	**Other Languages Spoken:**

Religion:

Cultural considerations for treatment:

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MINNETONKA COUNSELING
12301 WHITEWATER DRIVE, SUITE 30 MINNETONKA, MN 55343
952-223-1300 EXT. 3

REFERRAL INFORMATION:

Who referred you to your appointment today?

REASONS FOR WANTING SERVICES

Please ✓ all that apply:

☐ ADHD	☐ Grief/Loss/Death	☐ Panic Attack	☐ Sleep Problems
☐ Attachment Issues	☐ Health Problems	☐ Parenting Issues	☐ Stress
☐ Alcohol Issues	☐ Hearing Voices	☐ Phobia/s	☐ Suicidal Thoughts
☐ Anger Problems	☐ Help Finding Resources	☐ Physical Abuse	☐ Suicide Attempt/s
☐ Anxiety	☐ HIV/AIDS	☐ Physical Pain	☐ Trauma
☐ Body Image/Weight Issues	☐ Hyperactivity	☐ Psychiatric Hospitalization	**Other:**
☐ Bingeing and/or Overeating	☐ Identity Issues	☐ Purging (Throwing up)	☐
☐ Communication Issues	☐ Inattention	☐ Relationship Concerns	☐
☐ Developmental Delay/s	☐ Learning Problems	☐ Restricting Food	☐
☐ Depression	☐ Legal Problems	☐ Sadness	☐
☐ Disruptive Behavior	☐ Memory Problems	☐ Schizophrenia	☐
☐ Eating Disorder	☐ Mood Swings	☐ Self-Esteem Issues	☐
☐ Drug Issues	☐ Obsessions	☐ Sexual Abuse/Trauma	☐
☐ Fetal Alcohol Syndrome	☐ Out of Home Placement	☐ Sexuality Concerns	☐

What brings you in for therapy? How are you hoping I can help?

CHILD/ADOLESCENT CURRENT MEDICATIONS

(list more on separate page if necessary):

Prescribed by:

Current Medication	For What Condition?	Dose	Frequency	Date Started	Side Effects/Comments
1.					
2.					
3.					
4.					

Past Medication	For What Condition?	Past Medication	For What Condition?
1.		6.	
2.		7.	
3.		8.	

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FAMILY MEDICAL/PSYCHOLOGICAL HISTORY

CHILD/ADOLESCENT HISTORY: please ✓ all that apply

☐ Alcohol/Drug Abuse	☐ Domestic Abuse	☐ Hyperactivity	☐ Psychiatric Hospitalization
☐ Allergies	☐ Eating Disorder	☐ Inattention	☐ Schizophrenia
☐ Anxiety	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Sexual Abuse
☐ Autism	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Stomachaches
☐ Bedwetting	☐ Foster Care (past or present)	☐ Manic/Bipolar Disorder	☐ Suicide/Attempt
☐ Blood Clot/Stroke	☐ Headaches	☐ Mental Retardation	☐ Surgery/ies
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Tuberculosis
☐ Depression	☐ HIV/AIDS	☐ Physical Pain	**Other:**
☐ Diabetes	☐ High Blood Pressure	☐ Physical Abuse	

Please Describe Any Issues Checked Above:

MOTHER AND MOTHER'S SIDE OF THE FAMILY: ☐ Check here if history is unknown

☐ Alcohol/Drug Abuse	☐ Diabetes	☐ High Blood Pressure	☐ Physical Pain
☐ Allergies	☐ Domestic Abuse	☐ Hyperactivity	☐ Physical Abuse
☐ Alzheimer's	☐ Eating Disorder	☐ Inattention	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Schizophrenia
☐ Autism	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Foster Care (past or present)	☐ Manic/Bipolar Disorder	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Headaches	☐ Mental Retardation	☐ Suicide/Attempt
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Surgery/ies
☐ Depression	☐ HIV/AIDS	☐ Personality Disorder/s	☐ Tuberculosis
☐ **Other:**			

FATHER AND FATHER'S SIDE OF THE FAMILY: ☐ Check here if history is unknown

☐ Alcohol/Drug Abuse	☐ Diabetes	☐ High Blood Pressure	☐ Physical Pain
☐ Allergies	☐ Domestic Abuse	☐ Hyperactivity	☐ Physical Abuse
☐ Alzheimer's	☐ Eating Disorder	☐ Inattention	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Schizophrenia
☐ Autism	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Foster Care (past or present)	☐ Manic/Bipolar Disorder	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Headaches	☐ Mental Retardation	☐ Suicide/Attempt
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Surgery/ies
☐ Depression	☐ HIV/AIDS	☐ Personality Disorder/s	☐ Tuberculosis
☐ **Other:**			

SIBLINGS (if applicable): ☐ N/A ☐ Check here if history is unknown

☐ Alcohol/Drug Abuse	☐ Diabetes	☐ High Blood Pressure	☐ Physical Pain
☐ Allergies	☐ Domestic Abuse	☐ Hyperactivity	☐ Physical Abuse
☐ Alzheimer's	☐ Eating Disorder	☐ Inattention	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Schizophrenia
☐ Autism	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Foster Care (past or present)	☐ Manic/Bipolar Disorder	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Headaches	☐ Mental Retardation	☐ Suicide/Attempt

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☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Surgery/ies
☐ Depression	☐ HIV/AIDS	☐ Personality Disorder/s	☐ Tuberculosis
☐ **Other:**			

Are you concerned that your child is using drugs and or alcohol? If yes, please indicate concerns below

DRUG/ALCOHOL USE/ABUSE please √ appropriate boxes				
Alcohol	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Sedatives	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Crack Cocaine	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Club Drugs	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Cocaine	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Hallucinogens (i.e., LSD)	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Heroin	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Inhalants	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Marijuana	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Methadone	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Opiates	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Prescription Drugs	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
PCP	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Stimulants (i.e., methamphetamine)	☐ Never Used	☐ Currently Use	☐ Used in Past	Age at First Use:
Other:_____		☐ Currently Use	☐ Used in Past	Age at First Use:
Other:_____		☐ Currently Use	☐ Used in Past	Age at First Use:

EDUCATIONAL HISTORY							
Name of School:				**☐ Public ☐Private**		**Grade:** **Teacher:**	
Current:				**Past Year:**			
Attendance	☐good	☐average	☐poor	Attendance	☐good	☐average	☐poor
Quality of work	☐good	☐average	☐poor	Quality of work	☐good	☐average	☐poor
Homework behavior	☐good	☐average	☐poor	Homework behavior	☐good	☐average	☐poor
In school behavior	☐good	☐average	☐poor	In school behavior	☐good	☐average	☐poor
Friendships	☐good	☐average	☐poor	Friendships	☐good	☐average	☐poor
Has your child/adolescent ever:							
Repeated a grade?				☐ No ☐ Yes Grade:			
Received Special Education Services?				☐ No ☐ Yes When:			
Been diagnosed with a learning disability?				☐ No ☐ Yes When:			
Been diagnosed with ADHD?				☐ No ☐ Yes When:			
Had a previous Individualized Education Plan (IEP)?				☐ No ☐ Yes When:			
Does your child/adol. have a current IEP?				☐ No ☐ Yes			
Describe your child's academic strengths and weaknesses:							

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Motivational Problems:
Behavior Problems:

LEGAL HISTORY

Has your child/adolescent ever been arrested or in trouble with the law?
☐ No ☐ Yes Please explain:

Is your child/adolescent currently on probation? ☐ No ☐ Yes

Has the child/adolescent's mental health treatment been court ordered? ☐ No ☐ Yes

CURRENT LEVEL OF FUNCTIONAL IMPAIRMENT	*(circle corresponding level)* (0 = no impairment, 5 = moderate impairment, 10 = severe impairment)										
Relationship with caregiver	0	1	2	3	4	5	6	7	8	9	10
Relationship with family	0	1	2	3	4	5	6	7	8	9	10
Friendships/Peer Relationships	0	1	2	3	4	5	6	7	8	9	10
Job/School Performance	0	1	2	3	4	5	6	7	8	9	10
Cognitive/Learning	0	1	2	3	4	5	6	7	8	9	10
Hobbies/Interests	0	1	2	3	4	5	6	7	8	9	10
Physical Health	0	1	2	3	4	5	6	7	8	9	10
Activities of Daily Living	0	1	2	3	4	5	6	7	8	9	10
Eating Habits	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Ability to Control Temper	0	1	2	3	4	5	6	7	8	9	10

Notes:

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YOUR CHILD'S CURRENT PROVIDER(S) AND PROFESSIONAL(S)

PRIMARY CARE PHYSICIAN	PSYCHIATRIST	CASE MANAGER
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
Length of time services received:	Length of time services received:	Length of time services received:
PROBATION OFFICER	**CPS WORKER**	**SCHOOL COUNSELOR/SW**
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
Length of time services received:	Length of time services received:	Length of time services received:

PAST PROVIDERS AND PROFESSIONALS
(Include Psychologists, Psychiatrists, Social Workers, etc)

TYPE OF PROVIDER:	TYPE OF PROVIDER:	TYPE OF PROVIDER:
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
When services were received:	When services were received:	When services were received:

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

_____ _____

Parent/Guardian Signature **Date**

CLINICIAN NOTES (clarifications, follow up, etc.)

_____

_____

_____

_____

_____

_____

_____

Recommendations: _____

_____

_____

_____

_____

_____ _____

Clinician **Date**

_____ _____

Cosignatory **Date**

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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 LICSW, LLC.

"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 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 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 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 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 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 LICSW LLC 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 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 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 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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12301 Whitewater Drive suite 30
Minnetonka, MN 55345
P:952.223.1300 F:202.546.4025

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
[] Discharge Summaries
[] History and Physical Exams
[] Two-way communication between physicians and therapists
[] Phone Contacts
[] Medication Information
[] Psychological Tests / MMPI
[] 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
[] Sharing information about my stay and treatment
[] Other (specify) _____
[] Determining eligibility for insurance benefits
[] Determining eligibility for Social Security Benefits

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:

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