Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Age: _____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____
Who referred you? _____
What brings you into therapy? _____
_____

_____

_____

Email: _____ Primary language: _____
Cell phone: _____ Can I leave a message/texts? _____
Work phone: _____ Can I leave a message/text? _____
Address: _____
City: _____ State: _____Zip Code_____

Current Symptoms Checklist: (check once for any symptoms present)

( ) Depressed mood	( ) Racing thoughts	( ) Excessive worry	( ) Unable to enjoy activities
( ) Impulsivity	( ) Anxiety attacks	( ) Sleep pattern disturbance	( ) Increase risky behavior
( ) Avoidance	( ) Loss of interest	( ) Increased libido	( ) Hallucinations
( ) Suspiciousness	( ) Change in appetite	( ) Excessive energy	( ) Excessive guilt
( ) Increased irritability	( ) Fatigue	( ) Crying spells	( ) Decreased libido
( ) Decrease need for sleep		( ) Concentration	( ) Obsessions/compulsions

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

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Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
Are you sexually active? ( ) Yes ( ) No Gender Identity: _____
How would you identify your sexual preference? ( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual
( ) transgender ( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer
Gender/ Pronoun used: _____
Describe your relationship with your spouse or significant other:

_____
Are you now or have you ever been in a relationship where you have been hurt? _____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____ How long? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____
Do you have custody of your children: _____ If no why not? _____
List everyone who currently lives with you: _____

_____
Have you ever been arrested? ( )Yes ( )No If yes when and reason: _____
Currently on probation? ( )Yes ( )No If so what county: _____
How do you support yourself financially? _____
Do you have any financial or housing concerns? ( )Yes ( )No _____
Do you currently have a good support system currently? ( )Yes ( )No
What do you do for fun? _____
What do you do to relax? _____
List three things you like about yourself: _____

Your Exercise Level:
Do you exercise regularly? ( ) Yes ( ) No How many days a week do you get exercise? _____
How much time each day do you exercise? _____ What kind of exercise do you do? _____

Educational History:
Highest Grade Completed? _____ Currently enrolled? _____ Did you attend college? _____
Where? _____ What is your highest educational level or degree attained? _____
Did you ever receive special education in school?_____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long at current job? _____Current place of work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge _____

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Suicide Risk Assessment :

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

When? _____

If YES, please answer the following. If NO, please skip to the next section.

How often do you have these thoughts? _____

When was the last time you had thoughts of suicide? _____

Has anything happened recently to make you feel this way? _____

Would anything make it better? _____

Do you have access to guns? If yes, please explain. _____

Medical History:

Current Medication	For what condition	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Who prescribes your medication? _____

Allergies:_____ Current Weight: _____ Height: _____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Recent/Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

_____

For women only: Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Do you have any concerns about your physical health that you would like to discuss with me? ( ) Yes ( ) No

Date and place of last physical exam: _____

Date of last dentist appointment: _____

Is there any additional personal medical history? ( )Yes ( )No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Concussions, Head injuries or brain damage ever? ( )Yes ( )No If yes explain: _____

_____

Do you have an infectious disease? ( )Yes ( )No (MRSA, AIDS, Hepatitis, Influenza, Bed Bugs, Lyme Disease, Measles, ect…) If yes explain: _____

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Mental Health History:

Current Therapist: _____ Current psychiatrist: _____

Past Outpatient treatment ( )Yes ( )No If yes, Please describe when, by whom, and nature of treatment.

_____

_____

_____

Psychiatric Hospitalization ( )Yes ( )No If yes, describe for what reason, when, where and reason

_____

_____

Have you been to the ER for self harm in the last 6 months? ( )Yes ( )No

Has your mental health ever been court ordered? ( )Yes ( )No

Would you like to discuss any problems related to rape, sexual/emotional/physical/verbal abuse? ( )Yes ( )No

Previous diagnoses you have had: _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for: *check yes for all that apply*

( )Bipolar disorder	( ) Schizophrenia	( )Depression	( )Post-traumatic stress	( )Anxiety
( )Alcohol abuse	( )Anger	( )Substance abuse	( )Suicide	( )Violence
( ) ADHD	( ) OCD	( )Other_____		

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( )Yes ( )No

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( )Yes ( )No

Have people annoyed you by criticizing your drinking or drug use? ( )Yes ( )No

Have you ever felt bad or guilty about your drinking or drug use? ( )Yes ( )No

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? ( )Yes ( )No

Do you think you may have a problem with alcohol or drug use? ( )Yes ( )No

Have you used any street drugs in the past 3 months? ( )Yes ( )No If yes, which ones? _____

_____

Have you ever abused prescription medication? ( )Yes ( )No If yes, which ones and for how long? _____

_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ( )Yes ( )No Currently? ( )Yes ( )No Packs per day? _____

Pipe, cigars, or chewing tobacco: Currently? ( )Yes ( )No In the past? ( )Yes ( )No How many years? _____

Vaping? ( )Yes ( )No How often? _____

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Drug/Alcohol Use/Abuse History: *Please check all appropriate boxes*

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

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Who were you raised by? _____

Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with?_____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

How would you describe childhood? _____

_____

_____

_____

Which of the following describes your childhood environment? *Check all that apply*

[]Warm	[]Affectionate	[]Validating	[]lonely	[]Hostile	[]Scary	[]Critical
[]Loving	[] Supportive	[]Loud	[]Accepted	[]safe	[]Involved	[]Fun
[]Ignore	[]Trusting	[]Connected	[]Chaos	[]Protected	[]Religious	[] Sad
[]Worried	[]Happy	[] Lonely	[] Violent	[] Outdoors	[] Laughter	[] Unsure

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Does your mental health affect the following areas? *Check all that apply*

[] Family	[] Friends	[] Hobbies	[] Physical health	[] Memory
[] Job	[] School	[] Finances	[] Housing	[] Hygiene
[] Legal	[] Relationships	[] Movement	[] Appetite	[] Weight

Religion/Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? _____

Is there any religious/spiritual/cultural issues you want to discuss in therapy? ( )Yes ( )No

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

Day treatment/Partial program	**School counselor**	**Other**
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax

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Is there anything else that you would like us to know?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

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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 ____**

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

Client signature: _____ Date: _____

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Insurance Form

PATIENT INFORMATION:

Legal Name: _____ Email address_____

Date of Birth: _____Social Security Number: _____

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

Phone Number: _____ ☐ Cell ☐Home ☐Other

Phone Number: _____ ☐ Cell ☐Home ☐Other

Sex: ☐ Male ☐Female ☐Other Marital Status: ☐ Single ☐Married ☐Widowed ☐Divorced ☐Separated

PRIMARY INSURANCE INFORMATION:

Primary Insurance Company: _____Phone Number: _____

Member ID Number: _____Group Number: _____

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

Name: _____Date of Birth: _____

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

Relationship to Patient: _____ Phone Number: _____ Sex: ☐ Male ☐Female

SECONDARY INSURANCE INFORMATION: (*If Applicable*)

Primary Insurance Company: _____Phone Number: _____

Member ID Number: _____Group Number: _____

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

Name: _____Date of Birth: _____

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

Relationship to Patient: _____ Phone Number: _____ Sex: ☐ Male ☐Female

RESPONSIBLE PARTY: If Patient is Under 18

Name: _____Date of Birth: _____

Address: _____ City: _____ State: _____Zip: _____

Relationship to Patient: _____ Phone Number: _____

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

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

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RACHEL RIPPEL MA, LP
LICENSED PSYCHOLOGIST

Client's Full Name: _____

Date of Birth: _____

_____

I authorize:

Rachel Rippel MA, LP
12301 Whitewater Drive suite 30. Minnetonka, MN 55343
P: 952-466-6002 F: 952-955-4411

To release information to and from to: _____
Phone/Fax:_____
Address:_____

Relation to this person: _____

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: [] mental health [] chemical dependency [] HIV/AIDS

Dates of information to be released: [] All [] Other

This information may be released for the purposes of:

- [] Planning/continuing my care and treatment
- [] Billing/financial
- [] Emergency contact
- [] Other _____

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 Clause: I understand that I may withdraw my authorization by written notice. My authorization will expire when I am terminated as a client from the clinic or if I revoke this release in writing.

Client Signature: _____ Date: _____

Parent or guardian signature: _____ Date: _____

Please fill out a release of information for anyone you want me to be able to talk to. I require one for your emergency contact, primary physician, psychiatrist or any other professional involved in your care.

Release of Information

Client's Full Name: _____

Date of Birth: _____

_____

I authorize:

Rachel Rippel MA, LP
12301 Whitewater Drive suite 30. Minnetonka, MN 55343
P: 952.466.6002 F: 952.955.4411

To release information to and from: _____

Phone/Fax: _____

Address: _____

Relation to this person: _____

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

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

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- [] Other _____

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Client Signature: _____ Date: _____

Parent or guardian signature: _____ Date: _____

Please fill out a release of information for anyone you want me to be able to talk to. I require one for your emergency contact, primary physician, psychiatrist or any other professional involved in your care.

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 Rachel Rippel, MA, LP, LLC.(RR)
"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 RR. With your consent, we may disclose certain health information specified by you to your family, others involved in your care or organizations outside of RR 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
We may use and disclose information about you within Rachel Rippel, MA, LP, 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 Rachel Rippel, MA, LP, LLC for medical or scientific research. You will be asked to sign additional authorizations for clinical research trials involving treatment

Complaints
If you have any questions or complaints, or would like to obtain a copy of your medical records, contact:
Rachel Rippel, MA, LP, LLC
12301 Whitewater Drive, Suite 30
Minnetonka, MN 55343

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 Rachel Rippel, MA, LP, 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 Rachel Rippel, MA, LP, 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 Rachel Rippel, MA, LP, 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 Rachel Rippel, MA, LP, 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 Rachel Rippel, MA, LP, 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 Rachel Rippel, MA, LP, 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 Rachel Rippel, MA, LP, LLC at the address shown on the back of this brochure. Notices will be available whenever we provide you with health care.

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