

CLIENT INFORMATION

The purpose of this form is to provide you with information about your rights at Minnesota Psychological Resources. We are committed to providing quality professional services to all our clients. In order to do so, we need your informed participation. As you read this form, please feel free to discuss any questions you may have with your therapist.

1. The information which is requested about you is used by us to determine your eligibility for services, to evaluate your needs and to develop a plan to address those needs.
2. It is necessary to keep records on all services provided to you. The records must include diagnosis, treatment plans, and specific treatment given.
3. As a client of this Center, you have a right to privacy and a right to see your records. You have a right to a copy of your records (There is a charge for this service). Your therapist can make a clinical decision to deny you access to part or all of your private records if it is determined that your psychological and/or physical well-being or that of another person would be jeopardized.
4. You have the right to challenge your records and to insert your own explanation about that which you object to in your records.
5. You have the right to appeal the content of your records. To file an appeal, you can contact your therapist, the Director of Minnesota Psychological Resources, or you can write directly to the Department of Human Services, Licensing Division, Human Services Building, 444 Lafayette Road North, St. Paul, Minnesota, 55155.
6. If you are a minor, your parents or legal guardians have the right to request access to information related to your assessment and treatment at Minnesota Psychological Resources. You are encouraged to discuss your concerns related to this with your therapist.
7. Your Minnesota Psychological Resources records are kept confidential and ONLY with your written authorization can your records be released to another person or agency EXCEPT when such release is specifically required by law.
8. It is required by law for therapists to disclose confidential information in some specific situations to prevent harm from occurring (for example, child abuse, injury to yourself or others, etc.). In some circumstances a court might be able to obtain your records or subpoena your therapist.
9. You have the right to know the specifics of your treatment plan including treatment options and possible treatment side effects. You also have the right to discuss the outcomes of your treatment.
10. You have the right to know the professional qualifications of your therapist. You are encouraged to ask your therapist about his/her professional background and training.
11. You have the right to request corrective action be taken if your rights are violated. You may present your concern or complaint to your therapist or to the Director of Minnesota Psychological Resources. You may also file a complaint if your concern is not resolved in a satisfactory manner by writing the Department of Human Services, Licensing Division, Human Services Building, 444 Lafayette Road North, St. Paul, Minnesota, 55155.
12. You have a right to a copy of the *Minnesota Psychological Resources Notice of Privacy Practices* brochure which describes how mental health information about you may be used and disclosed, and how you can get access to this information.

A copy of the Minnesota Psychological Resources Notice of Privacy Practices brochure has been provided or made available to me. _____ Please Initial

Again, if you have any questions regarding the information in this form, please direct your questions to your therapist.

Client Signature

Date

Medical History Form

Directions: Please answer the following questions to the best of your knowledge

Your records are considered confidential. Your records will not be released to any party without your written consent.

Patient Information				
Last Name	First Name	Middle	Primary Language	Social Security No.
Street Address	City	State	Zip	OK to Send Letter? <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone	Ok to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone	Ok to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, How can you be reached?
Birthdate	Marital Status: <input type="checkbox"/> Single without partner <input type="checkbox"/> Single with partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Length of Time: _____
Children: <input type="checkbox"/> Yes <input type="checkbox"/> No	How Many?	Number of Persons Living in Your Home:		Race/Ethnicity:
Emergency Contact Person	Phone Number	Relationship		

Primary Physician(s)		
Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

Medication Allergies? Yes No

Substance or Food Allergies? Yes No

If yes, what medication(s) _____

If yes, what substance(s) _____

Family History: Please if your family has a history of the following

- Diabetes High Blood Pressure Heart Attack, Heart Disease Blood Clots or Stroke Tuberculosis
- Cancer Alzheimer's Family History Unknown Mental Illness Epilepsy/Seizure

Any other major conditions? _____

If you have answered YES to any of the above, please explain: _____

Are you currently being treated for medical conditions? Yes No If YES, please list: _____

Medications (List more on separate page if necessary)

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

Past Medications / For what condition? (list sedatives, pain medications, sleeping pills, antidepressants, etc.)

Social / Sexual Risk History

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke? If yes, how many cigarettes per day?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use alcohol? If yes, how often, how much?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had or would you like help now with an alcohol or drug problem?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like to discuss problems related to a rape or emotional / physical / sexual abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

Medical History Form

Directions: Please answer the following questions to the best of your knowledge

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Review of Systems: Please ✓ if you currently have or have ever had the following			
1. General			
Productive cough (3 weeks or more)			Unusual discharge (vaginal or from penis)
Dry, unproductive cough (3 weeks or more)			Bloody or painful urination
Shortness of breath			Dark, bloody or painful bowel movements
Chest pain			Hepatitis A
Recurrent night sweats, chills, fevers			Hepatitis B
Swollen glands (neck, armpits or groin)			Hepatitis C
Persistent weight loss without dieting			Chronic Fatigue
Weight problem / eating disorder			Cancer
Tuberculosis: Ever tested? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date and result of last test:	If Positive, did you have a chest x-ray?
Ever treated? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date(s) and type(s) of treatment:	
HIV: Ever tested? <input type="checkbox"/> Yes <input type="checkbox"/> No		Would you like information regarding HIV / AIDS or testing sites? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Review of Systems: Please ✓ if you currently have or have ever had the following			
2. Skin			
Allergies / Rash / Itching	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Psoriasis / Eczema	<input type="checkbox"/> Current <input type="checkbox"/> Past		
3. Eyes			
Vision problems	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Eye infections	<input type="checkbox"/> Current <input type="checkbox"/> Past		
4. Ears, Nose, Throat, Lungs			
Hearing problems	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Teeth / gum problems or disease	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Frequent nosebleeds	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Recurrent sinusitis	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Frequent sore throats	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Recurrent Pneumonia	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Asthma	<input type="checkbox"/> Current <input type="checkbox"/> Past		
5. Cardiac			
Palpitations / arrhythmia	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Heart disease / murmur	<input type="checkbox"/> Current <input type="checkbox"/> Past		
High blood pressure / Low blood pressure	<input type="checkbox"/> Current <input type="checkbox"/> Past		
High cholesterol	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Thrombophlebitis / blood clots	<input type="checkbox"/> Current <input type="checkbox"/> Past		
6. Neurologic			
Stroke	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Frequent headaches or migraines	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Seizures / Epilepsy	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Weakness / paralysis / unsteady walking	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Dizziness / confusion / wandering	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Forgetfulness / memory lapse / memory loss	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Other conditions / problems not listed:			
7. Gastrointestinal			
Recurrent nausea / vomiting / diarrhea	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Stomach / bowel problems	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Gall bladder disease	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Pancreatitis	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Diabetes / hyperglycemia / hypoglycemia	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Encopresis (incontinent of feces)	<input type="checkbox"/> Current <input type="checkbox"/> Past		
8. Genitourinary			
Bladder / kidney problems or infection	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Incontinence (unable to control bladder)	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Enuresis (bedwetting)	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Sexually transmitted disease:			
<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Herpes			
<input type="checkbox"/> Chlamydia <input type="checkbox"/> Trichomonas			
<input type="checkbox"/> HPV or genital warts			
Females:			
Menstrual Difficulties	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Cycle: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular			
<input type="checkbox"/> Pre-Menopause <input type="checkbox"/> Menopause			
Problems / infection of tubes / ovaries / uterus	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Abnormal Pap Smear(s)	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Number of pregnancies:			
Number of births:			
Problems with pregnancies / births (explain)			
Breast disease / tumor / surgery (explain)			
Miscellaneous:			
Anemia / blood disorder	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Arthritis	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Sleep disturbance	<input type="checkbox"/> Current <input type="checkbox"/> Past		

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

Patient Signature: _____ Date: _____

Clinician's Notes	
Reviewed by (Clinician):	Date:

Developmental and Medical History
(For Child/Adolescent Clients: 18 years and under only)

Name: _____

Complete all items as accurately as possible.

1. Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.) _____
2. Length of delivery (number of hours from initial labor to birth) _____
3. Mother's age when child was born _____
4. Child's birth weight _____

5. Did any of the following conditions occur during the pregnancy/delivery?

- | | | |
|---|----|-----|
| a. Bleeding | NO | YES |
| b. Excessive weight gain | NO | YES |
| c. Toxemia/Preclampsia | NO | YES |
| d. RH factor incompatibility | NO | YES |
| e. Frequent nausea or vomiting | NO | YES |
| f. Serious illness or injury | NO | YES |
| g. Used prescription medications during pregnancy | NO | YES |
| i. If yes, name of meds taken _____ | | |
| h. Took illegal drugs | NO | YES |
| i. Used alcoholic beverages | NO | YES |
| i. If yes, approximate number of drinks per week _____ | | |
| j. Smoked Cigarettes | NO | YES |
| i. If yes, approximate number of cigarettes per day _____ | | |
| k. Used Caffeine | NO | YES |
| i. If yes, approximate number of cans or cups per day _____ | | |
| l. Was given medication to ease labor pains | NO | YES |
| m. Delivery was induced | NO | YES |
| n. Forceps were used during delivery | NO | YES |
| o. Had a breech delivery | NO | YES |
| p. Had a cesarean section delivery | NO | YES |
| q. Other problems | NO | YES |
| i. Describe: _____ | | |

6. Did any of the following conditions affect your child during delivery or within the first few days after birth?

- | | | |
|---|----|-----|
| a. Injured during delivery | NO | YES |
| b. Cardiopulmonary distress during delivery | NO | YES |
| c. Delivered with cord around neck | NO | YES |
| d. Had trouble breathing following delivery | NO | YES |
| e. Needed oxygen | NO | YES |
| f. Was cyanotic, turned blue | NO | YES |
| g. Was jaundiced, turned yellow | NO | YES |
| h. Had an infection | NO | YES |
| i. Had seizure(s) | NO | YES |
| j. Was given medication | NO | YES |
| k. Born with a congenital defect | NO | YES |
| l. Was hospitalized more than seven days | NO | YES |

7. During the first 12 months, was your child:

- | | | |
|---|----|-----|
| a. Difficult to feed | NO | YES |
| b. Difficult to get to sleep | NO | YES |
| c. Colicky | NO | YES |
| d. Difficult to put on a schedule | NO | YES |

- e. Alert..... NO YES
- f. Cheerful..... NO YES
- g. Affectionate NO YES
- h. Sociable NO YES
- i. Easy to comfort NO YES
- j. Difficult to keep busy NO YES
- k. Overactive, in constant motion..... NO YES
- l. Very stubborn, challenging NO YES

8. At what age did your child first accomplish the following:

- a. Sitting up without help _____
- b. Crawling _____
- c. Walking alone, without assistance _____
- d. Using single words (i.e. mama, dada, etc.) _____
- e. Putting two or more words together (i.e. mama up) _____
- f. Bowel training, day and night..... _____
- g. Bladder training, day and night _____

9. Date of child's last physical exam

10. At any time, has your child had the following:

- | | | | |
|---|-------|------|---------|
| a. Asthma | Never | Past | Present |
| b. Allergies | Never | Past | Present |
| c. Diabetes, arthritis, or other chronic illnesses..... | Never | Past | Present |
| d. Epilepsy or seizure disorder | Never | Past | Present |
| e. Febrile seizures | Never | Past | Present |
| f. Chicken pox or common childhood illnesses | Never | Past | Present |
| g. Heart or blood pressure problems..... | Never | Past | Present |
| h. High fever (over 103)..... | Never | Past | Present |
| i. Broken bones | Never | Past | Present |
| j. Severe cuts requiring stitches..... | Never | Past | Present |
| k. Head injury with loss of consciousness..... | Never | Past | Present |
| l. Lead poisoning..... | Never | Past | Present |
| m. Surgery..... | Never | Past | Present |
| n. Lengthy hospitalization | Never | Past | Present |
| o. Speech or language problems | Never | Past | Present |
| p. Chronic ear infections | Never | Past | Present |
| q. Hearing difficulties | Never | Past | Present |
| r. Eye or vision problems | Never | Past | Present |
| s. Fine motor/handwriting problems..... | Never | Past | Present |
| t. Gross motor difficulties, clumsiness..... | Never | Past | Present |
| u. Appetite problems (overeating or under-eating)..... | Never | Past | Present |
| v. Sleep problems (falling asleep, staying asleep)..... | Never | Past | Present |
| w. Soiling problems..... | Never | Past | Present |
| x. Wetting problems | Never | Past | Present |
| y. Other health difficulties- please describe _____ | | | |
