



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> <input type="checkbox"/> PICA		<input type="checkbox"/> <input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
<input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ()		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. RESERVED FOR NUCC USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
c. RESERVED FOR NUCC USE		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		b. OTHER CLAIM ID (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		c. INSURANCE PLAN NAME OR PROGRAM NAME	
X SIGNED Text /2023		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
15. OTHER DATE MM DD YY QUAL.		X SIGNED Text	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
1		NPI	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED DATE		a. NPI b.	
33. BILLING PROVIDER INFO & PH # ()		a. NPI b.	

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

CURE COUNSELING & ASSESSMENT TRAINING CENTRE

SNAP ASSESSMENT

CLIENT:

DOB:

DATE:

<p><u>STRENGTHS</u></p> <p>What personal qualities do you have which we can build upon in treatment?</p>	<input type="checkbox"/> Open minded <input type="checkbox"/> Friendly <input type="checkbox"/> Creative <input type="checkbox"/> Good Listener <input type="checkbox"/> Quick Learner <input type="checkbox"/> Good Grooming <input type="checkbox"/> Organized	<input type="checkbox"/> Takes personal responsibility <input type="checkbox"/> Strong personal or spiritual values <input type="checkbox"/> Independent <input type="checkbox"/> Assertive <input type="checkbox"/> Hard Worker <input type="checkbox"/> Able to learn from my experiences <input type="checkbox"/> Can collaborate/ work with others	<input type="checkbox"/> Good Problem Solver <input type="checkbox"/> Good Decision Maker <input type="checkbox"/> Dependable <input type="checkbox"/> Motivation <input type="checkbox"/> Good health <input type="checkbox"/> Other (Please List) _____ _____ _____
<p><u>NEEDS</u></p> <p>What would help you achieve your goals? Please, check your most important needs.</p> <p>(Prioritize your top three)</p>	<div style="display: flex;"> <div style="flex: 1;"> <input type="checkbox"/> Increase my knowledge of resources that provide me with support <input type="checkbox"/> Referral to resources for job training or education <input type="checkbox"/> Access to medical care for health related concerns <input type="checkbox"/> Staying in a sober environment to help me not use drugs and or alcohol <input type="checkbox"/> Gain more knowledge and understanding about: <input type="checkbox"/> My mental health diagnosis <input type="checkbox"/> My medication(s) <input type="checkbox"/> My symptoms / behaviors related to my mental health diagnosis <input type="checkbox"/> Get help to stop smoking <input type="checkbox"/> Learn how to empower myself to take a more active role in my treatment </div> <div style="flex: 1;"> <input type="checkbox"/> Increasing effective communication skills to improve my relationships with others <input type="checkbox"/> Learn how to talk about my concerns/issues/feelings <input type="checkbox"/> Practice my coping skills in a safe environment <input type="checkbox"/> Learn more about effective coping skills related to: <input type="checkbox"/> Improving my sleep <input type="checkbox"/> Reducing anxiety and using relaxation <input type="checkbox"/> Managing my depression <input type="checkbox"/> Leisure skills <input type="checkbox"/> Organizing daily activities <input type="checkbox"/> Managing anger <input type="checkbox"/> Mood Regulation <input type="checkbox"/> Improving reality-based thinking <input type="checkbox"/> Eating Healthy <input type="checkbox"/> Other (Please List) _____ _____ </div> </div>		
<p><u>Abilities</u></p> <p>What skills do you possess?</p>	<div style="display: flex;"> <div style="flex: 1;"> <input type="checkbox"/> Basic ability to read and write <input type="checkbox"/> Computer knowledge and skills <input type="checkbox"/> Ability to work effectively with others <input type="checkbox"/> Knowledge or tools that I use to help me manage my emotions <input type="checkbox"/> Ability to have positive relationships with others </div> <div style="flex: 1;"> <input type="checkbox"/> Ability to make healthy decisions about my life <input type="checkbox"/> Job Skills _____ <input type="checkbox"/> Education / Training _____ <input type="checkbox"/> Leisure Skills _____ <input type="checkbox"/> Ability to manage my time and structure my daily activities <input type="checkbox"/> Other (Please List) _____ </div> </div>		
<p><u>Preferences</u></p> <p>How do you want your treatment?</p>	<input type="checkbox"/> I prefer my family or friends to be involved in my treatment <input type="checkbox"/> I would like to have a family meeting I learn new information better: <input type="checkbox"/> Face to face <input type="checkbox"/> Hands on instruction and practice <input type="checkbox"/> Reading written material <input type="checkbox"/> Alone <input type="checkbox"/> In discussion with others <input type="checkbox"/> Sharing information in a group of my peers	<input type="checkbox"/> I would like to live: <input type="checkbox"/> Independently, on my own <input type="checkbox"/> Independently, with community support <input type="checkbox"/> With others <input type="checkbox"/> Other ideas I have about my living situation (Please List) _____ _____ _____	<input type="checkbox"/> I am interested in learning more about <input type="checkbox"/> Outpatient programming <input type="checkbox"/> Community resources <input type="checkbox"/> Other areas of interest (Please List) _____ _____ _____

CURE COUNSELING & ASSESSMENT TRAINING CENTRE

2594 Highway 34 East #B
Newnan, GA 30265
(770) 252-3760 office@curecounseling.com

BIOPSYCHOSOCIAL ASSESSMENT – ADULT

Today's Date _____	Name _____
Date of Birth _____	Email Address _____
Preferred Language _____	Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete this form in its entirety. If you wish not to disclose personal information, please check "No Answer" (NA).

PRESENTING PROBLEM

1. Please describe what brings you in today? _____
2. How long have you been experiencing this problem? ☐ Less than 30 day ☐ 1-6 months ☐ 1-5 years ☐ 5+ years
3. Rate the intensity of the problem 1 to 5 (1 being mild and 5 being severe): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
4. How is the problem interfering with your day-to-day functioning? _____
5. What are your current goals for therapy? If treatment were to be successful, what would be different?

6. Are you currently or in the last 30 days experienced any of the following symptoms? (check all that apply)

<input type="checkbox"/> Sadness	<input type="checkbox"/> Hopeless/Helpless	<input type="checkbox"/> Sleep Too Much	<input type="checkbox"/> Fatigue/No Energy	<input type="checkbox"/> Poor Memory
<input type="checkbox"/> No Motivation	<input type="checkbox"/> Lack of Interest	<input type="checkbox"/> Thoughts of Dying	<input type="checkbox"/> Guilt	<input type="checkbox"/> Feel Worthless
<input type="checkbox"/> Not Hungry	<input type="checkbox"/> Prefer Being Alone	<input type="checkbox"/> Irritable/Angry	<input type="checkbox"/> Can't Sleep	<input type="checkbox"/> Too Much Energy
<input type="checkbox"/> No Need for Sleep	<input type="checkbox"/> Talk Too Fast	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Can't Concentrate	<input type="checkbox"/> Restless/Can't Sit Still
<input type="checkbox"/> Suspicious	<input type="checkbox"/> Hearing Things	<input type="checkbox"/> Seeing Things	<input type="checkbox"/> Have Special Powers	<input type="checkbox"/> People Watching Me
<input type="checkbox"/> People Out to Get Me	<input type="checkbox"/> Feeling Nervous	<input type="checkbox"/> Fearful	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Can't be in Crowds
<input type="checkbox"/> Easily Startled	<input type="checkbox"/> Avoidance	<input type="checkbox"/> Re-occurring Nightmares		

7. Do you now or have you ever contemplated suicide?.....
8. Are you a survivor of trauma?.....
9. Are you pregnant now?.....
10. If yes, when are you due? (day/month/year) _____
11. Are you at risk for HIV/AIDS/Sexually Transmitted Diseases (unsafe sex, using needles?)
12. Please list allergies to medications or food: _____

13. Has your physical health kept you from participating in activities?.....

	Yes	No	NA
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOBACCO

1. Have you ever used any forms of tobacco (cigarettes, snuff, etc.)? **IF NO SKIP TO NEXT SECTION**

2. Are you a former tobacco user?

3. If yes, what form(s) of tobacco have you used in the past (*please check all that apply*)

☐ Cigarettes ☐ Cigars ☐ Snuff ☐ Chewing Tobacco ☐ Snuff ☐ Other

4. How many times on an average day do you use tobacco (1-99)?

Cigarettes _____ Cigars _____ Snuff _____ Chewing Tobacco _____ Snuff _____

5. Have you been involved in a program to help you quit using tobacco in the past 30 days?

6. If so, which self-help group was used? _____

Yes No NA

1. ☐ ☐ ☐

2. ☐ ☐ ☐

5. ☐ ☐ ☐

SUBSTANCE USE/ADDICTION PRESENT

1. Would you or someone you know say you are having a problem with alcohol?

2. Would you or someone you know say you are having problems with pills or illegal drugs?

3. Would you or someone you know say you are having problems with other addictions, ie. gambling, pornography or shopping?

4. Have you ever been to a self-help group?

Yes No NA

1. ☐ ☐ ☐

2. ☐ ☐ ☐

3. ☐ ☐ ☐

4. ☐ ☐ ☐

SUBSTANCE USE/ADDICTION PAST

1. Would you or someone you know say you had a problem with alcohol?

2. Would you or someone you know say you had problems with pills or illegal drugs?

3. Would you or someone you know say you had problems with other addictions, ie. gambling, pornography or shopping?

4. Is there a family history of addiction in your family?

5. If yes, please describe: _____

Yes No NA

1. ☐ ☐ ☐

2. ☐ ☐ ☐

3. ☐ ☐ ☐

4. ☐ ☐ ☐

PERSONAL, FAMILY AND RELATIONSHIPS

1. Who is in your family? (parents, brothers, sisters, children, etc.) _____

2. Has there been any significant person or family member enter or leave your life in the last 90 days?

3. How are the relationships in your family?

4. How are the relationships in your support system (friends, extended family, et.?).

5. Are there any problems in your family now? (check all that apply)

6. Were there any problems with your family in the past? (check all that apply)

7. Are there any problems in your support system now? (check all that apply)

8. Were there any problems with your support system in the past? (check all that apply)

9. What is your marital status now? ☐ Single ☐ Married ☐ Living as Married ☐ Divorced
☐ Widowed ☐ Never Married

Yes No NA

2. ☐ ☐ ☐

Good Fair Poor Close Stressful Distant Other

☐ ☐ ☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐ ☐ ☐

Conflict Abuse Stress Loss Other

☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐

Client Name: _____ Date of Birth: ____/____/____

	Yes	No	NA
10. Have you ever had problems with marriage/relationships?.....	10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. If yes, please check why <input type="checkbox"/> Stress <input type="checkbox"/> Conflict <input type="checkbox"/> Loss <input type="checkbox"/> Divorced/Separation <input type="checkbox"/> Trust Issues <input type="checkbox"/> Other _____			
12. Do you have any close friends?.....	12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have problems with friendships?.....	13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you get along well with others (neighbors, co-workers, etc.)?.....	14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. What do you like to do for fun? _____			

EDUCATION

	Yes	No	NA
1. What is the highest grad you completed in school? (please check) <input type="checkbox"/> No Education <input type="checkbox"/> K-5 <input type="checkbox"/> 6-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> GED <input type="checkbox"/> College Degree <input type="checkbox"/> Masters Degree			
2. Would you describe your school experience as positive or negative? _____			
3. Are you currently in school or a training program?.....	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LEGAL

	Yes	No	NA
1. Have you ever been arrested? IF NO SKIP TO NEXT SECTION	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the past month?.....	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. If yes, how many times? _____			
4. In the past year?.....	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If yes, how many times? _____			
6. If yes, what were you arrested for? _____			
7. What was the name of your attorney? _____			
8. Were you ever sentenced for a crime?.....	8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. If yes, number of prison sentences served? _____			
10. What year(s) did this occur? _____			
11. Are you currently or have you ever been on probation or parole?.....	11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. If yes, what is the name of your attorney or probation officer? _____			

WORK

	Yes	No	NA
1. What is your work history like? <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Sporadic <input type="checkbox"/> Other			
2. How long do you normally keep a job? <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years			
3. Are you retired?.....	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. If yes, what kind of work do you do/did you do in the past? _____			
5. Have you ever served in the military?.....	5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If yes, are you <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Other			

MEDICAL

- Current Primary Care Physician: _____ Phone _____
- Past and Current Medical/Surgical Problems: _____
- Past and Current Medications and Dosages: _____
- Have you seen a Mental Health Professional Before? ☐Yes ☐No
- If yes, Name, When, and Reason for Changing: _____
- Current Psychiatrist/APRN, if applicable: _____
- Is there anything else you would like me to know about you? _____

Client Name: _____ Date of Birth: ____/____/____