Jessica L. Hermanson, MSW, LICSW

Child and Family Therapist
1165 S. Columbia Rd., Ste D
Grand Forks, ND 58201-4007
701-738-0888

Please complete all information correctly and legibly or **you will be responsible for the bill.**

PATIENT INFORMATION:

Last name: _____ First Name:_____ M.I. _____

SSN: _____-____-_____ Birth date: _____/_____/_____ Medication Allergies: _____

Sex: M or F Patient's marital status: _____ Patient's Spouse's Name:_____

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

Phone: home _____ work _____ cell _____

Referring Doctor: _____ Primary Doctor: _____

RESPONSIBLE PARTY (if other than patient):

Last name: _____ First Name:_____ M.I. _____

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

Phone: home _____ work _____ cell _____

Employer's Name: _____ City: _____ State: _____

INSURANCE INFORMATION:

Primary Insurance	*Secondary Insurance (if applicable)*
Card Holder _____	Card Holder _____
Birth Date _____	Birth Date _____
SSN _____	SSN_____
Address (if different) _____	Address (if different) _____
_____	_____
Phone # _____	Phone # _____
Employer _____	Employer _____
Insurance Company _____	Insurance Company _____
Policy ID # (begins with a letter)	Policy ID # (begins with a letter)

BILLING INFORMATION – Read and sign:

1. I authorize Jessica L. Hermanson, MSW, LICSW to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize Jessica L. Hermanson, MSW, LICSW, to release my medical records and billing information to my Primary Care and Referring Physician.
3. I authorize my insurance benefits to be paid to Jessica L. Hermanson, MSW, LICSW.
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.
7. I understand I am responsible for payment of my bill beyond insurance coverage.
8. I understand that my scheduled time slot will be forfeited if I miss three scheduled sessions without contacting the provider and per the provider's discretion.

Name of person completing this form (please print) _____

Signature of person completing this form_____ Date: _____

Relationship to Patient: _____

Patient Name: _____
Date of Birth: _____ **Phone:** _____

I authorize: Circle One
Diane K. Baumbach, MSW, LICSW, BCD
Katie Benson, MSW, LICSW
Randall C. Nedegaard, PhD
Jessica L. Hermanson, MSW, LICSW

To release and exchange with
Clinicians who provide services at
1165 S. Columbia Rd, Ste D
Grand Forks, ND 58201
(701)738-0888

Clinicians operate independently but share space and staff together.

Items to be released:
___ Progress Notes
X Acknowledgement of Care

I authorize verbal and/or written exchange of my medical information.
The information is to be used for:

X Office work related to Management of care
X Supervision
X Referral
___ Other _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OF FEDERAL LAW I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATE TO:

1. **Substance Abuse**
2. **Mental Health (includes psychological testing)**
3. **HIV-Related Information (AIDS related testing)**
4. **Developmental Disabilities**
5. **Adoptee/Adopting Parents**
6. **Physical Abuse**

This release of information consent form remains in effect for 12 months or until the patient or legal guardian shall revoke this authorization. However your revocation will not be effective to the extent that action that relied on the authorization of this consent and was obtained as a condition for insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to re-discloser by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Office policy for release of medical records:

a) **No charge for medical records released to physician(s) or other health care providers.**
b) **A fee schedule is applicable for medical records released directly to patient(s) or nonmedical related parties.**

Copying fee: $_____

Signature: _____ **Date:** _____

Relationship to client_____

Witness: _____ **Date:** _____

Name _____ Date _____

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems	**Duration** (months)	**Additional information**:
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild =** Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe =** Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	circumstantial symptoms	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) _____	[ ]	[ ]	[ ]	[ ]

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] [ ] Prior outpatient psychotherapy?
No Yes If yes, on _____occasions. Longest treatment by _____ for _____ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

[ ] [ ] Has any family member had outpatient psychotherapy? If yes, who/why (list all):_____
No Yes _____

[ ] [ ] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?
No Yes If yes, on _____occasions. Longest treatment at _____ from ___/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

[ ] [ ] Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes,
No Yes who/why (list all):_____

Name _____ Date _____

[ ] [ ] Prior or current psychotropic medication usage? If yes:

No	Yes	Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

[ ] [ ] Has any family member used psychotropic medications? If yes, who/what/why (list all):_____

No Yes _____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

_____

toward others

from others

Parents' current marital status:

[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ___

Describe parents:

	Father	**Mother**
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse
[ ] experienced physical/verbal/sexual abuse

Special circumstances in childhood:_____

_____

_____

IMMEDIATE FAMILY

List all persons currently living in patient's household:

Name Age Sex Relationship to patient

_____

_____

_____

List children <u>not</u> living in same household as patient:

_____

_____

_____

Frequency of visitation of above: _____

Describe any past or current significant issues in <u>immediate family</u> relationships: _____

_____

_____

_____

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

_____

List name of primary care physician:

Name _____ Phone _____

List name of psychiatrist: (if any):

Name _____ Phone _____

List any medications currently being taken (give dosage & reason):

_____

_____

_____

Is there a history of any of the following in the family:

[ ] tuberculosis
[ ] birth defects
[ ] emotional problems
[ ] behavior problems
[ ] thyroid problems
[ ] cancer
[ ] mental retardation
[ ] heart disease
[ ] high blood pressure
[ ] alcoholism
[ ] drug abuse
[ ] diabetes
[ ] Alzheimer's disease/dementia
[ ] stroke
[ ] other chronic or serious health problems _____

_____

Name _____ Date _____

List any known allergies: _____

List any abnormal lab test results:
Date _____ Result _____
Date _____ Result _____

Describe any serious hospitalization or accidents:
Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date: _____ Age _____ Reason _____

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used:

(complete all that apply)	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol					
[ ] amphetamines/speed					
[ ] barbiturates/owners					
[ ] caffeine					
[ ] cocaine					
[ ] crack cocaine					
[ ] hallucinogens (e.g., LSD)					
[ ] inhalants (e.g., glue, gas)					
[ ] marijuana or hashish					
[ ] nicotine/cigarettes					
[ ] PCP					
[ ] prescription_____					
[ ] other_____					

Treatment history:

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)
[ ] stopped on own (age[s]_____)
[ ] other (age[s]_____
describe:_____

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other _____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:

[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
_____
birth weight ____lbs ___oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:

[ ] chickenpox (age _____)
[ ] German measles (age _____)
[ ] red measles (age _____)
[ ] rheumatic fever (age _____)
[ ] whooping cough (age _____)
[ ] scarlet fever (age _____)
[ ] autism
[ ] ear infections
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems _____
_____

[ ] lead poising (age _____)
[ ] mumps (age _____)
[ ] diphtheria (age _____)
[ ] poliomyelitis (age _____)
[ ] pneumonia (age _____)
[ ] tuberculosis (age _____)
[ ] mental retardation
[ ] asthma

Name _____ Date _____

Delayed developmental milestones (check only those milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other _____
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):

[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things
[ ] other _____

Social interaction (check all that apply):

[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other _____

Intellectual / academic functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation

Current or highest education level _____

Describe any other developmental problems or issues: _____

_____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income

Social support system:
[ ] supportive network
[ ] few friends
[ ] no friends
[ ] distant from family of origin

Legal history:
[ ] no legal problems
[ ] now on probation
[ ] court ordered this treatment
describe last legal difficulty: _____
_____

Cultural/spiritual/recreational history:
cultural identity (e.g., ethnicity, religion): _____
_____
describe any cultural issues that contribute to current problem: _____
_____
currently active in community/recreational activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: _____

SOURCES OF DATA PROVIDED ABOVE: [ ] Patient self-report for all [ ] A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Family History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Developmental History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Emotional/Psychiatric History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Medical/Substance Use History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Socioeconomic History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____