Face to Face Health & Counseling Service, Inc.
1165 Arcade Street * St. Paul, MN 55106 * www.face2face.org
Phone: 651-772-5555 * FAX: 651-772-5656

LABEL HERE

Patient Registration Form

Preferred Name: _____ **Pronouns:** _____

Which of the following best describes your gender?

☐ Woman ☐ Transgender Woman ☐ Gender Queer

☐ Man ☐ Transgender Man ☐ Other:_____

Legal Last Name: _____ **Legal First Name:** _____

Social Security #:_____ **Birth Date:**_____

Your assigned sex at birth: Female Male

Street Address: _____ **Apt/Unit #:** _____

City, State, Zip: _____

Mailing Address (if you cannot get mail where you live):_____

_____

Phone Number (to be used for reminder calls/text messages regarding for appointment reminders, provider calls, etc):

_____

Email Address:_____

Emergency Contact (Name/Relationship/Phone number)_____

If we need to reach you and we are unable to do so by phone, how should we contact you? Please write email or numbers we can contact:_____

How do you identify your Race(s)?_____

What is your preferred spoken language? _____

Do you need an interpreter for your visit? ☐ Yes ☐ No

Are you Hispanic or Latino? ☐ Yes ☐ No

Are you currently homeless? ☐ Yes ☐ No

If yes, where are you living? Street Doubling Up Shelter Transitional

How did you hear about Face to Face? _____

Are you interested in information on any of the additional services listed below and offered by Face to Face?

☐ **SafeZone** ☐ **Mental Health** ☐ **Insurance** ☐ **Other:** _____

Please turn over- there are a few questions on the other side

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Income Information (report only the patient's income)

By signing below I hereby give my permission to Face to Face to allow review of my financial information for the purpose of reporting to funders on general income levels. Specific information will not be shared. This will not release any records or information of why you are here.
I certify that the information on this form is accurate and complete. I authorize Face to Face to verify information provided if necessary.

Check all the types of income below you receive ***each month*** and the amount you receive:

- ☐ None
- ☐ Employment (Job) Amount:_____ per month
- ☐ Social Security Disability(SSI) Amount:_____ per month
- ☐ MFIP Amount:_____ per month
- ☐ General Assistance Amount:_____ per month
- ☐ Other Amount:_____ per month

Are you married? Yes No

Do you have children? Yes No How many children do you have? _____

Payment Authorization

Face to Face serves everyone, regarding of an individual's income, insurance status, or ability to pay. For patients that are self-pay, we charge based on a sliding scale. We are happy to work out payment plans and we are committed to meeting the healthcare needs of everyone. If my insurance denies any part of my claims, I hereby agree to pay for my services on a sliding fee scale.

By signing below I authorize Face to Face Health and Counseling Service Inc. to release any information, concerning my health care to my insurance company. I hereby authorize payment of the amount due for any pending insurance claim be made directly to Face to Face Health and Counseling Service Inc. Payment is authorized upon your receipt of an itemized statement of services. *I understand that if I am covered under my parents' policy and want Face to Face Health and Counseling Service Inc. to bill my insurance company, my parents may receive a copy of the charges

Rights, Responsibilities, Privacy and Electronic Communication

There is a copy of our Rights, Responsibilities, Privacy & Electronic Communication notice available on our website www.face2face.org

By signing below you also indicate that you have been given a copy of Face to Face Health and Counseling Service Inc. Rights, Responsibilities, Privacy and Electronic Communication notice today or at a previous visits and understand that it provides information about how Face to Face Health and Counseling Service Inc. may use or disclose protected health information. I understand that I may request a copy to retain for my own records at any time in clinic.

This Authorization is valid for one year unless I cancel by giving written notice to: Face to Face Health and Counseling Service Inc. or it expires as required by law.

Client Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____
(required if client is under 18

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Consent

I hereby authorize and give my expressed consent to Face to Face Health and Counseling, Inc. for medical treatment of minor illness or injuries, vaccinations, testing, treatment and routine health maintenance for _____(client's first and last name) as deemed necessary by the professional medical staff. This staff includes medical assistants, registered nurses, nurse practitioners, and, physicians.

I authorize **MEDICAL CARE** for above named client at Face to Face Health and Counseling Service Inc.
(Please check yes or no)

☐ **YES** ☐ **NO**

I hereby authorize and give my expressed consent to Face to Face Health and Counseling, Inc. for the administration of mental health treatment, including counseling services and assessment as well as coordination of services for:_____(client's first and last name) as deemed beneficial or necessary by professional mental health staff including graduate clinical interns, mental health practitioners and licensed mental health professionals. I understand that my provider may be supervised by a licensed mental health professional for supervision and insurance billing purposes. I understand that my mental health provider will consult with the mental health team as deemed necessary. I further understand I can contact Mental Health Manager: Megan Holm, LMFT with any additional questions or concerns regarding this.

I authorize **MENTAL HEALTH CARE** for above named client at Face to Face Health and Counseling Service Inc.
(Please check yes or no)

☐ **YES** ☐ **NO**

I accept responsibility for understanding the content of this document. My signature below constitutes my acknowledgement:

1. That I have read and agree to the above.

2. That I hereby give my authorization and consent to treatment and/or consultation for the above named client to receive routine medical care and, mental health care to my child unless checked NO above.

I understand that this consent will last for one year unless I change my mind and withdraw by consent sooner in writing. If I withdraw consent, it will not affect actions already taken by authorized person.

Client Signature:_____Date: _____

Legal Guardian Signature:_____Date: _____
(required if client is under 18)

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WELCOME TO FACE TO FACE!

Face to Face Health and Counseling Service, Inc. will maintain your privacy and confidentiality. The confidentiality of this and other forms you complete here is protected by Federal laws and regulations. You are not required to answer the questions in this form. The questions are being asked so Face to Face can give you the best service possible

Date:_____

Legal Name:_____ **Preferred Name:**_____

Parent/Guardian first, last name and email address_____
(if client is under 18)

_____

Are you attracted to: (check all that apply) ☐ Males ☐ Females ☐ Both ☐ Neither ☐ Unsure

What language is spoken in your home?_____

Do you speak another language? ☐ Yes ☐ No If "yes", which language(s)?_____

Have you ever been pregnant? ☐ Yes ☐ No **Are pregnant or a parent to be?** ☐ Yes ☐ No

Are you a parent? ☐ Yes ☐ No **If yes, Child/Children names and ages:**_____

Do you receive other services with us?
☐ SafeZone ☐ Medical Clinic ☐ Connect Prenatal Program/Case Management ☐ Health Education ☐ Insurance

Where are you living? (Please check all that apply):
☐ Parent(s)' home ☐ Relative's home ☐ Friend's house ☐ Group home ☐ Shelter

How long can you live there? ☐ Less than a week ☐ A month or more ☐ Permanently ☐ Unknown

Do you feel safe where you live? ☐ Yes ☐ No

Names and ages of your siblings:_____

_____

What/Who are the support system(s) in your life? (Please check all that apply):
☐ Family/Relative ☐ Friends ☐ School ☐ Other: explain
☐ Sports ☐ Art/Music ☐ Church
☐ Partner ☐ Youth Group ☐ Community Group

Are you currently in school? ☐ Yes ☐ No If Yes, where?_____What Grade?_____

Do you have a job? ☐ Yes ☐ No If Yes, Where?_____How Many Hours Per Week?_____

How would you rate your current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you taking any medications? ☐ Yes ☐ No If "yes", what and what for? _____

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Have you ever had suicidal thoughts? ☐ Yes ☐ No **Have you ever tried to hurt yourself?** ☐ Yes ☐ No

Has anyone ever tried to hurt you physically or in any way? (ex, kicking, slapping, biting etc.) ☐ Yes ☐ No

Have you been involved, or witnessed, any violence in the last year? If "Yes" where?

☐ At Home ☐ At School ☐ In the Community ☐ Other:_____

Are you in a relationship with a person who threatens or physically hurts you? ☐ Yes ☐ No

Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No

Has anyone emotionally and/or verbally abused you? ☐ Yes ☐ No

Have you ever been neglected? ☐ **Yes** ☐ **No**

Substance Use

Do you drink alcohol? ☐ Yes ☐No If yes, age of first use_____

How much do you drink?_____ How often do you drink?_____

What substances have you used?_____

Have you done things you've regretted because of substance use? ☐ Yes ☐No

Have you noticed a need to use more of a substance to get the desired effect? ☐ Yes ☐No

CAGE-AID Chemical Health Assessment:

1.Have you ever felt that you ought to cut down on your drinking or drug use? ☐ Yes ☐No

2. Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐No

3. Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐No

4. Have you ever had a drink or used drugs first thing in the morning (eye-opener) to steady your nerves, get rid of a hangover, or get the day started? ☐ Yes ☐No

What is your main reason for coming to counseling today? _____

What life changes or stressful events have been going on lately? _____

IF APPLICABLE: To Parents/Guardians: What goals do you have for your child in therapy?

What days and times would you prefer to have counseling appointments? _____

List three words that describe your life right now:

_____ _____ _____

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Please circle any symptoms or experiences that you have had in the past year

Sleeping too much, Sleeping too little **(please circle which one(s))**	Trouble Falling Asleep Trouble Staying Asleep **(please circle which one(s))**	Panic Attacks	Feelings of nervousness, tension or anxious	Worrying all the time	Racing thoughts
Eating more often Eating less often Under eating Not feeling hungry **(please circle which one(s))**	Sadness/tearfulness Feeling down or depressed **(please circle which one(s))**	Acting out sexually, Being unhappy during or after sex **(please circle which one(s))**	Skipping school Stay out late **(please circle which one(s))**	Poor attention, Trouble concentrating easily distracted **(please circle which one(s))**	Binge Eating Making yourself vomit **(please circle which one(s))**
Worried about weight: too much weight or not enough weight	Spending increased time alone	Social Anxiety	Self-Harming	Angry Often Trouble Controlling Anger	Suicidal thoughts/ feelings
Relationship with significant other/partner	Separation or divorce	Feeling Numb or Nothing	Feelings of loneliness	Low self-esteem/ low confidence	Getting into fights/arguing often
Loss of interest in previously enjoyed activities	Feeling or acting like a different person	Difficulty leaving your home	Mood swings	Repetitive behaviors (e.g. frequent checking, hand washing	Feeling hopeless and/ or helpless
Gender identity	Family problems	Trouble with Memory	Being tired during the day	Flashbacks	Hearing things that are not there
Sexual identity	Nightmares/ sleepwalking	School Anxiety	Low Impulse Control	Being abused	Seeing things that are not there
Issues with peers/friendships	Perfectionism	Finances	Being Bullied	Job/Work/Career	Stealing
Making/keeping friends	Pregnancy	Parenting	Troubled about future plans	Thoughts about harming or killing someone else	Fire setting
Feelings of guilt	Unresolved grief/loss	Worried about a place to live	Religious/ spiritual concerns	Other:	

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YOUR COPY TO KEEP

Rights, Responsibilities, Privacy, and Electronic Communication

Your Rights:

- Respect, dignity, confidentiality and privacy
- Request and receive a copy of your medical record
- Request another provider, or to get a referral to another agency
- Know that your service provider may consult with other Face to Face service providers including mental health, medical, health education and SafeZone staff to best serve your needs
- To informed participation in decisions involving your health care
- To a safe environment with suitable privacy
- To refuse treatment and be informed of the medical consequences of refusal
- To expect reasonable education regarding treatment options and prescribed treatment programs

Your Responsibilities:

- Be honest about what you need
- Respect the privacy of other clients
- Inform staff of complaints or problems
- Informing your provider if you do not understand the instructions or explanations given to you
- Provide your current and accurate health information at each visit
- Informing your healthcare provider if instructions cannot be followed and a more suitable plan is required
- Treating all Face to Face staff respect
- Cooperating in observing safety regulations and policies in the office

Your Privacy:

Face to Face Health and Counseling Services, Inc. will maintain your privacy and confidentiality. The confidentiality of this and other forms completed here is protected by federal laws and regulations.

Face to Face Health and Counseling Services, Inc. cannot disclose that a client receives services or any other information on a client unless:

- The client consents in writing
- The disclosure is allowed by court order
- Disclosure is to medical personnel in an medical emergency
- Disclosure is allowed for audit or for evaluation purposes,
- As otherwise allowed under HIPPA (Health Insurance Portability and Accountability Act)

Some exceptions to confidentiality under the law, which may require the provider to release information, include but are not limited to:

- Knowledge of or reasonable cause to believe that a child is being neglected, emotionally, physically or sexually abused
- Clients who are 16 and under who are victims of a crime
- Maltreatment of a vulnerable adult as specified in the Vulnerable Adult Act
- Person is a harm to themselves or others

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Please turn over- there is more information on the other side

Electronic Communication:

- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients. E-mail and other forms of electronic communication are not “secure” means of communication.
- Backup copies of e-mail or text messages may exist even after the sender or the recipient has deleted his/her copy.
- All e-mail and text messages may be discoverable in litigation regardless of whether it is in a patient’s medical record.
- Messages transmitted via e-mail may not be picked up in a timely fashion. To avoid unnecessary delays in the transmission of important information, do not use e-mail to send urgent messages.

EMAIL COMMUNICATION I (we) understand the assumptions stated above and understand that e-mail is not a secure means of communication. I am aware that the provider may decline to communicate via e-mail based upon the nature of the medical information. I give permission Face to Face Health & Counseling Service, Inc. to use electronic mail as a means of communication regarding my care. I understand that I may withdraw this authorization at any time by notifying Face to Face Health and Counseling Inc. administrative staff or my provider in writing.

TEXT MESSAGING I (we) understand the assumptions stated above and understand that text messaging is not a secure means of communication. I am aware that the provider may decline to communicate via text messaging based upon the nature of the medical information. I give permission for Face to Face Health and Counseling, Inc. to use text messaging as a means of communication both between myself regarding appointment reminders, scheduling and reminders regarding paperwork, or for client or guardian(if applicable) to call the clinic. I understand that I may withdraw this authorization at any time by notifying Face to Face Health and Counseling administrative staff or my provider in writing.

Strengths and Difficulties Questionnaire

S 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain . Please give your answers on the basis of how things have been for you over the last six months.

Your name..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CD's, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress you?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Your Signature ..... Today's Date .....

Thank you very much for your help

Strengths and Difficulties Questionnaire

P 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example CD's, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help