



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: _____



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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)



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? _____



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:



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

Sleeping <u>too much</u> Sleeping <u>too little</u> (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:	