Cornerstone Counseling of Bellevue, LLC
817 Kilbourne St Suite G
Bellevue, OH 44811
Phone: 419-483-9411 Fax: 419-483-9247

BILLING INFORMATION

Client:

Name_____ M☐ F☐ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Primary Phone_____ May we identify and leave a message by voice and/or text?_____

IF CLIENT IS A MINOR OR IS STILL IN HIGH SCHOOL, PLEASE PROVIDE PARENT OR LEGAL GUARDIAN'S INFORMATION.

☐ Client is a minor.

☐ Client is not a minor but enrolled **and** attending high school.

School name_____

Expected graduation date_____

Responsible Party: (If different than Client)

Name_____ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Are you legally married? Yes____ No____

Spouse/partner name_____ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Primary phone_____ Type____ May we identify and leave a message by voice and/or text?_____

Secondary phone_____ Type_____ May we identify and leave a message by voice and/or text?_____

Biological parent information-if client is a minor AND is different from above responsible party:

Name_____ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Are you legally married? Yes____ No____

Spouse/partner name_____ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Primary Phone_____ Type_____ Secondary phone_____ Type_____

Employment:

Employer_____

Address_____ City _____ State_____ Zip_____

Phone_____ Position_____ Full time_____ Part time_____

Spouse/partner employer_____

Address_____ City_____ State_____ Zip_____

Phone_____ Position_____ Full time_____ Part time_____

Insurance:

Insurance provider_____ Phone_____

Address_____ City_____ State_____ Zip_____

Subscriber_____ DOB_____/_____/_____ Policy number_____

Secondary insurance_____ Phone_____

Address_____ City_____ State_____ Zip_____

Subscriber_____ DOB_____/_____/_____Policy number_____

Emergency Contact_____

Relationship to patient_____ Phone_____

Nearest relative not living with you_____ **Phone**_____

Physician_____ **Phone**_____

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Cornerstone Counseling of Bellevue, LLC, the counselors, and other Cornerstone staff may use and share my confidential health information with others to treat me, in order to arrange payment of my bill, and for issues that concern Cornerstone operations and responsibilities.

INSURANCE SIGNATURE REQUIREMENT

By signing below, I hereby authorize payment of medical benefits to Cornerstone Counseling of Bellevue, LLC, for services rendered and authorize Cornerstone Counseling of Bellevue, LLC, to release information acquired in the course of my treatment to my insurance company.

I certify the information on this form is true and correct to the best of my knowledge and will notify Cornerstone of any changes in my status regarding the above information.

Printed: _____

Signature:_____ Date_____

Witness:_____ Date_____

CORNERSTONE COUNSELING OF BELLEVUE, LLC
ADULT PERSONAL HISTORY FORM

Please complete the following information to the best of your ability. Your counselor will review this information as part of the assessment process. This information will be very helpful to your counselor in deciding the best course of treatment for you. If you are uncomfortable or have difficulty answering any of the questions you may leave them blank and discuss them with your counselor. We appreciate your patience in completing this form.

Client Name: _____ Date: _____

I. Presenting Problem:

Who referred you for services? (check all that apply)

□ Self □ Family □ Spouse □ Friend □Employer □ Court □Family Doctor/other health care provider

□ Other (please explain): _____

Why are you seeking counseling at this time and/or why did any of the above refer you to counseling?

_____

_____

II. Social History:

Identify your current marital status:

□ Single, never married □ Married □ Divorced □ Living with significant other (unmarried)

□ Separated □ Widowed

Living Situation			
Identify your type of living situation: □ Own home □ Rent home □ Friend's home □ Relative's home □ Other:			
List household members (name)	Relationship to you	Age	Circle which best describes the quality of relationship with each household member.
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent
Significant family members (not living with you)	Relationship to you	Age	Circle which best describes the quality of relationship with each person.
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent
			Poor Fair Good Excellent

Would you like any family members involved in your treatment? □ Yes □ No

If yes, list who you would like involved in your treatment here. _____

Community Resources: Do you currently use any of the following community resources?

□ Yes □ No If yes, check all that apply.

□ AA/ NA/ Al Anon □ Health Department □ Dept. of Job and Family Services

□ NAMI □ Church □ Other(s): Please list below

_____

Leisure and Recreation Activities:
How do you spend your free time? Check all that apply.

Activity	√	When was the last time you did this?
Outdoor activities (i.e. fishing, gardening, etc.)		
Hobbies & crafts (i.e. scrapbooking, sewing, painting, etc.)		
Attending social activities, events, & groups		
Physical activities (i.e. sports, exercise, etc.)		
Caring for pets		
Spending time with friends		
Reading		
Watching TV		
Surfing the internet		
Social Media		How many hours per day:

Are you currently satisfied with your social life? □ Yes □ No If no, please comment:_____

Have you ever been a victim of any of the following? Check all that apply. □ Physical Abuse
□ Sexual Abuse □ Emotional Abuse □ Verbal Abuse □ Neglect □ Exploitation (taken advantage of)

III. Cultural and Ethnic Section
What is your ethnic/cultural heritage (i.e. Irish, African American, etc.)? _____
What were your family's beliefs about the following?

Issue	Comments (my family believed, taught, etc.)
Showing Emotion	
Using alcohol/ other drugs	
Having a mental illness	
Seeking help	
Death/dying	

Do you have any traditions that were special to you/your family (i.e. special holidays, foods, music, celebrations, etc)?
_____

Will you let your family members know you are in treatment? □ Yes □No
If not, please explain why: _____
Do you think family beliefs/ cultural beliefs will affect your counseling treatment? □ Yes □ No
If yes, please explain how:_____

IV. Education, Employment, and Military Information
Education History: (Check all that apply) □ GED □ HS Grad □ Other degree:
□ College - # Years Degree/Major:
Highest grade completed:_____
Were you ever in special education classes in school? □ Yes □ No
If yes, why?

Do you have any history of learning difficulties?: □ Yes □ No
If yes, please specify:
□ Learning disability – Type:
□ Mental retardation

□ Special school placement
□ Other:
History of behavior problems/ disciplinary action at school:
Detentions for:
Suspensions for:
Expulsions for:

Any school problems (i.e. poor grades, acting out etc.) related to drug/alcohol use?
□ Yes □ No If yes explain: _____

Do you have problems learning new information? □ Yes □ No
If yes, please specify:
□ Inability to read or write □ Difficulty retaining information
□ Difficulty concentrating □ Other: _____

Employment: (Check all that apply)
Employed: □ Full time (35 hrs. or more per week) □ Part time (<35 hrs per week) □ Volunteer work
□ Unemployed – Date last worked: _____
Not in Labor Force: □ Disabled □ Retired □ Homemaker □ Student □ Living in institution
□ Other:
If employed, name of employer:_____
How long have you been employed with current employer? _____yrs _____months
Satisfied with job? □ Yes □ No
Job Performance History:
How many jobs have you had in the last five years?_____ Comments:_____
Identify your typical attendance habits at work: □ Above average □ Normal □ Tardiness □ Absenteeism

Identify your typical work performance: □ Excellent □ Good □ Average □ Below Average
Do you have any history of employment problems (i.e. due to drug/alcohol use, disciplinary actions, suspensions, problems relating to bosses/coworkers, termination, etc.)? □ Yes □ No
If yes, please explain:_____
Are you experiencing financial problems? □ Yes □ No Comments:_____
If you are not employed do you want to work? □ Yes □ No
If you are not employed are you able to work? □ Yes □ No

Military History: Were you ever or are you currently in the military? □ Yes □ No
□ Army □ Navy □ Air Force □ Marines □ Coast Guard □ National Guard
Reason for discharge and type:
Date of discharge:

V. Legal History:
Do you have a legal guardian of person? □ Yes □ No of estate? □ Yes □ No
If yes, name:_____ Relationship to client:_____
Phone #:_____

What is your current legal status? □ N/A □ On Probation □ Detention □ On Parole
□ Awaiting Charge □ AoD Related Legal Problems □ Court Ordered to treatment □Other: _____

Do you have a history of legal charges as a juvenile? □ Yes □ No
If yes, please explain: _____
Do you have a history of legal charges as an adult? □ Yes □ No

If yes, please explain:_____

Date of most recent charges: _____

Have you ever been convicted of a crime? □ Yes □ No
If yes, list crimes for which you have been convicted: _____

Have you ever been incarcerated? □ Yes □ No
If yes, complete the following:

Date of Incarceration	Location	Length of Incarc.	Reason(s) for Incarceration

Do you have a probation/parole officer? □ Yes □ No
If yes, list name:_____ Phone #: _____

Do you have a valid driver's license? □ Yes □ No If no, why not?_____

Is child protective services involved with your family? □ Yes □ No
If yes, why?_____

If yes, Name of case worker:

VI. Spirituality:
Do you believe in God or a Higher Power? □ Yes □ No
Do you identify yourself as a member of any particular faith? □ Yes □ No
If yes, please list faith: _____
Do you attend a church, synagogue, mosque, or other place of worship? □ Yes □ No Name of Place: _____
Has faith been a source of strength/support to you during difficult times in your life? □ Yes □ No
Do your spiritual beliefs ever contribute to feelings of worry or anxiety? □ Yes □ No
If yes, please explain: _____

What are your spiritual beliefs about suicide?_____
What are your spiritual beliefs about dying?_____
Do you see your faith playing a role in treatment? □ Yes □ No If yes, explain:_____

VII. Alcohol/Drug Use History
Have you ever used prescription drugs differently than how they were prescribed (i.e. higher dose or more frequent than prescribed) in the past year? □ Yes □ No
Have you used illegal drugs in the past year? □ Yes □ No
Have you used non-prescription drugs differently than the recommended dosage in the past year?
□ Yes □ No
Have you drank more alcohol than you or someone else thought you should have in the past year?
□ Yes □ No

Complete the following regarding your history of drug/alcohol use:	Date of last use	Amount typically used	How often?
Alcohol			
Cannabis (pot/marijuana/weed)			
Cocaine (any form)			
Opioids(Heroin, Percocet, Vicodin, Opana, etc)			

Sedatives			
Inhalants(Whippets, Nitrous, Poppers, Rush)			
Hallucinogens (acid/lsd/pcp/etc.)			
Stimulants (diet pills, speed, etc.)			
Club/designer drugs(ecstasy, Molly, GHB, Ketamine)			
Non-prescription (over the counter)			
Other (i.e. steroids, fat burners, etc.)			

Tobacco use: □ Yes □ No If yes, form (cigarettes, cigars, "chew", etc.)? Amount per week? _____
Caffeine use: □ Yes □ No If yes, form (coffee, pop, etc.)? Amount per week? _____

Have you had any of the following problems related to drug/alcohol use (check all that apply)?
□ Health problems
□ Legal problems
□ Relationship problems (arguments/strained relationships with family, etc.)
□ Employment problems (tardiness, poor performance, etc.)
□ Financial problems (not paying bills, etc. due to money spent on drugs or alcohol)

Have you ever or are you currently receiving treatment for alcohol and/or drug use? □ Yes □ No
If yes, please complete the following:

Agency Name	Currently in Treatment	Past Treatment (list dates)	Please rate results of your treatment experience 1 2 3 4 5 Not helpful helpful very helpful

Client signature or signature of person completing this form on behalf of the client:	Date:

CORNERSTONE COUNSELING OF BELLEVUE, LLC

Health History Questionaire

Please notify staff if you need any assistance in completing this form.

Client Name (First, MI, Last):	Date of Birth:

I. Any Allergies/ drug sensitivities? Yes____ No____

If yes specify below:

___ Food (Specify):
___ Medicine (Specify):
___ Other (Specify):

II. Medications: Are you currently taking any prescribed medication, over the counter medication, or herbal remedies?____Yes___No If yes, please complete the following:

Medication	Reason	Prescribed by:

III. History of Medical Problems: Please check "self" if any of the following health issues apply to you and/or check "family" if any apply to a family member.

Problem	Self	Family	List any treatment YOU have received for each problem identified.
Alcoholism/Drug Issues			
Anxiety			
Breathing Problems			
High Blood Pressure			
Cancer			
Depression			
Diabetes			
Epilepsy/ Seizures			
Head Injury/ Brain Tumor			
Heart Disease			
Hepatitis/ Jaundice			
Kidney Disease			
Stomach/ Bowel Problems			
Stroke			
Thyroid			
Have you tested positive for TB?			
Have you had exposure to TB?			
AIDS/ HIV			
Sexual Problems			
Sleep Problems			
Suicidal attempts or thoughts			
Other?			
Any medical/surgical hospitalizations in the past year- please list reasons:			
Do any of the medical problems you checked interfere with your daily living?		Yes	No
If yes, what problems and how?			

IV. Functional Screening

Problem/ Difficulty	YES	NO	Treatment received to help with the problem
Do you have problems with activities of daily living i.e. bathing, getting dressed or tying shoes?			
Do you have difficulty walking?			
Do you have any problems performing physical tasks at work or home?			
Do you use a walker, cane, wheelchair, or other ambulatory aid?			
Do you exercise regularly? If yes, what type? How often?			
Do any of the issues checked yes interfere with your daily living? If yes, which ones and how do they interfere?			

V. Pain Screening

Do you currently experience physical pain?	Yes	No
If yes, please rate your pain on a scale from 0 (no pain) to 10 (severe/worst pain). (Circle the one that best describes your pain) 0 1 2 3 4 5 6 7 8 9 10 No pain Severe/ worst pain		
Please indicate the location of your pain.		
Are you receiving medical treatment for the pain?	Yes	No
Are you taking pain medication?	Yes	No
Does the pain interfere with your daily living?	Yes	No
If yes, explain how.		

VI. Speech, Language, Vision, and Hearing Screening

Are you experienceing any of the following at this time? Please check "YES" or "NO."	YES	NO	If yes, list treatment and or services you received to help with these problems.
Do you ever have problems hearing others?			
Have you ever been tested for a hearing problem?			
Do people often ask you to repeat what you are saying?			
Is English your native language?			If no, what is?
Do you have difficulty seeing?			
Do any of the issues checked "yes" interfere with your daily living?			Yes / No
If yes what problems and how?			

VII. Nutritional Screening

Are you currently experiencing any of the following?	YES	NO	Details
Unplanned change in weight in the last 12 months?			If yes, Identify the change. ___ Gain ___ Loss Have you received medical treatment for this? ___ Yes ___ No
Has your physician asked you to follow a special diet?			If yes, type:
Any problems with chewing/ swallowing?			If yes, explain: Have you received medical treatment for this? Yes No

Do any of the issues checked interfere with your daily living? If yes, what problems and how?	Yes	No

VIII. Health Care

Last Physical Examination	Date:	By whom?	Phone Number:

Are your childhood immunizations up to date?		Yes	No
Have you had a flu shot this year?		Yes	No
Have you had a pneumonia vaccine in the last five years		Yes	No
Pregnancy (If applicable) Are you pregnant at this time? If yes, expected delivery date?	Yes	No	N/A
Are you receiving prenatal care? If yes, by whom?	Yes	No	N/A

Mental Health Treatment History:

Have you previously had outpatient mental health treatment? ☐ Yes ☐ No

If yes, please complete the following:

Agency name	Past Treatment Dates	Please rate your treatment experience (circle rating) Not helpful	Helpful	Very Helpful
		1	2	3
		1	2	3

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes complete the following:

Hospital Name	Admit Date	Discharge Date	Reason for entering hospital

Have you in the past or do you currently have a mental health diagnosis?

☐ Yes ☐ No

If yes, please list diagnosis:

Signature of person completing this form: _____