

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: <input type="checkbox"/> Own home <input type="checkbox"/> Rent home <input type="checkbox"/> Friend's home <input type="checkbox"/> Relative's home <input type="checkbox"/> 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	<input checked="" type="checkbox"/>	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		
Other:		

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

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)			
Cocaine (any form)			
Opioids, Heroin, Oxytocin, other opiates			
Sedatives			

Inhalants			
Hallucinogens (acid/lsd/pcp/etc.)			
Stimulants (diet pills, speed, etc.)			
Club/designer drugs			
Non-prescription (over the counter)			
Herbal remedies			
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 Questionnaire

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

Client Name (First, MI, Last):	Date of Birth:
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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
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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 experiencing 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? If yes what problems and how?			Yes No

