

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
Child/Adolescent Personal History

Please complete the following information to the best of your ability. We are required to ask the following information as part of your assessment today. Your counselor will review this information with you as part of the assessment process. This information will be very helpful to your counselor in making recommendations for treatment here. If you are uncomfortable or have difficulty answering any of these questions, you may leave them blank and discuss them with the counselor. We appreciate your patience in completing this form. Please ask our staff if you need any assistance completing this form – we are happy to help you.

Child's Name: _____ Today's Date: _____

Name of child's legal guardian: _____ Relationship: _____

I. PRESENTING PROBLEM:

Who referred the child for services? (check all that apply): Self Family School
 Friend Employer Court Family doctor/other health care provider
 Other (please explain) _____

Why are you seeking counseling for this child and/or why did any of the above refer him/her? _____

II. SOCIAL HISTORY:

LIVING SITUATION

Identify the child's type of living situation: House, apt. or trailer with family Friend's Home Relative's Home
 Foster Care home Residential Facility Group Home Jail/Prison Hospital (psychiatric)
 Homeless living with friend Homeless in shelter/no residence
 Other: _____

List Household Members (Name)	Relationship to child	Age	Circle which best describes the child's 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
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
Significant Family Members (not residing with the child)	Relationship to child	Age	Circle which best described the child's relationship with each household member			
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent

Would you like any family members involved in the child's treatment? Yes No

If Yes, list who you would like involved: _____

Community Resources:

Does the child currently use any of the following community resources? Check all that apply

AA/NA/Al Anon	Health Department	Parents Anonymous
Adult Protective Services	Home Health Care	Senior Services
American Red Cross	Hospice	Metropolitan Housing
Big Brothers/Big Sisters	Meals on Wheels	None
C.H.A.D.D.	MR/DD	Other(s): please list below
Catholic Social Services	NAMI	
Dept. of Job & Family Services	Support/Consumer Group	

Leisure and Recreation Activities:

Please check the appropriate boxes as they apply to the child's leisure/recreation activities:

Activity	Enjoyed in past	Enjoy now	Comments (i.e., types of activities, etc.)
Shopping			
Hobbies & Crafts			
Social Activities/Events			
Games			
Music			
Physical Activities			
Pets			
Spending time with friends			
Other:			

Does the child appear to have an age appropriate social life? Yes No If no, please comment: _____**Developmental History**

Place of Birth: _____

Birth: Weight: _____ Length: _____

Prenatal History:

- Medical Problems during pregnancy? Yes No Comments: _____
- Did parent use drugs/alcohol during pregnancy? Yes No Comments: _____
- Pregnancy or birth complications? Yes No Comments: _____

Infancy & Early Childhood

- Appeared to bond soon after birth? Yes No Comments: _____
- Crawled by 9 months? Yes No Comments: _____
- Walked by 18 months? Yes No Comments: _____
- Speech: words by 18 months, sentences by age 3-4? Yes No Comments: _____
- Completed toilet training by age 3? Yes No Comments: _____

Middle & Late Childhood:

- Has learned physical skills for age? Yes No Comments: _____
- Able to play and get along with peers? Yes No Comments: _____
- Follows rules at home & away from home? Yes No Comments: _____
- Activity level, sleep, appetite normal? Yes No Comments: _____
- Maturity level appropriate for age? Yes No Comments: _____

Adolescent Years:

- Socializes with friends as expected? Yes No Comments: _____
- Follows rules as required by the situation? Yes No Comments: _____
- Activity level, sleep, appetite normal? Yes No Comments: _____
- Maturity level appropriate for age? Yes No Comments: _____

Has the child ever been a victim of the following? (Check all that may apply):

- Physical abuse Sexual abuse Emotional abuse Verbal abuse
 Neglect Exploitation (taken advantage of in an unethical and/or illegal way)

OTHER:Any significant illnesses, injuries, or surgeries in the child/adolescent's history? Yes No If Yes, explain: _____

How has the child's/adolescent's condition affected the family? _____

What do you as the parent/guardian of this child expect or hope to gain from treatment? _____

Are you willing to be involved in this child's treatment? Yes No If No, please explain: _____

III. CULTURAL AND ETHNIC SECTION:

- What is the child's ethnic/cultural heritage (for example Irish, African-American, Native Indian, etc)? _____
- What are the child's family's beliefs about the following? _____

Issue	Comments (my family believed, taught.....)
Discipline	
Taking responsibility for one's actions	
Showing emotions	
Death/dying	
Respecting the laws/rules of society	
Using alcohol/other drugs	
Having a mental illness	
Seeking Help	

- Are there any traditions that were/are special to the child's family (i.e., special holidays, cooking certain foods, music, celebrations, traditions, etc.)? _____

- Do you think any family beliefs/cultural beliefs will affect the child's treatment at this agency? Yes No
If Yes, please explain how _____

IV. EDUCATION & EMPLOYMENT INFORMATION:

<p>Education History: (Check all that apply) <input type="checkbox"/> GED <input type="checkbox"/> HS Grad</p> <p>Name of School: _____ Principals' Name: _____</p> <p>Highest Grade Completed: _____</p> <p>Is the child on an IEP at school? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, why? _____</p> <p>Does the child have a history of learning difficulties? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please check all that apply:</p> <p><input type="checkbox"/> Learning Disability – Type _____ <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Special School Placement</p> <p><input type="checkbox"/> Other: _____</p> <p>Does the child have a history of behavior problems/disciplinary action at school? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please check all that apply:</p> <p><input type="checkbox"/> Detentions for (explain): _____</p> <p><input type="checkbox"/> Suspensions for (explain): _____</p> <p><input type="checkbox"/> Expulsions for (explain): _____</p> <p>Any school problems (i.e., disciplinary actions, poor grades, acting out, etc.) related to drug/alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, explain; _____</p> <p>Does the child have any special communication needs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please check all that apply:</p> <p><input type="checkbox"/> TDD/TTY Device</p> <p><input type="checkbox"/> Sign Language interpreter</p> <p><input type="checkbox"/> Assistive Listening Device(s)</p> <p><input type="checkbox"/> Language Interpreter Services Needed – Other Spoken Language: _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Does the child have problems learning? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please check all that apply:</p> <p><input type="checkbox"/> Inability to Read or Write (that is NOT age appropriate)</p>

Employment/Volunteer Work: (Check all that apply)

Does the child do volunteer work? Yes No If Yes, where? _____

Is the child employed? Yes No N/A

If Yes, complete the following:

Employed: Full Time (35 hours or more per week) Part Time (<35 hours per week)

Name of Employer: _____

Identify the child's typical attendance habits at work: Above Average Normal Tardiness Absenteeism

Identify the child's typical work performance: Excellent Good Average Below Average

Does the child have any history of employment problems due to drug/alcohol use? (i.e., disciplinary actions, suspensions, problems relating to bosses/coworkers, termination, etc.) Yes No If Yes, explain: _____

V. LEGAL HISTORY:

- **What is the child's current legal status?** None On Court Diversion Program On Probation
- Detention On Parole Awaiting Charges Conditional Release Court Ordered to Treatment
- Drug/alcohol related legal problems
- Other: _____

- Does the child have any history of legal charges? Juvenile Yes No
- If Yes, list charges:

Date of most recent charges: _____

- Has the child ever been charged as an adult for a crime? Yes No
- If Yes, list charges:

- Has the child ever been incarcerated? Yes No
- If Yes, complete the following:

Date(s) of incarceration	Location	Reason(s) AA/NA

- Does the child have a Probation/Parole Officer? Yes No
- If Yes, list name: _____ Phone: _____

- Is Children's Protective Services involved with the child or the child's family? Yes No
- If Yes, why? _____

If Yes, name of Caseworker: _____ Caseworker's Phone: _____

VIII. ALCOHOL/DRUG USE HISTORY:

- Has the child used illegal drugs in the past 12 months? Yes No
- Has the child used prescription drugs different from how they were prescribed (e.g., higher dose or more frequently than prescribed) in the past 12 months? Yes No If Yes, please explain:

- Has the child used non-prescription drugs different from the recommended dosage (e.g., higher dose than recommended) in the past 12 months? Yes No If Yes, explain:

Complete the following regarding your child's history of drug/alcohol use:	Date of Last Use	Amount Typically Used	How Often?
Alcohol			
Cannabis (pot)			
Cocaine (any form)			
Opioids, Heroin, Oxycontin, 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? (i.e. packs, etc.)?

Caffeine use: Yes No If yes, form (coffee, pop, etc.)? Amount per week? (i.e. cups, cans, etc.)?

Has your child had any of the following problems related to drug / alcohol use (check all that apply)

- Health problems (medical treatment or hospitalization for conditions related to drug / alcohol use)
- Legal problems
- Relationship problems (arguments / strained relationships with partner, children, friends, family, etc.)
- Employment problems (tardiness, poor performance, etc.)
- Financial problems (not paying bills or failing to meet ones financial obligations due to money spent on drugs / alcohol)

Has your child ever received 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 your treatment experience (circle response)				
			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:
Parent/Guardian Signature:	Date:
Clinician Signature/Credential:	Date:
Supervisor Signature/Credential:	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:
--------------------------------	----------------

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 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

