Love the Journey
Phone: 320-679-6964
Fax: 320-679-8183

23 Pine St N
Mora, MN 55051
www.lovethejourneymn.com

Name: _____Client chart #_____

Sex _____ Co-pay: _____

Birth Date: _____ Primary Provider: _____

Address: _____

Phone:_____ Work #_____

Insurance(s)

Insurance/Subscriber Eff Date/Rel Policy # Group #

_____

_____

Reason for intake:

I verify that the above information, as printed or as modified by me this date, is true and correct to the best of my knowledge.

_____Date:_____

Signature of Client or Guardian

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information, by Love the Journey to my insurance company, and or designated payer on behalf of myself and or dependents.

_____Date:_____

Signature of Client or Guardian

Assignment of benefits: I hereby authorize payment of Medical Benefits to Love the Journey for services rendered to myself and/or dependents.

_____Date:_____

Signature of Client or Guardian

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Safe Harbor Agreement

In order to preserve the safety and confidentiality of your child's therapeutic environment, it is essential that he/she feels free to speak openly with their therapist without fear of their statements being disclosed. The therapist's office is to serve as an environmental "safe harbor" for your child(ren). Therefore, any information given by the mental health provider to other professionals will be maintained as confidential. Neither parent shall nor will either parent permit his or her attorney to subpoena the information contained in this specific file or to subpoena the child's therapist for purpose of litigation related to custody, separation or divorce. Any party (or his or her attorney who seeks to interrogate the child's therapist or subpoena the information in this separate file shall be liable for all attorney fees and costs incurred to resist answering discovery requests or to quash a subpoena. I understand that this agreement is being made because it is in the best interest of the child(ren) to have confidential counseling services through the legal family proceedings.

_____

Child's name

_____ _____

Parent Date

_____ _____

Therapist Date

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Mora, MN 55051
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CONSENT TO PROVIDE SERVICES TO A MINOR

Name of Client/child: _____Date of birth:_____

I _____ _____

(Print name of Responsible party or parties) (Relationship to Minor)

Herby authorize Love the Journey to provide therapeutic and support services to the above named minor* child. I/we understand that treatment goals, frequency, and estimated length of treatment will be established on a case by case basis.

There is Limited Access to personal information to ensure a healthy therapeutic relationship. Information will be given based on the clinical/professional opinions for the child with the child's best interest in mind. Parents have a right to a copy of the DA, treatment plan(s), and progress notes upon written request.

I acknowledge receipt of the Notice of Privacy Practices and Client Bill of Rights.

*If there is a report of sexual or physical abuse, thoughts or actions towards suicide (unable to safety plan), homicide or neglect will be reported.

*It is the practice of Love the Journey to honor the consent of both custodial parents when applicable.

* I understand that I may revoke this consent at any time in writing and that this consent expires upon completion of the goals listed in the individualized treatment plan.

* A minor is any client age 17 and under.

_____ _____ _____

Signature of responsible party Signature of 2nd responsible party if app Date

_____ _____

Signature of Staff Date

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CONSENT TO PROVIDE THERAPY IN A SCHOOL

Name of Client/child: _____Date of birth:_____

I _____ _____

(Print name of Responsible party or parties) (Relationship to Minor)

Herby authorize Love the Journey to provide therapeutic and support services to the above named minor* child in his or her school. I/we understand that treatment goals, frequency, and estimated length of treatment will be established on a case by case basis.

If the school is unable or unwilling to provide space for medical necessary therapy appointment, I give my permission to Lori Petersen at Love the Journey to transport my child back to her office at 23 Pine St N, Mora MN and drive him/her back to school. I will not hold Love the Journey or Lori Petersen liable for an automobile accident. In return she agrees to follow all traffic rules.

* I understand that I may revoke this consent at any time in writing.

* A minor is any client age 17 and under.

_____ _____ _____

Signature of responsible party Signature of 2nd responsible party if app Date

_____ _____

Signature of Staff Date

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Release of Information

I authorize Love the Journey to use or disclose the protected health information of the individual named below as indicated. This information could be exchanged or leased via verbal, electronic, or written contact. Incomplete or invalid request will be returned to the proper individual.

Client Name: _____Chart #_____

Address:_____Date of birth:_____

City:_____State:_____Zip Code_____Phone #_____

This authorization is for the following information: I understand that sensitive information

__Case Notes/Treatment Plan

__Discharge Summary

__Diagnostic Assessment(s)

__Psychiatric/Medication Records

__Verbal

__Other_____

Dates of service to be used/disclosed:

__ ____/____/____ to ___/____/_____

___ Other:_____

I understand that sensitive information including information regarding HIV/AIDS, alcohol and drug abuse and or mental health treatment may be released as part of this disclosure unless I initial here and indicate what sensitive information I do not want disclosed. Initials:_____ Information not to be released_____.

I understand that signing this authorization is not required in order for me to receive treatment except as indicated in any privacy practices notices I received. I understand that I can revoke this authorization in writing by sending notice to the facility releasing the above information. I understand that once information is disclosed it may no longer be protected by federal or state privacy rules and therefore may be re-disclosed by the recipient of the information without permission. A photocopy or fax is equivalent to the original.

Unless otherwise indicated here, this authorization shall expire in one year. Other expiration date_____.

The Purpose for this request is for

__Medical Care __ Legal __Insurance __Communication Only __Coordination of Care __Emergency Contact
__Collateral Contact __Personal Record __Other:_____

Love the Journey is AUTHORIZED to send and receive the indicated information to the following person/group:

Person or Group_____

Address:_____Phone:_____

Signature_____Relationship:_____Date_____

Witness Signature:_____Date_____

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

Love the Journey

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Mora, MN 55051

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Informed Consent **Initial**

Consent to Treatment: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form and it has been offered to me in written form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. I am consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Love the Journey will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order. X____

Mandated Reporting: Each therapist is a mandated reporter, and as such is required by law to report if they have reason to believe that the abuse, neglect, or financial exploitation of a vulnerable adult or child has occurred. By initialing here, I indicate that I understand. X____

Social Media: To safeguard the professional relationship between client and therapist, clients should not reach out to their therapist via their therapist's private account on any form of social media. Therapists will not accept friend requests or any other form of connection through social media. By initialing here, I agree to this arrangement. X____

Cell Phone Use: Cell phones are very convenient, but may serve as a distraction during the therapy process. To help avoid distraction, Love the Journey requests that cell phones and other mobile devices are turned off during sessions and are not used, unless an individual arrangement is made between client and therapist. By initialing here, I agree to this arrangement. X____

Office Cell Phone: The office cell phone number is 763-227-7617. This phone is for making and confirming appointments, and confidential information should not be sent to this number. Therapists will not be giving out their personal cell phone numbers. If a patient's safety plan requires the use of a cell phone for check-ins, it will be done using this phone. This phone is not monitored on weekends or evenings. If you are in crisis or are in immediate danger, please dial 911. By initialing here, I indicate that I understand. X____

Printed Name of client_____

Preferred phone number_____

Is it ok to leave a message Y / N

Is it ok to text message Y / N

Who is your emergency contact:

_____phone_____

What is the relationship with your emergency contact? _____

By initialing here, I give Love the Journey permission to contact this person in the event of an emergency. X____

Signature _____ Date _____

(client's signature, or that of a legal guardian)

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle a number to indicate your answer)	**Not at all**	**Sometimes**	**Several days**	**Often**	**Every day**
1. Little interest or pleasure in doing things	0	1	2	3	4
2. Feeling down, depressed, or hopeless	0	1	2	3	4
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	4
4. Feeling tired or having little energy	0	1	2	3	4
5. Poor appetite or overeating	0	1	2	3	4
6. Feeling bad about yourself – or that you are a failure or have let yourself down or your family down	0	1	2	3	4
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	4
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3	4
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	4

10. If you checked off any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very Difficult _____ Extremely difficult _____

TOTAL

_____

Generalized Anxiety Disorder (GAD-7)

NAME: _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle a number to indicate your answer)	**Not at all**	**Sometimes**	**Several days**	**Often**	**Every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3	4
2. Not being able to stop or control worrying	0	1	2	3	4
3. Worrying too much about different things	0	1	2	3	4
4. Trouble relaxing	0	1	2	3	4
5. Being so restless that it is hard to sit still	0	1	2	3	4
6. Becoming easily annoyed or irritable	0	1	2	3	4
7. Feeling afraid as if something awful might happen	0	1	2	3	4

8. If you checked off any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very Difficult _____ Extremely difficult	TOTAL _____

CAGE-AID

*if you do not use drugs or alcohol, indicate so here ☐

	Yes	No
Have you ever felt you should cut down on your drinking/drug use?		
Have people annoyed you by criticizing your drinking/drug use?		
Have you ever felt bad or guilty about your drinking/drug use?		
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?		

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