Joseph B. Nelson M.A., L.P., CST

2040 Douglas Drive #100

Golden Valley, MN 55422

612-723-3693

Name _____ Birth Date_____/_____/_____ Age___

ADDRESS_____ Home Phone_____

City, State, zip _____ Work Phone_____

Email _____

Occupation _____ Cell_____

BCBS ID # _____ Group #_____

Policy Owner and DOB if different_____

Family Information

Spouse or Significant other _____

Children Age

_____ _____

_____ _____

_____ _____

_____ _____

Medical concerns and medications

_____

_____

Has anyone told you or do you think you have any of the following issues;

Depression____

Anxiety ____

Difficulty Accepting Illness ___

Relationship ___

Sexual ___

Excessive fears ___

Grief ___

Feelings or thoughts of suicide ___

Work or school ___

Parenting ___

Moving on with life ___

Eating ___

Other concerns ___

Describe

Have you seen a therapist before? Yes__ No __ When _____

Please describe your current concern

_____

_____

Referred by _____

My signature below authorizes Joseph Nelson to contact the person who referred me to notify them of my initiating therapy. (No other details unless separately authorized.)

Signature _____Date ____/_____/_____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance as noted above and assign directly to the health care provider listed at the top all insurance benefits, if any otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the HCP to release all information necessary to secure payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature **Relationship** **Date**