First Name:____________________________	Middle Name: __________	Last Name: ____________________
1. Date of Birth: ____ / ______/ _______ Height ________ Weight ____________	2. Current Age: __________ SSS#____________________ Sponsors # _______________	3. Gender: -___M ___ F Other: _________
4. Address: __________________________ ______________________________________ City: _________________________________ Zip: __________________________________ County: ______________________________ Tel: _________________________________ Email Address: _______________________ School/Employment: _________________ Tel #: __________________________	5: With whom do you live? ___ Spouse ____Mother __ Father __ Sisters __ Brothers __ Uncle __Grandmother/G-father __Other ________________	6. Parent's/Spouse's Name: _________________________________ 7. Address: ____________________ _________________________________ Employment: ___________________ 8. Home # : _____________________ 9. Cell #: ______________________ Email: _________________________
10. Emergency Contact________________ ______________________________________ 11. Cell #:___________________________ 12: Home #: __________________________ Relationship: _________________________ Address: _____________________________ _____________________________________ Email address: _______________________	13. Race: ___ African-American ___ Asian ___ Caucasian ___ Hispanic/Latino ___ Multi-Racial ___ Native American ___ Other _________	14. What are your favorite recreational activities and/or school activities: _______________ _________________________________ _________________________________ _________________________________ _________________________________
15. What are your strengths? ________ _____________________________________ ______________________________________ ______________________________________	16. What skills would you like to improve? __________________________ __________________________ __________________________	17. What are your weaknesses? _ _________________________________ _________________________________ _________________________________
18. What is your religious preference? ____________________________________ ____________________________________ ____________________________________ ____________________________________	19. What does spirituality mean to you? ____________ __________________________ _________________________	20. What are your plans for the future? ______________________ ______________________________ ______________________________

HEALTH CARE INFORMATION / RESOURCES

Primary Care Physician: ____ Phone: ___________________

Address: __________________________________ City: ___________________ State: ______ Zip: ______________

Designated/Preferred Hospital: ____ Phone: _____________________

Address: __________________________________ City: ___________________ State: ______ Zip: ______________

INSURANCE (*For Private Payment, please refer to Fee Schedule/Payment Agreement included in Client Orientation Handbook)*

Primary: ❑ Medicaid ❑ Medicare ❑ EPSDT ❑ Private Pay ❑ Private Insurance ❑ Other:___________________

Primary Policy Holder*: ____ Policy Number: ____________________________

Secondary: ❑ Medicaid ❑ Medicare ❑ EPSDT ❑ Private Pay ❑ Private Insurance ❑ Other: ___________________

Secondary Policy Holder*: ____ Policy Number: ___________________________

Other Information: ____

Referred By: ____ Referral Date: _____________________________

INITIAL ASSESSMENT INFORMATION: Intake Date: ____

Clinician Name & Credentials: ____

All Persons Present for Assessment ____

____

____

____

ADVANCE DIRECTIVE(S)

In the event of a health emergency it is wise to designate an Emergency Contact Person, Physician, and Hospital prior to any need(s) that might occur. This can be accomplished by establishing an Advance Directive to speak for you if you are unable to speak for yourself. Would you like to establish an Advance Directive? ❑ Yes ❑ No *If **Yes**, please complete the ADVANCE DIRECTIVE FORM with the therapist at this time.*

DESIGNATION OF A TREATMENT ADVOCATE

Each person served by a licensed, licensed eligible, mental health provider, or organization has the right to name a Treatment Advocate. This can be someone with whom you would like to partner during your course of treatment. A Treatment Advocate should be someone you trust and whose advice you value such as a family member, spouse, friend, or a representative from an advocacy organization. You have the right to set limits regarding the level of involvement of the person you select and you have the right to change your selection at any time. You also have the right not to name a Treatment Advocate. If you choose to name a Treatment Advocate, this person must agree to serve and to adhere with all policies and rules addressing confidentiality. Do you want to designate a Treatment Advocate at this time? ❑ Yes ❑ No If ***Yes***, please complete the TREATMENT ADVOCATE DESIGATION FORM with the therapist at this time.

Assistive Technology/Reasonable Accommodation(s)

Do you require access to and/or use of Assistive Technology and/or Reasonable Accommodation(s)?

❑ Yes ❑ No If ***Yes***, please provide details of the Assistive Technology and/or Reasonable Accommodation(s) you are requesting:

____

____

Medication & Other Allergies / Reactions ❑ Yes ❑ No If ***Yes***, please explain what you are allergic to and what the reaction is: ____

❑ No Known Drug Allergies ❑ No Known Food Allergies ❑ No Known Other Allergies

CURRENT MEDICATIONS ***Use page 16 if more room is needed to provide complete information***

Last Name of Prescribing Physician	Name Of Medication	Type of Medication	Dosage, Strength, Frequency of Medication	Efficacy of Medication	New Medication or Refill**	Length of time on Medication

** N = New Medication (30 days or less) R = Refill (> 30 days)

PREVIOUSLY USED MEDICATIONS ***Use page 16 if more room is needed to provide complete information***

Last Name Of Prescribing Physician	Name of Medication	Type of Medication	Dosage, Strength, Frequency of Medication	Efficacy of Medication	Length of time on Medication	*Reason for Discontinuing Medication*

Are your immunizations current (***child & adolescent only***)? ❑ Yes ❑ No If No, what are you lacking? ____________________

____

DEVELOPMENTAL HISTORY

Were developmental age factors, motor development and functioning accomplished within appropriate time frames? This includes but is not limited to: rolling over, sitting up, walking, talking, or being toilet trained. ❑ Yes ❑ No ❑ Unknown

If ***No***, please explain: ____

____

Language/Visual Functioning

Are you experiencing any problems with speech, hearing or visual functioning? ❑ Yes ❑ No

If **Yes**, please explain: ____

HISTORY OF PRESENTING PROBLEM(S)

SUBSTANCE ABUSE HISTORY/TREATMENT

Tobacco Use Do you currently smoke? ❑ Yes ❑ No ❑ Never smoked

If Yes, how long? _________ Age began smoking: _________

If Yes, how much per day? ❑ Less than 1/2 pack ❑ Less than 1 pack ❑ Between 1-2 packs ❑ More than 2 packs

If Former Smoker, when was the last time you smoked? ______ Years ______ Months ago

Alcohol Use – *History* Have you ever abused alcohol? ❑ No ❑ Lightly ❑ Heavily Age first used alcohol? _______

If Lightly or Heavily, did you prefer beer or hard liquor? ________________

If Lightly or Heavily, how much per day? ________________

Current Do you currently drink alcohol? ❑ No ❑ Lightly ❑ Heavily

If Lightly or Heavily, do you prefer beer or hard liquor? ________________

If Lightly or Heavily, how much per day? ________________

Drug Use – *History* Have you ever abused any drug? ❑ Yes ❑ No

Have you ever abused any substance by injection (needle)? ❑ Yes ❑ No

Please check substance(s) used and indicate age first used:

❑ Heroin - Age____ ❑ Morphine - Age_____ ❑ Methadone - Age_____ ❑ Cocaine/Crack - Age_____

❑ Methamphetamine/Amphetamine/Crank - Age_____ ❑ LSD - Age_____ ❑ Ecstasy - Age_____

❑ MDD, MTP, STP - Age_____ ❑ Mushrooms - Age_____ ❑ Marijuana - Age_____ ❑ Hashish - Age_____

❑ Steroids - Age_____ ❑ Inhalants/Gas/Glue/Freon - Age_____ ❑ Other: ____________ - Age_____

Current Do you currently use any of the following drugs? ❑ Yes ❑ No

Please check all that apply:

❑Heroin - Age_____ ❑ Morphine - Age_____ ❑ Methadone - Age_____ ❑ Cocaine/Crack - Age_____

❑ Methamphetamine/Amphetamine/Crank - Age_____ ❑ LSD - Age_____ ❑ Ecstasy - Age_____

❑ MDD, MTP, STP - Age_____ ❑ Mushrooms - Age_____ ❑ Marijuana - Age_____ ❑ Hashish - Age_____

❑ Steroids - Age____ ❑ Inhalants/Gas/Glue/Freon - Age_____ ❑ Other: ____________ - Age_____

Substance Abuse Treatment(s)

Have you received any treatment specifically for substance abuse? ❑ Yes ❑ No

*If **No** please proceed to the **Family History of Alcohol or Drug Use** section*

A. Have you ever received any of the following substance abuse treatment services?

❑ Inpatient Hospitalization- Number of times _____

❑ Day Treatment/Partial Hospitalization- Number of times _____

❑ Outpatient Treatment- Number of times _____

❑ School Based Treatment- Number of times _____

Substance Abuse Treatment(s) - *Continued*

Please provide the following details related to each item checked ***(if more room is needed please continue on page 16):***

1. Where: ___________________ When: ___________________ Age: _____ Length of stay ________________

Reason for Admission: ___________________________ Diagnosis: ___________________________
2. Where: ________________ When: ________________ Age: _____ Length of stay ______________
Reason for Admission: ___________________________ Diagnosis: ___________________________
3. Where: ________________ When: ________________ Age: _____ Length of stay ______________
Reason for Admission: ___________________________ Diagnosis: ___________________________
Records Ordered? ❑ Yes ❑ No If No, why not? ____

Family History of Alcohol or Drug Use
Did you experience any prenatal exposure to drugs or alcohol? ❑ Yes ❑ No ❑ Unknown
If Yes, please check all that apply**:** ❑ Alcohol ❑ Heroin ❑ Morphine ❑ Methadone ❑ Cocaine/Crack ❑ LSD
❑ Methamphetamine/Amphetamine/Crank ❑ MDD, MTP, STP ❑ Ecstasy ❑ Mushrooms ❑ Marijuana
❑ Hashish ❑ Steroids ❑ Inhalants/Gas/Glue/Freon ❑ Other: ____________ ❑ Other: ____________
Have any of your family members had drinking, drug or psychological problems? ***(Insert name in blank area)***

Spouse: _________________________ ❑ Alcohol ❑ Drugs ❑ Psychological
Mother: _________________________ ❑ Alcohol ❑ Drugs ❑ Psychological
Father: _________________________ ❑ Alcohol ❑ Drugs ❑ Psychological
Grandparent: _________________________ ❑ Alcohol ❑ Drugs ❑ Psychological
Sibling: _________________________ ❑ Alcohol ❑ Drugs ❑ Psychological
Sibling: _________________________ ❑ Alcohol ❑ Drugs ❑ Psychological
Other: _________________________ ❑ Alcohol ❑ Drugs ❑ Psychological
Other: _________________________ ❑ Alcohol ❑ Drugs ❑ Psychological

GAMBLING HISTORY/TREATMENT
History-Have you ever gambled? ❑ Yes ❑ No Age first gambled? ______
Have you experienced financial problems as a result of gambling? ❑ Yes ❑ No
Have you experienced family and/or social problems as a result of gambling? ❑ Yes ❑ No
Current Do you currently gamble? ❑ Yes ❑ No How often? ______________

Gambling Abuse Treatment(s) Have you received any treatment specifically for gambling abuse? ❑ Yes ❑ No
*If **No** please proceed to the **Mental Health History** section*

A. Have you ever received any of the following gambling abuse treatment services?
❑ Inpatient Hospitalization Number of times _____
❑ Day Treatment/Partial Hospitalization Number of times _____
❑ Outpatient Treatment Number of times _____
❑ School Based Treatment Number of times _____
Please provide the following details related to each item checked ***(if more room is needed please continue on page 16):***
1. Where: ________________ When: ________________ Age: _____ Length of stay______________
Reason for Admission: ___________________________ Diagnosis:___________________________
2. Where: ________________ When: ________________ Age: _____ Length of stay ______________
Reason for Admission: ___________________________ Diagnosis: ___________________________
3. Where: ________________ When: ________________ Age: _____ Length of stay______________
Reason for Admission: ___________________________ Diagnosis: ___________________________
Records Ordered? ❑ Yes ❑ No If No, why not? ____

MENTAL HEALTH HISTORY/ TREATMENT
A. Have you received any treatment specifically for mental health reasons?❑ Yes ❑ No

Which of the following mental health treatment(s) have you received?
❑ Inpatient Hospitalization Number of times _____
❑ Day Treatment/Partial Hospitalization Number of times _____

❑ Outpatient Treatment Number of times _____
❑ School Based Treatment Number of times _____
Please provide the following details related to each item checked ***(if more room is needed please continue on page 16):***

1. Where: ___________________ When: ___________________ Age: _____ Length of stay________________
Reason for Admission: ________________________________ Diagnosis: __________________________________

2. Where: ___________________ When: ___________________ Age: _____ Length of stay________________
Reason for Admission: ________________________________ Diagnosis: __________________________________

3. Where: ___________________ When: ___________________ Age: _____ Length of stay________________
Reason for Admission: ________________________________ Diagnosis: __________________________________

Records Ordered? ❑ Yes ❑ No If No, why not? ____

SUICIDE RISK ASSESSMENT

Have you ever thought about committing suicide? ❑ Yes ❑ No
Have you attempted suicide in the past? ***(If yes, provide details)*** ❑ Yes ❑ No
Age when attempted suicide: _____ Where was the suicide attempt made (***home – school – other***): __________________
Number of Previous Attempts: _____ Method of Previous Attempts: ____
Are you currently thinking about committing suicide? *(Suicidal Ideation)* ❑ Yes ❑ No
If ***YES***, do you have a plan for how you will commit suicide? ***(If yes, provide details)*** ❑ Yes ❑ No
Suicide Plan Details: ____
____

HARM TO OTHERS/HOMICIDE ASSESSMENT

Have you ever thought about committing homicide? ❑ Yes ❑ No
Have you attempted homicide in the past? ***(If yes, provide details)*** ❑ Yes ❑ No
Age when attempted homicide: _____ Where was the homicide attempt made (***home – school – other***): _________________
Number of Previous Attempts: ______ Method of Previous Attempts: ____
Number of homicides ***completed***: ______ Consequences for completed homicide(s) ***(Cross-reference with Legal History)***:
____
____
Are you currently thinking about committing homicide? (*Homicidal Ideation*) ❑ Yes ❑ No
If **YES**, do you have a plan for how you will commit homicide? ***(If yes, provide details)*** ❑ Yes ❑ No
Homicide Plan Details: ____
If **YES**, who is the intended homicide victim? ____

SUICIDE OR HARM TO OTHERS RISK ASSESSMENT OUTCOME

Is client determined to be a danger to self? ❑ Yes ❑ No
Is client determined to be a danger to others? ❑ Yes ❑ No
If client is determined to be a danger to either self and/or others please check all that apply and explain:
❑ EOD by authorities to: Name of Facility ____ ***(Triggers completion of an Incident Report)***
❑ Voluntarily admitted for Inpatient stabilization/treatment at: Name of Facility ______________________________
❑ Other Action, Please explain: ____
____

TRAUMA HISTORY

HISTORY OF TRAUMATIC INCIDENT/ACCIDENT, ABUSE, NEGLECT, VIOLENT BEHAVIOR, DOMESTIC VIOLENCE, AND/OR SEXUAL ASSAULT OF SELF AND/OR OTHERS

1. Have you ever been the victim of a traumatic incident or accident? ❑ Yes ❑ No
   * Examples of a traumatic incident or accident could include but not be limited to: head injury, automobile accident, or other accident *
   If yes, please provide details on *Additional Information* page # 16.
2. Have you ever been the perpetrator of a traumatic incident or accident upon another person? ❑ Yes ❑ No
   * Examples of a traumatic incident or accident could include but not be limited to: head injury, automobile accident, or other accident *
   If yes, please provide details on *Additional Information* page # 16.

3. Have you ever been the victim of abuse/abusive behavior? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
   Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
4. Have you ever been the perpetrator of abuse/abusive behavior upon another person? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
   Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
5. Have you ever been the victim of neglect? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
   Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
6. Have you ever been the perpetrator of neglect upon another person? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
   Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
7. Have you ever been the victim of violent behavior? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
   Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
8. Have you ever been the perpetrator of violent behavior upon another person? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
   Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
9. Have you ever been the victim of domestic violence? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
   Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
   If yes, please provide details on *Additional Information* page # 16.
10. Have you ever been the perpetrator of domestic violence upon another person? ❑ Yes ❑ No
    If yes, please provide details on *Additional Information* page # 16.
    Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
    If yes, please provide details on *Additional Information* page # 16.
11. Have you ever been the victim of sexual assault? ❑ Yes ❑ No
    If yes, please provide details on *Additional Information* page # 16 .
    Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
    If yes, please provide details on *Additional Information* page # 16.
12. Have you ever been the perpetrator of sexual assault upon another person? ❑ Yes ❑ No
    If yes, please provide details on *Additional Information* page # 16.
    Was the Department of Human Services involved (Child Welfare and/or Adult Protective Services)? ❑ Yes ❑ No
    If yes, please provide details on *Additional Information* page # 16.

DOMESTIC VIOLENCE HISTORY / TREATMENT

Have you received any treatment specifically for domestic violence? ❑ Yes ❑ No
If Yes, were you treated as the victim: ❑ Yes ❑ No
If Yes, were you treated as the perpetrator: ❑ Yes ❑ No

A. Have you ever received any of the following domestic violence treatment services?

- ❑ Inpatient Hospitalization Number of times _____
- ❑ Day Treatment/Partial Hospitalization Number of times _____
- ❑ Outpatient Treatment Number of times _____
- ❑ School Based Treatment Number of times _____
- ❑ Shelter/Crisis Center Services Number of times _____

Please provide the following details related to each item checked ***(if more room is needed please continue on page 16):***

1. Where: ________________ When: ________________ Age: _____ Length of stay________________
   Reason for Admission: ____________________________ Diagnosis: ______________________________
2. Where: ________________ When: ________________ Age: _____ Length of stay________________
   Reason for Admission: ____________________________ Diagnosis: ______________________________
3. Where: ________________ When: ________________ Age: _____ Length of stay________________
   Reason for Admission: ____________________________ Diagnosis: ______________________________

Records Ordered? ❑ Yes ❑ No If No, why not? ____

Have any of these people abused you? ❑ Yes ❑No If Yes, please provide details on *Additional Information* page # 16.

Spouse: __________________________ ❑ Emotionally ❑ Physically ❑ Sexually ❑ Other Abuse

Mother: __________________________ ❑ Emotionally ❑ Physically ❑ Sexually ❑ Other Abuse

Father: __________________________ ❑ Emotionally ❑ Physically ❑ Sexually ❑ Other Abuse

Grandparent: ______________________ ❑ Emotionally ❑ Physically ❑ Sexually ❑ Other Abuse

Sibling: __________________________ ❑ Emotionally ❑ Physically ❑ Sexually ❑ Other Abuse

Sibling: __________________________ ❑ Emotionally ❑ Physically ❑ Sexually ❑ Other Abuse

Other: ___________________________ ❑ Emotionally ❑ Physically ❑ Sexually ❑ Other Abuse

* Note: Examples of 'Other Abuse' could be verbal abuse, neglect, and/or abandonment *

SEXUAL HISTORY, INCLUDING HIV/AIDS & STD AT-RISK BEHAVIORS

Have you become sexually active yet? ❑ Yes ❑ No If **Yes**, give date of last sexual activity: ____________________

Do you use protection? ❑ Yes ❑ No If **Yes**, what kind? ____

Frequency of use? _____________ Age began dating: ______ Age began sexual activity (if pertinent): _____________

Sexual Orientation: ❑ Heterosexual ❑ Bi-sexual ❑ Homosexual

Any sexual problems? ❑ Yes ❑ No If **Yes**, explain: ____

Sexually transmitted diseases? ❑ Yes ❑ No If **Yes**, which: ❑ Gonorrhea ❑ Chlamydia ❑ Syphilis ❑ Warts

❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C ❑ HIV/AIDS ❑ HPV ❑ Other ____________________________

Are you more sexually active while using chemicals? ❑ Yes ❑ No

Do you feel guilty about any sexual behavior? ❑ Yes ❑ No

MARITAL/SIGNIFICANT OTHER RELATIONSHIP HISTORY (if more room needed please continue on *Additional Information page # 16)*

Status: ❑ Married, Number of times married: ______ ❑ Divorced, Number of times divorced: ______ ❑ Separated
❑ Widowed ❑ Never Been Married ❑ Common Law Marriage ❑ Cohabitating ❑ Dating

Significant Other's Name: ____ Phone: ____________________

❑ Same Address ❑ Different Address: ____

City: ___________________________ State: __________ Zip: _______________

MARITAL/SIGNIFICANT OTHER RELATIONSHIP HISTORY - Continued

How long do your relationships generally last? ❑ Hours ❑ One night/day ❑ Weeks ❑ Months ❑ Years

What behavioral patterns of interaction generally describe your relationships (*Please check all that apply*)

❑ Happy ❑ Angry ❑ Trust Issues ❑ Arguing ❑ Verbal Abuse ❑ Physical fighting/abuse ❑ Good communication

❑ Poor communication ❑ Drug use/abuse ❑ Alcohol use/abuse ❑ Other, please explain: ____________________

____

What factors generally end your relationships? ____

____

How many relationships have you had? ______ Are you currently in a relationship? ❑ Yes ❑ No

FAMILY AND SOCIAL HISTORY

Family Relationship History

❑ Both of my parents are living ❑ Father is deceased Did mother remarry? ❑ Yes ❑ No

❑ Mother is deceased Did father remarry? ❑ Yes ❑ No

Are they living together? ❑ Yes ❑ No Are they divorced? ❑ Yes ❑ No Separated? ❑ Yes ❑ No

While growing up, did you live under the care of anyone other than your parents? ❑ Yes ❑ No

If yes, with whom? ________________________ How long? _______ Why (if known)? _______________________

____

Address: ____________________________________ City: _____________________ State: _______ Zip: __________

**** BROTHERS/SISTERS: (LIST: LAST, FIRST NAME AND AGE OF EACH) ****

(If more room needed please continue on *Additional Information page # 16*)

Last Name	First Name	MI	Age
1.			
2.			
3.			
4.			
5.			
6.			

Rate your relationship with the following people from 1 to 10 (1= bad, 10=excellent) and explain 'Why'

Father: _____________ Why: ____

Mother: _____________ Why: ____

Brother (s): __________ Why: ____

Sister (s): ___________ Why: ____

Spouse:_____________ Why: ____

Child: ______________ Why: ____

Child: ______________ Why: ____

Other: ______________ Why: ____

Who administered discipline in the home? ❑ Father ❑ Mother ❑ Brother(s) ❑ Sister(s) ❑ Other_______________

Was it deserved and fair? ❑ Yes ❑ No If No, why not? ____________________________________

How were you disciplined / punished? ____

Social History

Do you have at least one person you consider a friend? ❑ Yes ❑ No

Do you have difficulty making friends? ❑ Yes ❑ No

Do you have difficulty keeping friends? ❑ Yes ❑ No

How long do your friendships generally last? ❑ Hours ❑ One night/day ❑ Weeks ❑ Months ❑ Years

What behavioral patterns of interaction generally describe your friendships (Please check all that apply):

❑ Happy ❑ Angry ❑ Trust Issues ❑ Arguing ❑ Verbal Abuse ❑ Physical fighting/abuse ❑ Good communication

❑ Poor communication ❑ Drug use/abuse ❑ Alcohol use/abuse ❑ Other, please explain: ____________________

____

What factors generally end your friendships? ____

____

How many friendships have you had that are now over? ______

Do you engage in activities outside the home for the purpose of socializing? ❑ Yes ❑ No If **Yes**, what activities do you participate in outside the home? ____

EDUCATIONAL ATTAINMENT, DIFFICULTIES & HISTORY (if more room needed please continue on *Additional Information page # 16)*

Do you have a Bachelor's degree or higher? ❑ Yes ❑ No
Do you have some college hours? ❑ Yes ❑ No If **Yes**, how many hours have you completed? _______
Are you currently enrolled in college or technical school? ❑ Yes ❑ No
Do you have a high school diploma? ❑ Yes ❑ No If **No**, do you have a GED? ❑ Yes ❑ No
If No, are you attending GED classes? ❑ Yes ❑ No
What is the highest grade in school you satisfactorily completed? ________
Did you repeat any grades? ❑ Yes ❑ No If **Yes**, which grades? _______ Why? ________________________________
Name of school last attended? ______________________________
Did you experience any academic difficulty in school (*Example: reading, math, behavioral, or other*) ❑ Yes ❑ No If **Yes**, please explain ____
____
Were there any family difficulties while you were attending school? ❑ Yes ❑ No If **Yes**, please explain ________________
____
Did you experience any behavioral difficulty in school? ❑ Yes ❑ No If **Yes,** please explain __________________________
____
What subjects did you like in school? ❑ Art ❑ Drama ❑ English ❑ Mathematics ❑ Language ❑ Shop ❑ Science ❑ Public Speaking ❑ Social Studies ❑ History ❑ Other ___________________
What subjects did you dislike in school? ❑ English ❑ Art ❑ Shop ❑ Mathematics ❑ Language ❑ Drama ❑ Public ❑ Speaking ❑ Social Studies ❑ Science ❑ History ❑ Other: ____

Learning Ability/Intellectual Functioning

Would you describe yourself as a: ❑ Slow Learner ❑ Average Learner ❑ Quick Learner
Have you ever taken an I.Q. test? ❑ Yes ❑ No If Yes, what was your score? __________________________

Current Educational Functioning - *(child, adolescent, adult college or vocational/trade school students)*

Are you currently in school ❑ Yes ❑ No If No, why not? ____
What grade (or program year) are you currently attending? ____
What is your current school performance (grades or GPA)? ____
Are you part of the Gifted & Talented Program ❑ Yes ❑ No
Do you experience any academic difficulty in school (example: reading, math, behavioral, or other) ❑ Yes ❑ No, If Yes please explain: ____
Do you experience any behavioral difficulty in school? ❑ Yes ❑ No, If Yes please explain
____
____

Current Educational Functioning - *Continued*

Are you currently being served on an IEP? ❑ Yes ❑ No
Do you have a special education classification? ❑ ESL ❑ LD ❑ ED/SED ❑ MR ❑ Other Health Impairment
How long have you been receiving special education classes? ________________ (If applicable)
In what grade did you start receiving special classes? ___________ (If applicable)
Are you experiencing any family difficulties that affect your school performance? ❑ Yes ❑ No If Yes please explain: ___
____
____

LEGAL HISTORY ❑ Yes ❑ No If Yes, please provide information on offenses as requested below
Offenses (Start with most recent - if more room needed please continue on *Additional Information page # 16*)

1. Date ______________ City_______________ State _______
Type: ❑ Misdemeanor ❑ Statutory ❑ Felony

Charge: ❑ Moving Violation ❑ Vandalism ❑ DUI ❑ Drug Possession ❑ Drug Sales ❑ Larceny ❑ Forgery ❑ Burglary ❑ Theft ❑ Robbery ❑ Assault Arson ❑ Rape ❑ Shooting ❑ Murder ❑ Other crime against property ❑ Other crime against person

Outcome: ❑ Acquittal ❑ Conviction ❑ Time in Jail/Residential Placement ❑ Fine/Ticket

2. Date ______________ City_______________ State _______
Type: ❑ Misdemeanor ❑ Statutory ❑ Felony

Charge: ❑ Moving Violation ❑ Vandalism ❑ DUI ❑ Drug Possession ❑ Drug Sales ❑ Larceny ❑ Forgery ❑ Burglary ❑ Theft ❑ Robbery ❑ Assault Arson ❑ Rape ❑ Shooting ❑ Murder ❑ Other crime against property ❑ Other crime against person

Outcome: ❑ Acquittal ❑ Conviction ❑ Time in Jail/Residential Placement ❑ Fine/Ticket

3. Date ______________ City_______________ State _______
Type: ❑ Misdemeanor ❑ Statutory ❑ Felony

Charge: ❑ Moving Violation ❑ Vandalism ❑ DUI ❑ Drug Possession ❑ Drug Sales ❑ Larceny ❑ Forgery ❑ Burglary ❑ Theft ❑ Robbery ❑ Assault Arson ❑ Rape ❑ Shooting ❑ Murder ❑ Other crime against property ❑ Other crime against person

Outcome: ❑ Acquittal ❑ Conviction ❑ Time in Jail/Residential Placement ❑ Fine/Ticket

Probation / Parole Officer Name (if applicable): _____________________________ Phone: ________________________

Address: ______________________________ City: ________________________ State: ___________ Zip: ___________

Attorney Name (if applicable): _____________________________ Phone:________________________

Address: ______________________________ City: ________________________ State: ___________ Zip: ___________

Custody Status *(Children & Adolescents Only)*

❑ Parental ❑ Kinship (Please provide details and place copy of custody/guardianship court order in clinical record) ________________
____

❑ OJA Custody ❑ DHS-CW Custody ❑ CW (Tribe: ___________________) ❑ Other: ____________________

Caseworker Name: ____ Phone: ____________________

Address: ____

City: __________________________________ County: ________________________ State: ________ Zip:

MILITARY HISTORY

Have you ever served in any branch of the armed forces? ❑ Yes ❑ No

If Yes, which branch of service? ❑ Army ❑ Navy ❑ Air Force ❑ Marines ❑ Coast Guard ❑ National Guard ❑ Merchant Marine

Duty Status: ❑ Active Duty, If Active Duty give current rank: ____________❑ Reserves ❑ Retired ❑ Other: __________

Rank at Discharge: ___________Type of discharge? ❑ Honorable ❑ Medical ❑ Dishonorable ❑ Court Martial

Were you ever wounded in the line of duty? ❑ Yes ❑ No If Yes, please describe: _____________________________

RECREATIONAL / LEISURE HISTORY

Any special interests or hobbies? ❑ Yes ❑ No If yes, please describe: ______________________________
____

What did you do for fun or enjoyment when you were a child (under age 13)? ______________________________________
____

What did you do for fun or enjoyment when you were a child (ages 13 - 18)? ______________________________________
____

What do you do for fun or enjoyment now (ages 19 and older)? ____
____
_

PRESENT LIVING ARRANGEMENT (check only one)
Individual Home ❑ Owns Home ❑ Rents Home ❑ Section 8 Housing ❑ Lives with parents
Out-of-Home Placement ❑ Residential Care Facility ❑ Group Home (Level _____) ❑ ICF/MR (Admit date: ______)
❑ Foster Care (Placement date: ________) ❑ Multiple placements in the past 2 years (please give number of placements ____)
❑ DHS / OJA / ICW Custody (Worker: ___________________ Phone # _______________)
Other Living Arrangement ❑ Homeless Shelter ❑ Halfway house ❑ Other: _____________________
Persons Living In Home - ***Applies to Individual Home and Foster Care Homes Only!***

If Foster Care, '*DO NOT*' list the 'Names' of other foster children, Use the TERMS 'BOY' or 'GIRL'

Name: ______________________________________ Age: ________ Relationship: ____________________
Name: ______________________________________ Age: ________ Relationship: ____________________
Name: ______________________________________ Age: ________ Relationship: ____________________
Name: ______________________________________ Age: ________ Relationship: ____________________
Name: ______________________________________ Age: ________ Relationship: ____________________
Name: ______________________________________ Age: ________ Relationship: ____________________
Name: ______________________________________ Age: ________ Relationship: ____________________

CLIENT / CAREGIVER RESOURCES (Circle one or both if applicable)
Economic Resources / Financial Situation
Source of Income 1: ❑ Employment ❑ Spouse's Employment ❑ Parent's Employment ❑ Mother's Employment
❑ Father's Employment ❑ Medicaid / TANF ❑ Disability ❑ Pension ❑ Child Support ❑ Alimony
❑ Other: ________________________________ Yearly Amount: $___________
Source of Income 2: ❑ Employment ❑ Spouse's Employment ❑ Parent's Employment ❑ Mother's Employment
❑ Father's Employment ❑ Medicaid / TANF ❑ Disability ❑ Pension ❑ Child Support ❑ Alimony
❑ Other: ________________________________ Yearly Amount: $___________

ISSUES OR CONCERNS ABOUT MEETING BASIC NEEDS (food, shelter, health, transportation, etc.)
Are the resources available to your family adequate in meeting your basic needs? ❑ Yes ❑ No
If NO, describe the limitations:
____

VOCATIONAL/OCCUPATIONAL HISTORY
Employment Status
Are you currently employed? ❑ Yes ❑ No If Yes, what is your current occupation: __________________________
Are you (please check all that apply) ❑ Unemployed ❑ Full-time Student ❑ Part-time Student ❑ Erratic job history
❑ Threat of job loss ❑ Job affected by usage/behavior ❑ Dependent Minor
Have you worked at any job outside the home? ❑ Yes ❑ No
If yes, what type of work is/was it? ______________________________________ For how long? ______________
When was the last time you worked? __________________ What type of work was it? ________________________
What type of work do you intend to do or have you done as a career? ____
Do you have special job skills or training? ❑ Yes ❑ No
If Yes, what type of special job skills or training? ____
If No, are you interested in receiving job training information and referral? ❑ Yes ❑ No

If you are not interested in receiving job training information and referral please explain why not: _____________________
____

CURRENT SUPPORT SYSTEM

Family Supportive? ❑ Yes ❑ No Employer Supportive? ❑ Yes ❑ No Peers Supportive? ❑ Yes ❑ No

Self-help involvement? ❑ Yes ❑ No Church Supportive? ❑ Yes ❑ No Other: _______________________

Comments/Details: ____

PRESENT LIFE SITUATION (Check those that apply and comment as needed)

❑ Recent death ❑ Divorce ❑ Separation from a significant relationship ❑ Other: _________________________

Comments: ____

❑ Emotionally unable by past history to remain separated from a destructive relationship (i.e. living with chemical abuser, physical, emotional, or sexual abuser)

Comments: ____

❑ Experiences anxiety, boundary difficulties and separation issues in intimate relationships.

Comments: ____

❑ Assumes responsibility for meeting others needs to the exclusion of their own.

Comments: ____

❑ Other:

____

Comments: ____

WHAT ARE YOUR EXPECTATIONS OF TREATMENT/SERVICES? ____
____
____

Services to be provided (*Check all that apply*)

❑ Individual Therapy ❑ Group Therapy ❑ Family Therapy ❑ Drug/Alcohol Counseling ❑ Case Management

❑ Individual Rehabilitation ❑ Group Rehabilitation ❑ Parenting Education ❑ Support Group (by referral)

Client Certification – 3 Sections

1. Consent for Treatment

I, ______________________________________, do hereby certify, as evidenced by my initials below and my signature on page 21, that I:

Circle One: Client / Parent / Legal Guardian/Custodian

Hereby make application for voluntary admission to the services of MHSCEO, as a voluntary client under the provision of OS 43A Section 9-101. I certify that I am 18 years of age or over. Voluntary admission may be made for any person 18 years of age or over on his or her own signature.

I have read, or had read to me, the following information about my rights: (A) All persons receiving services from this facility shall retain all rights, benefits, and privileges guaranteed by the laws and Constitution and State of Oklahoma and the United States of America, except those specifically lost through due process of law (OS 43A, Section 1-103) (H); (B) All persons shall have their rights guaranteed by the Clients Bill of Rights, unless an exception is specifically authorized by these standards or an order of a court of competent jurisdiction; (C) I have been given a summary or full copy of my rights as a client and fully understand the content of this document.

I have read, or had read to me, the following information about confidentiality and the limits thereof as pursuant to HIPAA and 43A O.S. Paragraph 3-416 and 3-418; and [U.S.] 42 CFR, Part 2. That by signing below, I consent to the use and disclosure of protected health information by MIND, HEART & SOUL COUNSELING, its' staff, and its' business associates for treatment, payment and health care operations.

I certify that a more detailed description or uses and disclosures for these purposes have been read by me, or read to me, from the Notice of Information Practices ("Notice").

I understand that I have the right to the "Notice" prior to signing this consent. I understand that the terms of this "Notice may change and if the terms do change, I may obtain a revised "Notice" by contacting MIND, HEART & SOUL COUNSELING, and requesting a revised "Notice". MIND, HEART & SOUL COUNSELING, will also post any revised "Notice" at their offices in Purcell, Oklahoma, Ada, Oklahoma, Wewoka, Oklahoma, Lawton, Oklahoma, or Tahlequah, Oklahoma.

I understand that I have the right to request that MIND, HEART & SOUL COUNSELING, restrict its' uses or disclosures of my protected health information which it is otherwise permitted to make for treatment, payment and health care operations, although MIND, HEART & SOUL COUNSELING, is not required to agree to these restrictions. However, if MIND, HEART & SOUL COUNSELING agrees to further restrictions, they are binding on MIND, HEART & SOUL COUNSELING

I understand that I have the right to revoke this consent in writing, except to the extent that MIND, HEART & SOUL COUNSELING, has taken action in reliance on it.

I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate services delivered.

I understand that OS 43A, Section 4-201 requires that each client of this agency be charged for care and treatment provided. I have been given a copy of the current rate schedule and I understand that payment on all charges is adjustable according to my ability to pay. No individual will be refused needed treatment because of inability to pay (OS 43A, Section 4-202).

I understand that I may refuse a particular service but that my refusal, if any, will not preclude me from accessing other mental health and/or substance abuse services I might need.

I understand that I will be periodically contacted during my treatment to give an assessment of my progress or lack thereof to assist MHSCEO in providing better services.

I understand that I am free to withdraw consent at anytime.

Client Initials & Date ____________________ **Parent and/or Legal Guardian Initials & Date**____________________

(Age 14 and over)

2. Consent for Follow Up

I, ______________________, do hereby certify, as evidenced by my initials below and my signature on page 21, that I:
Circle One: Client / Parent / Legal Guardian/Custodian

Agree to participate in two follow-up surveys during the year after my treatment. This survey will let MHSCEO know how I am doing.

One follow-up will be conducted when I have been discharged for three months and the other after I have been discharged for one year. My survey forms will not be marked to ensure my Confidentiality although I will be able to provide my contact information if I should wish to do so, and the responses will be kept strictly confidential. MHSCEO will combine and summarize survey information from all responding clients in order to show how effective the treatment was and what improvements may need to be made.

I understand that my current treatment will be continued regardless of whether I agree to participate in the surveys. My participation is strictly voluntary. I am free to withdraw at any time. If I have any questions concerning this survey, I may contact a representative of MHSCEO or the Advocate General for the Oklahoma Department of Mental Health and Substance Abuse Services at 405-516 -4256or toll-free 1(866) 699-6605.

___I consent to participate in this survey by (check one):

___mailed questionnaire ___telephone interview ___in-person interview

___I decline to participate in this survey.

Below I am providing an address and phone where I believe I can be located in the future and the names and addresses of others who may be of help in contacting me. I understand that all information I provide will be kept confidential, that those persons whose names I provide will only be contacted concerning my whereabouts and that my treatment or condition will NOT discussed with them or anyone else.

I expect to live at: ____________________________, ________________, ___________, _______________
Street City State Zip Code

(______) - ______ - _________________
Area Code Telephone Number

Other person(s) living at that address:

______________________ ______________________
Name Relationship

______________________ ______________________
Name Relationship

______________________ ______________________
Name Relationship

Client Initials & Date ___________________ **Parent and/or Legal Guardian Initials & Date** ___________________
(Age 14 and over)

3. Receipt of/for Information, Acknowledgement of Participation in Transition/Discharge Planning, Consent for Treatment, Consent for/or Declination of Participation in Follow-Up and Consent for Referral

I, _________________________________ do hereby certify, as evidenced by my signature below, that I/We have received MHSCEO's:

Circle One: Client / Parent / Legal Guardian/Custodian

CLIENT ORIENTATION HANDBOOK relating to program participation while a client at MIND, HEART & SOUL COUNSELING. My **ORIENTATION** included the following:

1. Hours of Operation & After Hours Appointments
2. Client Grievances & Appeals
3. Client Rights
4. Events - Behaviors - Attitudes That May Lead to Loss of Privileges - Rights
5. Reinstatement of Lost Privileges - Rights
6. Code of Ethics
7. Confidentiality of Client Records
8. HIPAA Notice of Privacy Practices
9. Services Available
10. Program & Treatment Goals
11. Entrance Policy
12. Admission/Dismissal/Re-Admission
13. Evaluation/Assessment
14. Treatment Plan Development
15. Coordination of Services
16. Transition/Discharge Plan
17. Referral
18. Follow Up
19. Input From Persons Served - Client Satisfaction - Quality of Care - Outcomes Management
20. Fee Schedule and Financial Arrangements
21. Contacting Your Counselor for After Hours Crisis or Emergency

16\. Emergency Procedures - Orientation to Clinic Premises - Floor Plan - Posted in Clinics

23. Incident Reporting
24. Smoking/Tobacco Use Policy
25. Advance Directives
26. AIDS - Acquired Immunodeficiency Syndrome Information
27. Transportation
28. Substance Abuse/Use
29. Weapons
30. Seclusion and Restraint
31. Assistive Technology/Reasonable Accommodations
32. My/Our signature(s) below acknowledge my/our participation in the development of the Transition/Discharge Plan
33. My/Our signature(s) below acknowledge my/our Consent for Treatment
34. My/Our signature(s) below acknowledge my/our Consent for Follow-Up
35. My/Our signature(s) below acknowledge my/our Consent for Referral, as appropriate.

_________________________________ _________________________________

Client Signature (age 14 and over) Date **Parent and/or Legal Guardian Signature Date**

____

Staff Signature Date

ADDITIONAL INFORMATION

____

____

____

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MIND, HEART & SOUL COUNSELING

Consent for RELEASE OF CONFIDENTIAL INFORMATION

***Expiration Date:* ___________________**

I understand that records are protected under Federal and State Confidentiality Law and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.

I, ____, the undersigned, hereby authorize the Mind, Heart & Soul Counseling Enrichment Center to:

____ exchange with:

TRICARE	Yes	No
SOONER CARE	Yes	No
OTHER INSURANCE	Yes	No
DHS	Yes	No
STUDENT COUNSELOR	Yes	No

the following information pertaining to myself:

_____ Attendance
_____ Drug/Alcohol Issues
_____ Intake
_____ Psychosocial History
_____ Treatment Progress
_____ Treatment Planning
_____ Psychiatric Evaluation/Medication History
_____ Testing Results
_____ Other ____
____

For the purpose of:
_____ Continuity of Treatment ______ Evaluation/Assessment ____ BILLING

I understand that I may revoke this consent in writing at any time. This Consent for Release can also expire under the following events or conditions: ____

I understand that the record requested may be protected under federal laws and regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records (42 U.S.C. § 290dd-2; 42 C.F.R., Part2) and State Confidentiality Laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal Law regulations prohibit any further disclosures of such records without my specific written consent or except when otherwise permitted by such regulations.

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNE DEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). RECORDS MAY ALSO INCLUDE PSYCHIATRIC INFORMATION AND ALCOHOL AND DRUG ABUSE INFORMATION.

!!NOTICE TO RECIPIENTS OF ALCOHOL AND DRUG ABUSE RECORDS!!

The information received in accordance with this release may be used for the purpose as set forth above. This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment made to you with consent of the client. This information has been disclosed to you from records protected by Federal Confidentiality rules (42 C.F.R.). The Federal Rule prohibits you from making any further disclosure of this information unless further disclosure is in connection with their official duties with respect to the particular criminal proceeding and may not be used in other proceedings or is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Re: Psychiatric Records - Oklahoma State Law (76 O.D. Supp. 1986, Section 19) provides that psychological or psychiatric records may be provided to the patient if the treating physician or practitioner consents to the release or upon receipt of a court order, issued by a court of competent jurisdiction. Therefore, psychological or psychiatric records will not be released to patients, their guardians, or agents (including attorneys) except with the consent of the treating physician or practitioner or upon receipt of a court order, issued by a court of competent jurisdiction.

This consent is being given freely and voluntarily. I understand that treatment services are not contingent upon or influence by my decision to permit the release of information.

____ __________ ______________________ ________
Signature of client, parent, guardian, or authorized representative (when required) Date Witness Date

____ __________
Signature of minor's parent, guardian, or attorney Date