CEDAR BRANCH COUNSELING GROUP

Informed Consent for Psychotherapy

General Information
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process
You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality
The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally We may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, We will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, We will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Practice Policies

APPOINTMENTS AND CANCELLATIONS Please remember to cancel or reschedule 24 hours in advance. You may be responsible for the entire fee if cancellation is less than 24 hours.
The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.
A $30.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a $40 charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time. This is another reason your credit card or debit card is needed before we can schedule appointment to confirm commitment to therapy and arranging appointment for therapists' time commitment to you as well. There may be times when we may be faced with a client crisis and need to cancel our session with you and we will make every effort to reschedule as soon as possible.

TELEPHONE ACCESSIBILITY If you need to contact therapist between sessions, please leave a message on confidential voice mail. Therapist may often not immediately be available; however, therapist will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when you meet with therapist and we can talk more about it.

ELECTRONIC COMMUNICATION
We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, we will do so. While I may try to return messages in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Please use Secure Client Messaging Portal for confidential messages about personal matters beyond appointment scheduling.
Services by electronic means, including but not limited to the Internet and e-mail is considered telemedicine. Telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parent's what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. We may terminate treatment after appropriate discussion with you and a termination process if we determine that the psychotherapy is not being effectively used or if you are in default on payment. We will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, we will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.
Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider the professional relationship discontinued.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. PLEDGE REGARDING HEALTH INFORMATION: We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which may be used and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.
For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.
Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.
Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. At times, we may keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For use in treating you.
   b. For use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As psychotherapists, we will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As psychotherapists, we will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on our premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. we may use and disclose your PHI to contact you to remind you that you have an appointment with me. we may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. we may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if we believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How we Send PHI to You. You have the right to ask to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures we Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost-based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. we may say "no" to your request, but we will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.
   Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received and/or offered a copy of HIPPA Notice of Privacy Practices.

EFFECTIVE DATE OF THIS NOTICE This notice went into effect on May 8, 2018

Informed Consent for Psychotherapy
Privacy & Practice Policies Agreement

BY INITIALING AND SIGNING BELOW, I CONSENT AND AGREE TO ABIDE TO THE FOLLOWING DOCUMENTS.
I ALSO CONFIRM THAT I HAVE READ OR HAVE BEEN INFORMED AND UNDERSTAND THE FOLLOWING DOCUMENTS:

Please Initial the following

_____INFORMED CONSENT FOR PSYCHOTHERAPY
_____NOTICE OF PRACTICE POLICIES
_____ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING OF PRIVACY NOTICE & POLICIES

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received and/or offered a copy of HIPPA Notice of Privacy Practices.

Printed Name_____

Signature _____ Date _____

Witness Name_____

Witness Signature_____ Date_____

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International Falls, MN 56649
218-319-7171
Fax 218-260-4749
Info@cedarbranchcounseling.com

CEDAR BRANCH COUNSELING GROUP

Intake Form

Date_____

Name (First, Middle and Last):

_____

Referred by / Reason for Referral:

_____
_____
_____

Current Age_____ **Date of Birth:**_____/_____/_____

Current Living Arrangements:

Rent or Own_____

Who lives in your home? (Include Names and ages)

_____
_____
_____
_____

Present Relationship Status:

____ 1) Single
____ 2) engaged to be married
____ 3) married now for first time
____ 4) married now after first time
____ 5) separated
____ 6) divorced and not remarried
____ 7) widowed and not married
____ 8) Significant Other

If in a relationship, are you presently living with your partner? Yes ____ No

Length of time together_____

Who are the most Significant people in your life that you are close to?

_____
_____
_____
_____

Employment Status:

_____Full time
_____Part time
_____Unemployed
_____Student
_____Retired
_____Stay at home Parent
_____Other_____
_____

Are your basic needs met/ (Housing, financially, transportation, enough food)

Are you struggling to make ends meet or are you able to easily meet basic needs?

Current Problem

_____
_____
_____
_____

History of Problem:

:_____
_____
_____
_____

Risk Assessment

DEPRESSION SYMPTOMS

_____ frequent crying
_____ feeling sad, empty, or down
_____ loss of energy
_____ fatigue
_____ loss of interest
_____ loss of enjoyment
_____ hopelessness
_____ helplessness
_____ loss of appetite (with weight loss)
_____ increased appetite (without weight gain)
_____worthlessness
_____purposelessness
_____ difficulty concentrating
_____recurrent suicidal thoughts
_____recurrent thoughts about death /dying
_____ insomnia
_____Excessive sleepiness during the day
_____ loss of appetite (without weight loss)
_____ increased appetite (with weight gain)
_____social withdrawal, agitation

Other depression Symptoms that are helpful for me to know:

_____

_____

_____

ANXIETY SYMPTOMS

_____ feeling on edge or tense
_____excessive worry
_____difficulty controlling worry, difficulty concentrating
_____Leaving home/Social anxiety, etc.
distractibility
difficulty falling or staying asleep
restlessness

Other Anxiety Info that is helpful for me to know:

_____

_____

_____

POSTTRAUMATIC STRESS Questions (If no Trauma history, skip ahead) Please describe briefly what the Trauma was. We can talk about more details at Intake appt.

Have you had direct experience, witnessing, or learning of a traumatic event(s)? More info

Have you experienced repeated or extreme exposure to details of the traumatic event(s)?

Have you experienced recurrent, involuntary, and intrusive distressing memories of the event(s)?

Have you experienced repetitive thoughts or repeated or played parts of the trauma involving aspects of the traumatic event(s)?

Have you experienced recurrent distressing dreams related to the event(s)?

Have you experienced recurrent distressing dreams related to the event(s) , dissociate reactions, such as: flashbacks, re-enactment of trauma?

Have you experienced intense or prolonged mental/emotional distress at exposure to triggers from the trauma?

Have you experienced intense or prolonged physical symptoms, getting sick, physical symptoms when thinking about event?

Have you ever avoided places or people, etc. that remind you of the trauma?

Have you had unhealthy behaviors, difficulty falling or staying asleep or

negative alterations in thinking, cognition and mood (examples such as lapse in memory, extreme moods)?:

_____
_____
_____

More Info:

_____
_____
_____
_____

Obsessive Compulsive Symptoms

Do you experience any repeating of behaviors of any kind such as the following or add your own under others?

_____ checking repeatedly
_____ washing
_____counting
_____ordering and arranging things
repeating routines
hoarding
reassurance seeking

More Info:

_____
_____
_____

PANIC symptoms

_____ accelerated heart rate
_____ pounding heart
_____ heart palpitations
_____ sweating
_____ shortness of breath
_____ difficulty breathing
_____ sensation of choking
_____abdominal pain or discomfort
_____ feeling dizzy, unsteady, lightheaded, or faint
_____tingling, stinging on skin
_____derealization
_____depersonalization
_____fear of losing control or “going crazy”
_____fear of dying

Panic symptoms continued

_____trembling or shaking
_____ chest pain or discomfort
_____nausea or abdominal distress
_____persistent concern or worry about additional panic attacks or their consequences
_____ significant, maladaptive change in behavior related to the attacks

More Info on Panic Symptoms:

_____

Mood symptoms you may be experiencing:

_____ persistently irritable mood
_____ persistently elevated mood
_____ persistently expansive mood
_____increased energy
_____ inflated self-esteem
_____feelings of grandiosity
_____ distractibility
_____diminished judgment
_____decreased need for sleep
_____more talkative than usual
_____rapid speech
_____pressured speech
_____flight of ideas (many ideas)
_____racing thoughts
_____increase in goal-directed activity
_____diminished insight
_____ increased involvement in activities that have a high potential for painful consequences
_____ psychomotor agitation (slowing down of thoughts and a reduction of physical movements)

More information:

_____
_____
_____

PHOBIAS: Fears you may have: (fear of heights, spiders Illnesses, etc.)

_____
_____
_____

More Mood Types of Behavior:

Have you ever experienced times where you may have had any unwanted thoughts of the Following, please check those that apply

_____ of being controlled or controlling others (but it's not true)
_____of grandeur (false belief in one's own superiority, greatness, or intelligence)
_____ of guilt or sin
_____ of reference
_____of persecution
_____mood-incongruent
_____mood-neutral

Mood symptoms continued

_____ of grandiosity
_____of love (erotic)
_____ of jealousy
_____ somatic - pain, pleasure
_____ thoughts are being broadcasted
_____ flat affect (little emotions)
_____ disorganized speech
_____ thoughts are being broadcasted
_____ disorganized behavior
_____ bizarre thoughts

Info about above checked information:

_____
_____
_____

Have you ever experienced Hearing or seeing things/voices that others may not? This could include a sense of being touched, smells, taste. Please check below:

_____Hearing commands
_____ visual
_____ Being Touched
_____Smells
_____Taste
_____Others

More Info:

_____
_____
_____

EATING DISORDERED BEHAVIORS

_____ restricting
_____ binging
_____ Purging
_____use of diuretics or laxatives
_____use of appetite suppressants
_____excessive exercise

ADHD Symptoms

_____Inattention
_____ distractibility
_____hyperactivity and impulsivity
_____ Past Diagnosis_____,
_____

Who gave you this diagnosis:

_____

ADHD More Info:

_____
_____
_____

How are you functioning in current relationships with family or partners?

_____
_____
_____

State any problems that you are experiencing with them:

_____
_____
_____

Family Functioning currently

_____ Mild Problems
_____ Severe Problems
_____Moderate-Severe Problem
_____ No Problems
_____Moderate-Severe Problems
_____Moderate Problems
_____ Severe Problems

More Information about Relationships with family members:

_____

_____

_____

Sexuality Information/Concerns.

:_____

_____

Any stressors regarding sexual activity, safe sex, partners, lack of sex, disease, gender identity, curiosities, lifestyle:

_____

_____

Employment

Are you currently working? YES NO Where: _____

If employed, are you experiencing any troubles in the work environment?

_____ No problems

_____Yes, more info

_____

_____

Education History

Did you graduate high school? Any degrees/diplomas/GED, Majors, interests

_____

_____

What is your social life like?

Do you have close friends, activities that you stay busy with?

_____

_____

Mental Health History

Current Medications for mental health: _____

Past Outpatient Mental Health / Chemical Dependency Treatment History:

_____

_____

_____

Current Outpatient Mental Health / Chemical Dependency Treatment:

_____

Hospital Admissions for mental health reasons?_____ No_____Yes, when and please describe why you were admitted

_____

Suicidal/ Self Injury/Violent Behaviors

History of suicide attempt(s)?
_____No
_____Yes, please describe these with ages/years/info
_____
_____
_____
_____

History of non-lethal self-injury?
_____No
_____ Yes, please describe these with ages/years/info
_____
_____
_____

SELF-INJURIOUS BEHAVIOR: (Please Mark all that apply)
_____ cutting or excoriating skin
_____ burning skin
_____ pinching or picking skin
_____pulling out hair
_____ hitting head
_____ Other: _____

Violence / Threats / Abuse / Neglect to Others (child protection involvement in past or current):_____
_
Total number of Treatment centers or hospital admissions.
_____
Please provide info for both if this is applicable
._____
_____

Have you ever harmed or have been cruel to animals?
_____ Yes_____
_____ No
Medical History
Who is your primary care physician? Please include name and phone number and clinic city and address if known.
_____
_____

Current Medical Conditions:

_____
_____
_____

Current Medications for medical conditions:

_____
_____
_____

Developmental History - any problems with pregnancy, when you were born, age you walked, talked, toilet trained, anything significant in your developmental history?

_____
_____
_____

Have you ever experienced any Head injuries/Trauma?

_____No
_____ Yes, Please describe:

_____
_____

Have you ever experienced Seizures and/or diagnosed with seizure disorder?

_____No
_____ Yes, Please describe:

_____
_____

Sleep problems?

_____No
_____ Yes, Please describe:

_____
_____

Psychosocial History

Are you an only child? Oldest? Youngest? Etc.: How many siblings and ages?

_____
_____
_____
_____

Is there any Family History of Mental Illness and/or Substance Abuse:

_____No

_____ Yes, Please describe:
_____
_____
_____
_____

Employment History:
(Currently working part time or full time, past jobs, unemployed, off work due to Covid, student)
Please describe:
_____
_____
_____
_____

Substance Use History: (Please include age you first tried, age you abused these substances, drugs of choice, drugs you experimented with, substances you still use regularly, or on occasion, addictions, social use, etc.)
AGE: TYPE
_____ Alcohol_____
_____Tobacco_____
_____ Marijuana/Hash, etc._____
_____Opioids_____
_____ Cocaine_____
_____Other_____
_____
_____

Legal History:
Are you on Probation/Parole (if yes, please state probation/parole officer, include age, offenses and dates and charges)
_____No
_____Yes_____
_____
_____

Cultural Influences and Impact.
Do you have any cultural practices that are helpful?
Do you have any spiritual beliefs or non-beliefs that you feel strongly about?
Have you ever experienced racism, discrimination of any kind because of who you are?
_____
_____
_____
_____

Abuse History

Emotional:

_____
_____
_____
_____

Physical

_____
_____
_____
_____

Sexual

_____
_____
_____
_____

Neglect

_____
_____
_____
_____

Household Dysfunction Current or past

_____
_____
_____
_____

More Abuse History Information

_____
_____
_____
_____

Do you feel you are the following: Please check those that apply

_____ Caring and Compassionate
_____Cooperative
_____ Motivated to Pursue Treatment
_____ Open to Self-Disclosure
_____Have Good Insight
_____ Organized and Hard Working
_____ Personable, with good social skills
_____ Sensitive to Others
_____ Personable, with good social skills
_____ Willing to Participate in Treatment

What are some of your strengths?

_____

What are some of your weaknesses?

_____

Check the following that apply to you:

_____ A good sense of humor
_____ A good work ethic
_____ A stable living setting
_____ A strong sense of independence
_____Pride in your skills and accomplishments
_____The capacity to benefit from treatment
_____ A good support system
_____A stable financial situation
_____ A strong faith with helps you cope
_____ Good intellectual abilities
_____ Supportive family members

Have you applied or currently receive disability?

_____ applied
_____ receiving
More information:

_____
_____
_____

Check ones that apply to you

_____Strong Wish for things to be going better
_____ An Intent to Remain Sober
_____ The importance of positive family relationship
_____ Willingness to change/explore problems
_____ Self well verbally
Other_____

Type of Therapy

Are you seeking therapy for yourself or do you want to include Family participation during intake or future sessions?_____

Frequency of Treatment Requested and Type (Individual, Couples, Family Therapy) (Weekly, bi-weekly, monthly_____

What are your Goals for Therapy?

_____
_____
_____
_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PHQ-9 Patient Health Questionnaire

Patient Name _____ **Date** _____

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Total: /27				

2. **If you checked off any problem on this questionnaire so far, 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
0	1	2	3

To score the first question, tally each response by the number value of each response:

Not at all = 0 Several days = 1 More than half the days = 2 Nearly every day = 3

Add the numbers together to total the score.

GAIN-Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS 2.0.3

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) ____/____/_____

The following questions are about common psychological, behavioral, and personal problems. These problems are considered <u>significant</u> when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0

IDScr

1. <u>When was the last time</u> that you had <u>significant</u> problems…
   a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? 3 2 1 0
   b. with sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? 3 2 1 0
   c. with feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? 3 2 1 0
   d. with becoming very distressed and upset when something reminded you of the past? 3 2 1 0
   e. with thinking about ending your life or committing suicide? 3 2 1 0

EDScr

2. <u>When was the last time</u> that you did the following things <u>two or more times</u>?
   a. Lied or conned to get things you wanted or to avoid having to do something? 3 2 1 0
   b. Had a hard time paying attention at school, work, or home? 3 2 1 0
   c. Had a hard time listening to instructions at school, work, or home? 3 2 1 0
   d. Were a bully or threatened other people? 3 2 1 0
   e. Started physical fights with other people? 3 2 1 0

SDScr

3. <u>When was the last time</u> that…
   a. you used alcohol or other drugs weekly or more often? 3 2 1 0
   b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs? 3 2 1 0
   c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? 3 2 1 0
   d. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events? 3 2 1 0
   e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? 3 2 1 0

(Continued) After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0

CVScr

4. <u>When was the last time that you</u>…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	3	2	1	0
b. took something from a store without paying for it?	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	3	2	1	0

5. Do you have other <u>significant</u> psychological, behavioral, or personal problems that you want treatment for or help with? (If yes, please describe below) ..... <u>Yes</u> 1 <u>No</u> 0

v1. _____

v2. _____

v3. _____

6. What is your gender? (If other, please describe below) ……1-Male 2-Female 99-Other

v1. _____

7. How old are you today? |__|__| years

For Staff Use Only

8. Site ID: _____ Site Name v. _____
9. Staff ID: _____ Staff Name v. _____
10. Client ID: _____ Comment v. _____
11. Mode: 1) Administered by staff 2) Administered by other 3) Self-administered
12. Number of 2s and 3s: IDSscr: ____ EDScr: ____ SDScr: ____ CVScr: ____ TDScr: ____
13. Referral: MH____ SA ____ ANG ____ Other ____ 14. Referral Code: _____
15. Referral comments:

v1. _____

v2. _____

v3.

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page...

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In the past 30 days, how much difficulty did you have in:						
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ____

This completes the questionnaire. Thank you.