

Running Creek Counseling

18425 Pony Express Drive, Suite 203, Parker, CO 80134 Telephone (303)805-1218 Fax: (303) 805-3679
www.rccounseling.com

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

DISCLOSURE STATEMENT

Kelly Baker, CAC III #6748
Shawn E. Griffin, MS, LPC, #2327
Nanci Gonzales, MA, LPC #3256, CACIII #3108,
Michael Lyons, MA, listed in unlicensed psychotherapist
Sylvia E. Moore, MSC, listed in unlicensed psychotherapist in database
Alana Rumley, BA, CAC III #2432

1. Running Creek Counseling is located at 18425 Pony Express Dr., Parker, CO 80134, (303) 805-1218. Psychotherapists at Running Creek Counseling are graduate students in psychology or counseling or postmasters clinicians working towards Colorado mental health licensure. The psychotherapists are under the clinical supervision of licensed mental health professionals. Everyone fifteen or older must sign a disclosure statement. This disclosure statement contains the policies and procedures of Running Creek Counseling and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law {42 U.S.C. 290dd-3& 43 U.S.C. 29033-3 for federal laws, 42 CFR Part 2 for regulations and Health Insurance Portability and Accountability Act of 1996 (HIPAA)}. You, as a client, may revoke your consent to treatment, release of confidential information, or disclosure in writing at any time during psychotherapy according to 45 CFR 164.508(b)(5).

ABOUT MY CLIENT RIGHTS:

The Colorado Department of Regulatory Agencies (DORA) has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy. The agency within DORA that has responsibility specifically is the Mental Health Section, 1560 Broadway, Suite #1370, Denver, CO 80202, (303) 894-7766. While all of our counselors are regulated by the Department of Regulatory Agencies (DORA), Running Creek Counseling Services is also licensed by the Division of Behavioral Health (DBH). Clients are encouraged to resolve any grievances through our internal process, by they may call DBH at any time with concerns. Division of Behavioral Health, 3824 West Princeton Circle, Denver, CO 80236-3111, phone number (303)866-7400. Clients may also contact the Office for Civil Rights, U.S. DHHS, 1961 Stout Street - Room 1426, Denver, CO 80294, (303) 844-2024 if you feel your rights have been violated.

2. Client Rights and important information:
 - a. You are entitled to receive information from each therapist about methods of therapy, the techniques used, the duration of your therapy (if it can be determined), and the fee structure. Please ask if you would like to receive this information.
 - b. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however RCCS is not required to agree to a requested restriction.
 - c. You are entitled to receive confidential communications of protected health information.
 - d. You are entitled to inspect and copy protected health information as provided by 45 CFR 164.522; amend protected health information (164.526); receive an accounting of disclosures protected health information; and obtain a paper copy of this notice upon your request.
 - e. You can seek a second opinion from another therapist or terminate therapy at any time.
 - f. In a professional relationship (such as psychotherapy), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-7766.
 - g. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

Information disclosed to a licensed clinical social worker, an unlicensed psychotherapist, a licensed marriage and family therapist, a licensed professional counselor, or a licensed psychologist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

However, there are legal exceptions to the general rule of legal confidentiality. These legal exceptions include: intent to harm others or yourself; abuse or suspected abuse of children, and possibly the abuse of the elderly or others unable to care for themselves; neglect or suspected neglect of children; subpoenaed testimony in criminal court cases and orders to violate privilege by judges in child-custody, divorce and other court cases. Also, be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions, such as threats to national security under the federal Patriot Act, which will be identified to you as the situations arise during therapy.

3. Persons with a limited ability to pay for psychotherapy services may use the option of receiving services from students or interns. The rate for psychotherapy services will be negotiated based on the average annual income of the client and the ability of the client to pay. If clients use Running Creek Counseling's clinical services, they agree for the clients and their minor children to be observed by Running Creek Counseling staff and students and possibly videotaped. Signing this disclosure statement for you and/or minor children under your legal guardianship or legal custody authorizes staff and interns to observe in the same room and possibly videotape the psychotherapy sessions. Psychotherapy fees and treatment are based on a 45 to 50 minute clinical hour instead of a 60 minute clock hour.

AS A PSYCHOTHERAPY CLIENT:

1. I understand that RCCS may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. I understand that court testimony on my/our behalf is charged at a higher rate including testimony related matters like case research, report writing, travel, depositions, actual testimony and cross examination time and courtroom waiting time. Signing this disclosure statement gives permission for my psychotherapist(s) to release confidential information in courtroom testimony and written reports to the Court.
3. I understand that there may be times when my psychotherapist(s) may need to consult with a colleague or another professional, like an attorney, about issues raised by me in therapy. My confidentiality is still protected during consultation by my psychotherapist and the professional consulted. Signing this disclosure statement gives my psychotherapist(s) permission to consult as needed to provide professional services to me as a client.
4. I understand in marriage and family counseling, my psychotherapist(s) hold(s) a "NO SECRETS" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the psychotherapist(s) that require differential or discriminatory treatment of family members. I understand that any information shared in individual therapy MUST be also shared in couple or family therapy to insure this "NO SECRETS" policy. Signing this disclosure statement affirms permission to share this confidential information.
5. I understand my psychotherapist(s) provides non-emergency psychotherapeutic services by scheduled appointment. If my psychotherapist(s) believe(s) my psychotherapeutic issues are above her or his level of competence, or outside of his or her scope of practice, he or she is legally required to refer, terminate, or consult. If, for any reason, I am unable to contact my psychotherapist(s) by telephone, (303) 805-1218, and I am having a true emergency, I will call 911 or check myself into the nearest hospital emergency room. In the case of an after hours, non-life threatening, clinical emergency I may call the agency cell phone (720) 940-5628 to contact an on-call clinician.
6. I understand that I have any questions or would like additional information, I may feel free to ask during the initial session and any time during the psychotherapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in psychotherapy when deemed necessary by myself or my psychotherapist(s). They will also have to sign separate disclosure statements.

7. **I understand that I am legally responsible for payment for my psychotherapy services, if, for any reason, my insurance company, HMO, third-party payor, etc. does not compensate my therapist. I also understand that signing this form gives permission to my psychotherapist to communicate with my insurance company, HMO, third-party payor, collections agency or anyone connected to my psychotherapy funding source. Failure to pay will be a cause for termination of psychotherapy services.**

8. I understand this form is compliant with HIPAA regulations and no medical or psychotherapeutic information, or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in paragraph 1 of this document. Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date.

9. **CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT**

I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation and I provide release for my psychotherapist(s) to seek consultation with the agency that referred me and/or my minor children, other psychotherapists or professionals as the need arises. I also consent for me, my minor child, and/or any of my minor children to be observed in the same room and/or videotaped during psychotherapy by Running Creek Counseling staff, students, trainees, and/or treatment team members. I also affirm, by signing this form that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children for whom I am requesting psychotherapy services here at Running Creek Counseling. This disclosure statement will be automatically revoked one year after signing in compliance with HIPAA guidelines.

Client Signature

Date

Primary Psychotherapist

Date

Running Creek Counseling

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CLIENT CONTRACT

This contract represents an agreement between you and Running Creek Counseling. The purpose of this contract is to outline exactly what your responsibilities are to meet the minimum requirements of your treatment program. **Please read the entire document carefully.** You will be asked to sign this contract, and be held accountable for any violations of it. **Violations of this contract may result in revocation of your probation.**

Please read and initial each condition:

- _____ 1. I, _____ consent to attend a minimum of _____ sessions and/or _____ treatment plan review sessions of _____ treatment. I understand attendance is to be consecutive. I further consent to follow-up contact for information or research purposes.
- _____ 2. I agree to refrain from using alcohol or drugs for the entire duration of treatment; that I will be subject to random Urine Screens (UAs), and I may be discharged as non-compliant if I am found to be using alcohol/drugs. I understand medications, breathalyzers, or UA's may be a condition of my treatment. **I may be required to submit to these tests during treatment and understand there will be fees for these services.**
- _____ 3. I understand not only must I attend group; I am expected to participate in group discussion, and complete all homework assignments. I agree to respect confidentiality of other group members. I understand inappropriate behavior will not be tolerated. If I break a client's confidentiality or act inappropriately, my treatment may be terminated.
- _____ 4. I understand I will be allowed only **three (3) absences.** **The fourth (4th) absence** is a non-negotiable violation of the treatment contract. Running Creek Counseling must notify and consult with the probation dept/officer to determine appropriate consequences. (CDVOMB, Standard 6.5, Jan, 2002)
- _____ 5. I understand that all absences are considered unexcused until I can provide written documentation to excuse my absence. I am allowed only **three (3) excused** absences throughout the course of my treatment.
- _____ 6. **I understand that I will have to pay the group fee for any unexcused absences.** If I have **excessive absences (4 or more)** throughout treatment or **three (3) consecutive unexcused absences.** I will be subject to appropriate consequences. These consequences include but are not limited to additional treatment sessions, termination of treatment and/or revocation of my probation/parole.
- _____ 7. I am aware at the agency that referred me to Running Creek Counseling will receive record of my attendance, participation, progress, completion, violations and monitored sobriety results. Should I need a written report other than those regularly supplied; I understand that the counselor should be given a **seven (7)** day advance notice of that need. Without 7-day notice, we cannot guarantee that you will receive the report on time.
- _____ 8. I understand that I need to keep Running Creek Counseling aware of my current address, phone number and employment.
- _____ 9. I understand if I have any domestic violence related conviction I may not possess firearms or consume alcohol/drugs.
- _____ 10. I understand I will be paying _____ per group; the fee is due weekly unless other arrangements are made.
- _____ 11. I understand that should any dispute arise from these conditions I must follow Running Creek Counseling's Grievance Policy Provisions for appealing any actions as a result of my failing to follow this contract.
- _____ 12. By my initials, I acknowledge that I have read and received a copy of the agency Disclosure Statement.
- _____ 13. I understand that I will be charged the following additional fees as applicable: re-admission \$30; attempts to collect past due accounts-35% of total/final bill; returned check fee \$20; or individual sessions-to be determined. I agree that if my account should be turned over to a collection agency, I lose my right to confidentiality.
- _____ 14. I understand if I carry a balance within 3 weeks of my discharge from Running Creek Counseling, I will not be allowed to attend group until the balance is paid in full.
- _____ 15. I understand if my balance exceeds 2 group fees or \$30 for clients only doing monitored sobriety my services will be suspended until the balance is paid in full. These suspensions are unexcused absences and charged to my account.
- _____ 16. I acknowledge entering into this contract voluntarily. My initials signify acceptance of the conditions of the contract. I further give my consent to Running Creek Counseling to utilize current treatment modalities. I am aware that treatment in this area is not an exact science and that Running Creek Counseling does not make any guarantees to me as to the results of treatment.

Client's Signature

Date

Staff Signature

Date

Running Creek Counseling

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INTAKE RECORD/CLIENT DATA FORM

Counselor _____ Admit Date ____/____/____ Group Start ____/____/____ Grp Assigned _____ at _____ Fee _____
Discharge Date ____/____/____ Administrative, Successful, Non-Compliant, Clinical, Other _____

Colorado ID or Driver's Lic.# _____ Current Spouse/Partner _____
Social Security # _____ Address _____
Name _____ City _____ Zip _____
Address _____ Phone (Home) _____ (Work) _____
City _____ Zip _____ (Cell) _____
Phone (Home) _____ (Work) _____ County of Residence _____
(Cell) _____ Age _____ Birth Date ____/____/____ Ethnicity/Race _____
County of Residence _____ Currently Living _____ Together _____ How Long _____
Age _____ Birth Date ____/____/____ Sex _____ Separately _____ How Long _____
Ethnicity/Race _____ Marital Status _____ Married _____ How Long _____

Current Employer _____ Children Information: *Put check mark by those living with you*
Occupation/Title _____ Name _____ Sex _____ Age _____ Whose Child _____
Length of Employment _____
Hourly Income _____ Monthly Income _____
Military Branch _____ # of yrs. _____
Rank @ Discharge _____ Type of D/C _____
Status (Circle One): Current Past Reserve None Do you pay child support? ____Yes ____No
Current Medication: ____Yes ____No If yes, what is the amount _____
Name of Medication(s): _____ Are you current? ____Yes ____No

Number of previous marriages _____
Length of each: #1 _____ #2 _____ #3 _____ #4 _____
Is maintenance paid? ____Yes ____No
How Much _____

Prior Treatment or Counseling: ____Yes ____No
(Individual, Marital, Family, Drug, Alcohol, DUI, Domestic Violence)
Type Year Location Length

EMERGENCY NOTIFICATION/RELATIONSHIP:

Court/Probation Requirements of Services Requested (Please check)

____ DUI Level II Ed/Therapy ____ Domestic Violence ____ DV Repeat Offender ____ Anger Management ____ IOP
____ Dual DX/Relapse Prevention ____ Pre-trial ____ Individual Therapy ____ Couples ____ Assessment/Evaluation
____ Antabuse ____ Breathalyzer ____ Urine Screen ____ Saliva Swabs ____ Parenting ____ Substance Abuse

If applicable: Probation Officer: _____ Probation Dept.: _____ Case #: _____

Domestic Violence Clients Complete (Mandatory) If different than current partner

Victim: _____ Phone (Home) _____ (Work) _____
Address _____ (Cell) _____
City _____ State _____ Zip _____ Age _____ Birth Date ____/____/____ Sex _____ Ethnicity/Race _____
County of Residence _____ Currently living: ____ Together ____ Separately
Restraining Order ____ Yes ____ No
If Yes, type
____ Permanent ____ Modified ____ No Contact ____ Limited Contact

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CLIENT QUESTIONNAIRE

The following questions must be answered by all clients seeking admission to a program at Running Creek Counseling and are required by Colorado law for alcohol and drug education or treatment. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring agency, will result in immediate discharge from the program and notification of the appropriate agencies, in accord with the requirements in 17-27.1-101, CRS.

1. Are you applying for treatment because of a current requirement to Attend a treatment program in Colorado by any court, department of Corrections, state board of parole, probation department, parole division, adult diversion program, or any other similar entity or program **IN ANOTHER STATE?** Yes _____ No _____

If **NO**, you have completed this form.

If **YES**, please answer the following question:

2. Are you, or will you be, under the supervision of a probation officer or a parole officer in Colorado? Yes _____ No _____

(Note: if you do not have an assigned Colorado probation or parole officer the Interstate Compact Office will be notified.)

3. Are you, or will you be, under the supervision of a Department of Human Services Caseworker. Yes _____ No _____

4. For DUI Offenders only: Are you seeking education/treatment For the sole purpose of restoring your driving privileges as the Result of an alcohol/drug related driving offense in another state, but are not under a court order to do so? Yes _____ No _____

Your Name: _____ Date of Birth: _____

Social Security Number: _____ Place of Birth _____

Signature: _____ Date: _____

If you answered "Yes" to number 1, 2, or 3 above, please provide the following:

Name, address, and phone number of your probation officer, parole officer, caseworker, judge and/or diversion officer. _____

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CLIENT RIGHTS/GRIEVANCE POLICY/GROUP RULES

Client Rights

1. To be treated with respect
2. To participate and review your own treatment plan
3. To access the grievance process and understand it
4. To confidentiality, except in cases of child/elder abuse suicide/homicide threats, etc.
5. To understand payment requirement and charges
6. To not enter this program or transfer to another program
7. To access a counselor in case of an emergency at 720-940-5628

Client Responsibilities

1. To respect the staff, clients, and facilities of RCCS
2. To adhere to commitments
3. To maintain the confidentiality of other clients
4. To be alcohol/drug free during treatment
5. To follow the client contract
6. To be on time for groups and appointments
7. To pay all fees for services rendered; regardless of discharge status

CLIENT GRIEVANCE POLICY AND PROCEDURE

All clients will be treated fairly in all respects. Those who feel they have been subjected to unfair treatment will have the right to present their grievance, in writing, to the Clinical Director. In filing or presenting a grievance, as a client you shall be free from restraint, coercion, discrimination, or reprisal. It is expected grievances shall arise. When they do, they shall not reflect unfavorably on either the client or the counselor. All clients must remember there is no grievance until your counselor, the Clinical director, or others with authority have been made aware of the dissatisfaction.

- Step 1 Discuss the problem with your counselor/parent supervisor.
- Step 2 If there is no satisfaction, the client and the counselor shall present the grievance to the Clinical Director in writing.
- Step 3 The Clinical Director shall make a fair and equitable decision within ten (10) working days (with the help of staff, staffing, and/or probation or the Dept. of Human Services).
- Step 4 If there is still no satisfaction, said grievance shall be presented to the Agency Executive Director for resolution and final disposition.

GROUP INFORMATION AND RULES

Group Goals: The goal of group work is to provide an opportunity to learn about and explore the dynamics of your behaviors. Once a foundation of accurate information is created, members of the group are supported in the decision making process of changing behaviors and practicing new methods of coping and management skills.

Programs: All programs have two levels of groups. The first level is educational. This level focuses on specific information and how this information applies to you. The second level of group is therapy. This portion of treatment addresses individual behavior, examines past influences and redirects energy toward healthier goals. Each group member is responsible for what they gain.

1. Group begins and ends on time. If you are more than 10 minutes late, come to group but you will not receive credit for that group. This is an unexcused absence and you will be charged for missing group. Missed groups must be made up.
2. If you cannot attend group, call the agency. Excused absences are for illness, injury, or family death and emergencies only. Work may be excused with 24 hours notice. Proof must be provided for any absence to be excused.
3. Information shared in group is confidential. If you violate this confidentiality, you will be discharged from this program.
4. No smoking, drugs, or alcohol are allowed in the facility. Intoxicated or "high" clients will not be allowed into the group, will not receive credit for group, will be required to submit a urine screen/breathalyzer, and may be discharged from RCCS. **Appropriate agencies will be notified.**
5. Active participation is required for successful progress. Progress reports are provided to your Probation Officer/DHS, monthly.
6. Fees are paid on an as-you-go basis. You may pay cash, check, money order, Visa, Mastercard, or Discover. Suspension of services will occur if you exceed a balance of 2 group fees or for monitored sobriety only clients \$30. These suspensions are unexcused absences and charged to your account.
7. Excused absences: Illness, injury, emergency, or family death. Special family events or work with 24 hour notice.
8. Unexcused absences: Failing to comply with excused absence requirements; failure to make/keep payment arrangements; or transportation.
9. Discharge paperwork will not be sent if an outstanding balance exists on your account.
10. **ALL** clients are subject to random urine screens and/or breath tests at the agency staff's discretion.

Client

Date

Staff Signature

Date

Running Creek Counseling

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Psychological and Social History

Name: _____

Family of Origin History

Who was/were your guardian(s) when growing up? _____

How many brothers and sisters do you have and where are you in the birth order? _____

Who in your family do you feel closest to? _____

Were your parents separated or divorced? (Circle one) _____

Describe your family and childhood. _____

Where were you raised? _____

Was there any violence, alcoholism or substance abuse in your family? (Circle any that apply. Include extended family) Who? _____

Have you ever been abused? _____ Physically _____ Sexually _____ Emotionally By Whom? _____

Has anyone close to you died? _____ Yes _____ No Relationship: _____ Cause of death: _____

Relationship History

Are you currently involved in a relationship? _____ Yes _____ No How long? _____

Describe your partner _____ Describe your partner's attitude toward you _____

How long was your longest relationship? _____ Have you been divorced or separated? _____

How many serious relationships have you had? _____

How do you feel about your partner? _____

Do you prefer relationships with: _____ Women _____ Men _____ Both

List your children/stepchildren.

<u>Name</u>	<u>Gender</u>	<u>Age</u>	<u>Living With You</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employment and Educational History

What was the highest grade you completed in school? _____

Did you experience learning difficulties in school? _____ Yes _____ No

If yes, briefly explain: _____

Have you ever been expelled/suspended from school? _____ Yes _____ No If yes, for what? _____

What is your current occupation? _____ Are you currently working? _____

Are you satisfied with your current job? _____ If unemployed, how long have you been unemployed? _____

What was your last job? _____

Are you a military veteran? _____ Yes _____ No If yes, which branch? _____ Rank at discharge _____

What years did you serve? _____ Did you see action during wartime? _____ Where? _____

Discharge status (i.e. honorable, medical, dishonorable, etc.) _____

Legal History

How many times have you been arrested and or ticketed? _____

Please list the dates and reasons for each arrest (regardless of conviction) _____

Current Offense Description

Describe the reasons you were arrested and/or sent here, **IN DETAIL** (include drug or alcohol use involved)

Behavior Checklist and Assessment

Please check those things that you have done:

- | | |
|--|--|
| <input type="checkbox"/> slapped or hit your partner or children | <input type="checkbox"/> blocked partner's path |
| <input type="checkbox"/> kicked your partner or children | <input type="checkbox"/> mocking or name calling |
| <input type="checkbox"/> shoved your partner or children | <input type="checkbox"/> withheld affection/sex |
| <input type="checkbox"/> punched walls or broke personal property | <input type="checkbox"/> restrained partner/person |
| <input type="checkbox"/> threatened to leave or divorce partner | <input type="checkbox"/> drank or did drugs to relieve anger |
| <input type="checkbox"/> Became more angry as a result of drinking or drugs | <input type="checkbox"/> threatened someone with a weapon |
| <input type="checkbox"/> Threatened to hurt partner, family, children, or pets | |

Please check the experiences that you have witnessed:

Parents hitting/hurting each other parents hitting/hurting you war street crime

When was the last fight you were in (with friends, in bars, at school, etc.) _____

Drug and Alcohol Use History

Please check what applies:	<u>Age First Used</u>	<u>Date Last Used</u>	<u>How Often?</u>	<u>How Many Years?</u>
<input type="checkbox"/> Alcohol	_____	_____	_____	_____
<input type="checkbox"/> Marijuana(Pot)	_____	_____	_____	_____
<input type="checkbox"/> Cocaine/Crack	_____	_____	_____	_____
<input type="checkbox"/> Barbiturates	_____	_____	_____	_____
<input type="checkbox"/> Amphetamines (speed)	_____	_____	_____	_____
<input type="checkbox"/> Hallucinogens (acid)	_____	_____	_____	_____
<input type="checkbox"/> Ecstasy	_____	_____	_____	_____
<input type="checkbox"/> Heroin	_____	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____	_____

What is the most of any substance you have ever used? _____

Have you ever felt that you needed to cut down on your drinking or drug use? _____

If yes, briefly explain: _____

The longest time you have remained drug/alcohol free? _____ How did you feel when you were drug/alcohol free? _____

How many times have you drank/used in the last 30 days _____ What substances _____

Please indicate which experience you have had while drinking or drugging:

- Memory loss or blackout; how often _____
- Loss of control (drank or used more than you intended)
- Personality changes; please describe _____
- Stealing, sneaking or hiding drugs or alcohol

Describe the consequences you have experienced from your drug or alcohol use.

Legal consequences: _____

Personal consequences: _____

Please indicate the number of times you have had prior treatment for a drug/alcohol problem.

Detox unit Halfway House DUI classes Residential treatment Outpatient treatment

List the programs or agencies in which you have been in treatment for a drug or alcohol problem.

<u>Program Name</u>	<u>Year</u>
_____	_____
_____	_____
_____	_____

Have you ever attended Alcoholics Anonymous or other recovery programs? _____ Type _____

Medical Survey

How would you rate your health? _____ Poor _____ Fair _____ Average _____ Good _____ Excellent
Are you currently under medical care? _____ For what reason? _____
Name of your doctor of clinic _____ Last doctor visit _____ Date of last physical _____
Do you have health insurance? _____ If yes, does it cover Mental Health/Substance Abuse? _____ Company? _____

Please list any prescription medications you are taking:

<u>Medication</u>	<u>Dosage</u>	<u>Reason for taking</u>	<u>Prescribing Physician</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had any of the following? (Circle all that apply)

- | | | | | |
|--------------|-----------------------|-----------------------|-----------------------|---------------------------|
| ADD/ADHD | Chicken Pox | Epilepsy | Heart Problems | Problems Sleeping |
| Anxiety | Chronic Fatigue | Eye Problems | Hepatitis | Recent Weight Gain/Loss |
| Arthritis | Cirrhosis | Eye Glasses/Contacts | High Blood Pressure | Seizures |
| Asthma | Colitis | Fainting/Dizzy Spells | Hypertension | Sinus Problems/Infections |
| Bi-Polar | Cardio Vascular Prob. | Fibromyalgia | Hypo(er)glycemia | Substance Abuse |
| Broken Bones | Depression | Headaches-Severe | Learning Disabilities | Thyroid |
| Bronchitis | Diabetes-Type _____ | Head Injury | Measles | Ulcers |
| Cancer | Dyslexia | Hearing Loss | Multiple Sclerosis | Vasectomy |

Venereal Diseases {type(s)} _____ Allergies (specify) _____
Pain (specify) _____ Other (specify) _____

Are you a smoker? _____ How much do you smoke daily? _____

In the past six (6) months prior to admission, how many times did you visit any of the following: Medical Emergency Room _____

Admitted to a Medical Hospital _____ Psychiatric Emergency Room _____ Admitted to a Psychiatric Hospital _____

FOR WOMEN: Are you pregnant? _____ If yes, are you receiving pre-natal care? _____ How far along? _____

Is there anything else you would like us to know about you? _____

Psychological History

Are you currently in counseling or mental health treatment? _____ If yes, with what person or agency? _____

How long have you been in this counseling? _____ How often are you seeing this therapist? _____

Have you ever had a delusion or hallucination? _____

Have you had thoughts of suicide in the last year? _____

If yes, when? _____

When was the last time you thought about suicide? _____

Are you still thinking about suicide? _____

Please describe your plan for attempting suicide. _____

Were drugs and/or alcohol involved in any of your attempts? _____

What is going on in your life when these thoughts occur? _____

Please check those things listed below that you have experienced in the past or are currently experiencing:

- _____ Phobias (Intense fears) Types: _____
- _____ Panic attacks. Please describe _____
- _____ Hallucinations/Delusions (i.e. voices, people, etc.) Please describe _____
- _____ Thoughts of killing someone _____
- _____ Fears of going crazy _____