ACC, LLC
Rebuilding Families Within The Community
Alternative Choice Counseling Center, LLC
Ltdouglas.acc@gmail.com
www.acc-wtn.org

Thank you for requesting a Tele-Health appointment with our agency. You must have internet access on your phone or computer and a place that is quiet for the session. We use a HIPPA compliant platform so you can be assured your privacy is protected. Please fill out all the forms attached and email them back to: tbeard.acc@gmail.com. If you have insurance please include in the email a picture of the front and back of your card. If you are self- pay please call the office at 731-784-8814 prior to your appointment and pay for your session.

Once we receive your paperwork you will get an email from tbeard.acc@gmail.com setting the time and date for your appointment.

Again thank you for choosing Alternative Choice Counseling Center, LLC.

Lori Lucille Douglas DS/LADAC2/IXCAC2/GCS

Office: 731-784-8814
Cell: 731-445-4807
Fax: 731-784-9920
1309 E. Main Street Humboldt, TN 38343

Alternative Choice Counseling Center, LLC
TITLE VI COMPLIANCE AGREEMENT BETWEEN ALTERNATIVE CHOICE STAFF AND CLIENT

Alternative Choice Counseling Center, LLC:

- Will not deny any person service, assistance or other benefit for which you are qualified;
- Will not provide any person with a service different from that provided to others under the same program;
- Will not subject any person to separate treatment in any manner related to services, aid or other benefits;
- Will not limit any person in any way in the use of services, facilities, or any other advantages, privileges or benefits provided to others under any program;
- Will not treat any person differently from others in deciding whether they meet requirements to receive aid, care, service or other benefit;
- Will not deny any person or offer an opportunity different from that offered others in any program or service;
- Will not adopt methods that limit participation by any group of recipients or subject them to discrimination and
- Will not refer any person to agencies that do not obey civil rights law.

I have read and understand that what the above states is that I will not be discriminated against due to race, color, national origin, sex, sexual orientation, religion, or anything that may be discernible. I further understand that Alternative Choice Counseling Center, LLC will utilize their best efforts in maintaining compliance in all programs subject to the requirements of Title VI and all other federal regulations applicable to the administration of such programs. **I have read and received a copy of the Title VI Brochure, and I understand its contents.**

Client's Name _____ Date _____

All agencies receiving financial assistance through the department must sign a statement of compliance with Title VI of the Civil Rights Act of 1964.

ALTERNATIVE CHOICE COUNSELING CENTER, LLC
CRISIS PLAN AND RESOURCES

List major stressors that you struggle to deal with:

- _____
- _____
- _____

Those who are supportive of you reaching positive goals:

- Name: _____ Number: _____
- Name: _____ Number: _____
- Name: _____ Number: _____

Things that may help you in a crisis:

___ Deep breathing
___ A bubble bath
___ Watching TV
___ Listening to music
___ Walking
___ Other: _____
___ Exercising
___ Being outside
___ Other: _____

Emergency Numbers:

- Carey Counseling Center 24-Hour Crisis Line (Gibson County) – 1-800-353-9918
- Pathways Behavioral Health Services 24-Hour Crisis Line (Crockett County) – 1-800-372-0693
- Youth Villages 24-Hour Crisis Line (Juveniles) – 1-866-791-9227
- Alternative Choice Counseling Center, LLC After-Hours – (731) 445-4807

Inpatient Mental Health and Alcohol and Drug Treatment:

- Pathways Behavioral Health Services 1-800-587-3854
- Aspell Recovery Center 731-427-7238
- JACOA (Jackson Area Council on Alcoholism and Drug Dependency) 731-423-3653

I HAVE RECEIVED A COPY OF THIS DOCUMENT.

Client Signature: _____ Date: _____

Staff Signature: _____ Director Signature: _____

Client Rights and Responsibilities

Agency Rules

1. Phones are not allowed back to group or individual sessions. You may leave your phone at front desk if needed.
2. No tobacco products used inside ACCC, LLC.
3. Ensure you leave group room like you found it.
4. If problematic behavior continues after a counselor has you to stop, you will be asked to leave the group.
5. Treat others the way you want to be treated.

Client Rights

1. Clients are treated with consideration, respect and recognition of his/her dignity and individuality regardless of his/her condition.
2. Clients' medical and financial information is treated with privacy.
3. Clients will have rights and responsibilities provided to them and explained in a manner that is sensitive to their culture, language and level of functioning.
4. Clients may ask for and receive information about his/her medical record.
5. Clients may review his/her medical records, receive copies of the records and correct any errors in the record.
6. Clients will have services rendered to them without regard to race, color, birthplace, language, gender, age, religion or disability.
7. Clients are informed they can file an appeal and complaints about the care they receive.
8. Clients have the right to continue receiving care without the fear of receiving inadequate treatment if a complaint is filed.
9. Clients' treatment options, regardless of cost or benefit coverage is documented in the chart.
10. Clients are informed that they have a right to refuse treatment (unless court ordered).
11. Clients have the right to refuse audio and or video techniques to record or observe the client's activities during treatment.
12. Clients have the right to refuse to participate in community service, vocational, and or recreational activities.
13. Clients have the right to be provided treatment in the least restrictive setting (based on the outcome of the assessment).
14. The clients have a right to a listing of available advocacy services and contact information when requested.
15. Language assistance, interpretation and translation services are available to any client who needs such services, including but not limited to, clients with Limited English Proficiency and clients who are hearing impaired.
16. Recommend prompt evaluation and treatment with continuity of care being a priority.
17. Have some legal rights and responsibilities as other citizens unless as otherwise stated by law.
18. Have your record held and protected under CFR 42 Part 2 of confidentiality law.
19. Have your attendance regulated and fees explained to you upon admission.
20. Clients have the right to be protected by the licensee from neglect; from physical verbal and emotional abuse (including corporal punishment); and from all forms of misappropriation and/ or exploitation
21. Clients have the right to be assisted by the facility in the exercise of their civil rights
22. Clients have the right to be free of any requirement by the facility that they perform services which are ordinarily performed by facility staff
23. Clients have the right to privacy while receiving services
24. Clients have the right to their personal information being kept confidential in accordance with state and federal confidentiality laws.

25. Client have the right to ask the facility to correct information in their records. If the facility refuses, the client may include a written statement in the records of the reasons they disagree.
26. Clients have the right to vote, make contracts, buy or sell real estate or personal property, or sign documents, unless the law or a court removes these rights.
27. Clients have the right to participate in the development of their treatment plan, goals and objectives of treatment.
28. Clients have the right to be accorded privacy/freedom for the use of bathroom when needed.
29. Clients have the rights to receive alternative services from another provider and the right to be referred to alternative services that reasonably meet the requirements of timeliness, capacity, accessibility and equivalency as set forth in the Federal regulations, 42 CFR 54.8 and 54a.8.
30. Clients have the right to be referred by the agency upon request to receive alternative services from another provider. It is the agency's responsibility to make referrals by using the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's Substance Abuse Treatment Facility Locator to identify suitable alternative providers at http://dasis3.samhsa.gov

Client Responsibilities

1. Clients are responsible for providing accurate information to Alternative Choice Counseling Staff.
2. Clients are responsible for treating counselors and staff with respect and dignity.
3. Clients are responsible for cancelling any appointments with appropriate notice if they cannot keep them.
4. Participate in you treatment including paying fees if indicated and attending sessions and general participation.

_____ _____

Client Signature Date

_____ _____

Staff Signature Director Signature

ALTERNATIVE CHOICE COUNSELING CENTER, LLC

INFORMED CONSENT AND TREATMENT:

The type and extent of services that I will receive will be determined following an initial assessment. The goal of the assessment process is to determine the best course of treatment for me. I understand that this is a long term Outpatient Facility. I understand that upon circumstances where my counselor is no longer available, I will still be allowed continuation of services. I understand that I am allowed to contact the agency via the agency telephone number at 731-784-8814 and that the call will be as safe and confidential as possible between myself and the agency staff; however I do understand that any telephone communications are unsecured and remote services using electronic means of delivery cannot be entirely secured or confidential. I understand that in cases of social media, my counselor or any other staff member cannot accept 'friend' requests. I understand that I will be held responsible for any fees that I consent to on the Client Treatment Agreement, and I must pay for my services unless I have a consent to bill for insurance that the agency is allowed to bill and receive payment for. I understand that I have the right to refuse services. I understand the information shared with clinicians is confidential and no information will be released except under the following exceptions: Immediate Risk to harm myself or others; When suspicion that a child or elderly person is being abused; When a valid Court order is presented for action to release records; Signed Release of Information by Client and a Medical Emergency . All client information is presented in overview weekly during staff supervision. **I will be seen by a Professional. Some clinicians will be alcohol and other drug abuse counselors in training but in those instances they are supervised by a LADAC Level 2 Nationally Certified Addiction CRS Level 2. All counselors in training are working toward their LADAC; most already have a BS degree in related field. Some will be social workers. All attend numerous trainings a year. I understand that I have the right to refuse to be treated by a person-in-training without fear of retribution. I understand this agency does not dispense medication.**

Clients are responsible to report for group sessions 15 minutes early so they have time to check in and register with Support Services PRIOR to group session start time. Valid Reasons for being late include Medical emergencies; Emergency Car problems or Mandatory work overs AND client must call the center prior to group start time with the valid reason or it will not be approved. If the client is more than 10 minutes late to group, the client will be told so not to be disruptive to the group process they will be required to make up that session at some point during the same week. A non-compliance form is to be filled out on what time they arrived, when they are to make up the group. A $35 no show fee is charged when a client does not make their appointed time. Exception is ONLY for court/Jail appearance or removal from treatment by physician. The fee or court/jail/physician notification must be provided before the next treatment appointment (any treatment service). If payment is not received, treatment services will be discontinued and client given option to transfer to another provider; given opportunity to return to referral source or restart treatment in accordance to our policy and procedure.

GRIEVANCE PROCEDURE:

We strive to provide quality service to all of our clients. In the event that you have a consumer complaint (to report abuse, neglect, or concerns about the care or services provided by our agency), you must initially advise in writing the complaint to the Executive Director, Lori Tubbs-Douglas, BS/LADAC2/NCAC2/QCS at 731-784-8814. Your complaint will be addressed in a timely, fair and consistent manner. Most problems are able to be resolved at these levels. The first level will be to meet with the staff you have a grievance against and see if it can be resolved. The second level will be to have your grievance heard by a committee. If you have attempted to resolve your issue through the proper channels on the local level without success and/or satisfaction, you may then file a complaint with:

Tennessee Division of Consumer Affairs (West TN Complaint Intake Center)

Contact: 1-866-344-0858

FIRE EVACUATION PROCEDURE:

We strive to provide a safe environment for all of our clients. In the event of a fire, please go to the nearest exit via the safest route. The pre-determined assembly point for Humboldt is the back parking lot of the building. Assembly remains in effect until roll call is taken and all persons in the building at the time of the fire are accounted for. DO NOT RE-ENTER THE BUILDING WITHOUT PERMISSION FROM THE FIRE DEPARTMENT.

I HAVE READ AND UNDERSTAND THE ABOVE SECTIONS AND AM GIVING MY CONSENT AND AGREEMENT TO THE TERMS ABOVE. I UNDERSTAND I MAY ASK ANY QUESTIONS THAT MAY ARISE ABOUT THESE ISSUES.

Client Signature	**Parent / Guardian**	**Staff Signature**
Director Signature		**Date**

Consent to Bill Insurance Company

Alternative Choice Counseling Center
1309 E. Main St.
Humboldt, TN 38343

I, the undersigned, authorize Alternative Choice Counseling Center to submit claims to my insurance company. If it is the case that my insurance company utilizes a managed care company, my counselor may need to discuss my treatment with a case manager. I understand that my confidentiality will be compromised in such a case. I realize that his/her doing so is a necessity in his/her effort to secure ongoing care. I also authorize payment of medical benefits to Alternative Choice Counseling Center for services provided Alternative Choice Counseling Center files insurance as a courtesy and if insurance denies payment, you (the client) agree to assume total financial responsibility for any denied claims.

_____ _____
Client's Signature Date

_____ _____
Insured Signature Date
(If Different than Client)

_____ _____
Parent/Guardian Signature Date

_____ _____
Admissions Clerk Date

_____ _____
Director Date

Medical Insurance Information Form

To be completed during initial assessment for all clientele or potential clientele.

It is your responsibility to list any and all insurances you may have. You **MUST** inform us if you have any TennCare insurance coverage. If you do not disclose your **commercial** insurance information, you will be responsible for any and all fees occurred during treatment and we will be unable to submit claims on your behalf. All fees are due at the time of service. If you inform us at a later date that you do have insurance that will accept/pay for your treatment, a new Medical Insurance Information form must be completed and turned in. We will begin billing from that date forward; we will **NOT** backdate or refund any service that has already been administered and paid.

Current insurance Alternative Choice Counseling Center, LLC is in-network with:
BlueCare TennCare
BlueCare Coverkids
BlueCare TennCare Select
Blue Cross Blue Shield - Intensive Outpatient Treatment only
United HealthCare Tenncare
Amerigroup TennCare

If your insurance company is not listed above, we could attempt to bill out-of-network **ONLY IF** your deductible has been met. If your deductible has not been met, we will not submit claims on your behalf.

Current insurance Alternative Choice Counseling Center, LLC is out-of-network with and regularly sends claims to:
Veteran's Affairs
Cigna/Optum

Understand that the insurances listed above are the ones we are currently aware of. We are always trying to credential with different insurance plans and companies. In the event we find out later that we have been in-network with your insurance company without our knowledge, we can begin billing the day of acknowledgment. We will **NOT** backdate or refund any service that has already been administered and paid.

In the event that you have a different primary insurance than what you list and we are unable to bill your actual primary insurance (due to being out-of-network), you may be liable for all fees serviced.

Primary Insurance Company: _____
Name of Policy Holder: _____
Policy #: _____
Group #: _____
In-Network / Out-of-Network: _____

Secondary Insurance Company: _____
Name of Policy Holder: _____
Policy #: _____
Group #: _____
In-Network / Out-of-Network: _____

Any Other Insurance: _____

When checking insurance, we will give a quote of the estimated price of service provided by your insurance. This amount is subject to change according to claim(s) being billed and processed. If insurance pays more than anticipated and shows that you have overpaid, then we will issue you a refund. If insurance pays none or less than anticipated and shows that more is owed more than initially charged, then you are responsible for ensuring that the claim is paid in full.

By signing this form, you understand and are consenting to the information above. If any insurance information were to change, you understand and accept the responsibility to inform the agency by requesting and filling out a new Medical Insurance Information Form.

_____ _____
Client Signature Date

EQUAL OPPORTUNITY IS THE LAW IN TENNESSEE

The Civil Rights Act of 1964 was passed to ensure the people of the United States equal treatment, rights and opportunities regardless of race, color, or national origin. Title VI of that Act prohibits discrimination in federally funded programs.

"No person in the United States shall, on the basis of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Included under National Origin is discrimination based on a person's inability to speak, read, write, or understand English. Persons whose primary language is not English can be Limited English Proficient or "LEP." These individuals may be entitled to language assistance with respect to a particular type of service, benefit, or encounter.

All programs and operations of entities that receive assistance from the federal government must comply.

It is important that all applicants and recipients of services know about their rights under the law, and that employees of *Alternative Choice Counseling Center, LLC* as well as other agencies, organizations, institutions, and contractors providing services with state support understand what the law requires.

Any person who applies for or receives any benefit or service provided by *Alternative Choice Counseling Center, LLC* may file a complaint if he or she has had unfair or different treatment because of race, color, or national origin.

Complaints must be filed in writing with the Title VI representative of the location of the alleged discrimination *Alternative Choice Counseling Center, LLC;* or with the appropriate regional or central office of the Department of Mental Health and Substance Abuse Services; or with the Office of Civil Rights, 101 Marietta Tower, Suite 2706, Atlanta, Georgia 30323.

Alternative Choice Counseling Center, LLC does not, because of race, color, or national origin:

1. Deny and individual any services, opportunity, or other benefit for which he is otherwise qualified;
2. Provide any individual with any service, or other benefit, which is different or is provided in a different manner from that which is provided to others under the program;
3. Subject any individual to segregated or separate treatment in any manner related to his/her receipt of service;
4. Restrict an individual in any way in the employment of services, facilities or any other advantage, privilege or other advantage, privilege or other benefit provided to others under the program;
5. Adopt methods of administration which would limit participation by any group of recipients or subject them to discrimination;
6. Address an individual in a manner that denotes inferiority because of race, color, or national origin.

For further information, contact *Alternative Choice Counseling Center, LLC* Title VI Coordinator:

Chassity Tanner
1309 E. Main St Humboldt, TN 38343
731-784-8814

Client Printed Name	Client Signature	Date
Staff Signature	Director Signature	Date

KenH05182016

Charitable Choice Model Notice

Model Notice to Individuals Receiving Substance Abuse Services

No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

Referred to another provider ☐ Yes ☐ No

If yes, which provider? _____

SIGN:

The CAGE Questionnaire Adapted To Include Drugs (CAGE-AID)

1. **Have you felt you ought to cut down on your drinking or drug use?**

2. **Have people annoyed you by criticizing your drinking or drug use?**

3. **Have you felt bad or guilty about your drinking or drug use?**

4. **Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?**

Score: ___/4

2/4 or greater = positive CAGE, further evaluation is indicated

Source: Reprinted with permission from the *Wisconsin Medical Journal.* Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.

Modified Mini Screen (MMS)

Patient Name: _____ Date: _____

Section A – Please circle "yes" or "no" for each question.

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? ..... Yes No
2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? ..... Yes No
3. Have you felt sad, low, or depressed most of the time for the last two years? ..... Yes No
4. In the past month, did you think that you would be better off dead or wish you were dead? ..... Yes No
5. Have you ever had a period of time when you were feeling up, hyper, or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) ..... Yes No
6. Have you ever been so irritable, grouchy, or annoyed for several days, that you had arguments, had verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way? ..... Yes No

Section B – Please circle "yes" or "no" for each question.

7. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable, or uneasy, even when most people would not feel that way? Did these intense feelings get to be their worst within ten minutes? (If the answer to both questions is "yes," circle "yes"; otherwise circle "no.") ..... Yes No
8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples: O being in a crowd, O standing in a line, O being alone away from home or alone at home, O crossing a bridge, O traveling in a bus, train, or car? ..... Yes No
9. Have you worried excessively or been anxious about several things over the past six months? (If you answer "no" to this question, answer "no" to Question 10 and proceed to Question 11.) ... Yes No
10. Are these worries present most days? ..... Yes No
11. In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated? Examples: O speaking in public, O eating in public or with others, O writing while someone watches, O being in social situations. ..... Yes No

continued on other side

12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive, or distressing? Examples: O being afraid that you would act on some impulse that would be really shocking, O worrying a lot about being dirty, contaminated, or having germs, O worrying a lot about contaminating others, or that you would harm someone even though you didn't want to, O having fears or superstitions that you would be responsible for things going wrong, O being obsessed with sexual thoughts, images, or impulses, O hoarding or collecting lots of things, O having religious obsessions. ..... Yes No

13. In the past month, did you do something repeatedly without being able to resist doing it? Examples: O washing or cleaning excessively, O counting or checking things over and over, O repeating, collecting, or arranging things, O other superstitious rituals. ..... Yes No

14. Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples: O serious accidents, O sexual or physical assault, O terrorist attack, O being held hostage, O kidnapping, O fire, O discovering a body, O sudden death of someone close to you, O war, O natural disaster. ..... Yes No

15. Have you re-experienced the awful event in a distressing way in the past month? Examples: O dreams, O intense recollections, O flashbacks, O physical reactions. ..... Yes No

Section C – Please circle "yes" or "no" for each question.

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? ..... Yes No

17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking? ..... Yes No

18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed? ..... Yes No

19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you? ..... Yes No

20. Have your relatives or friends ever considered any of your beliefs strange or unusual? ..... Yes No

21. Have you ever heard things other people couldn't hear, such as voices? ..... Yes No

22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see? ..... Yes No

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra.hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No
   If yes enter 1 _____

2. Did a parent or other adult in the household **often** ...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No
   If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No
   If yes enter 1 _____

4. Did you **often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No
   If yes enter 1 _____

5. Did you **often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No
   If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No
   If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No
   If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No
   If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No
   If yes enter 1 _____

10. Did a household member go to prison?
    Yes No
    If yes enter 1 _____

Now add up your "Yes" answers: _____ **This is your ACE Score**

Alternative Choice Counseling Center, LLC

Tele-Health Assessment

Client Information

Date: _____

Name: _____ AKA (Aliases): _____

DOB: _____ SS #: _____

Address: _____ Phone: _____
Emergency Contact
Relation/Phone:

In Client Words: *Detailed explanation for coming for assessment:* _____

_____

_____

Client Report of MH/SA Issues/Concerns:

Client States Primary Issue: ☐ Alcohol/Drug Related ☐ Mental Health Related

- ☐ Anxiety
- ☐ Panic Attacks
- ☐ High Hostility/Aggression
- ☐ Sad Mood
- ☐ Mood Swings
- ☐ Racing Thoughts
- ☐ Poor Concentration
- ☐ Eating Disorder
- ☐ Sleep Hygiene Deficits

- ☐ Poor Hygiene
- ☐ Poor Appetite
- ☐ Health
- ☐ Current Sentence
- ☐ Visual
- ☐ Accusatory
- ☐ Commanding

Hallucinations:

- ☐ None
- ☐ Tactile
- ☐ Olfactory

- ☐ Cravings/Urges
- ☐ Withdrawal
- ☐ Excessive Drinking
- ☐ IV Use
- ☐ Fear of Dying if Use Cont.
- ☐ Excessive Rx or Illegal Drug Use
- ☐ Pregnant
- ☐ Fear of losing family due to A/D
- ☐ Can't Hold Job Due to A/D
- ☐ Auditory
- ☐ Threatening

Additional Comments: _____

Positive Childhood Memory: _____

Negative Childhood Memory: _____

_____

Substance Use History

☐ **No history or current use**

Substance	Route	Amount	Frequency	Age 1st Used	Last Use	Is substance causing a problem?	Precontemplation /Contemplation /Preparation/Action

How did each drug make you feel?

Drug of Choice:	1st:	2nd:	3rd:
Feeling of:			

What causes your drug use to increase/continue?

☐ Prevent dopesick/shakes ☐ My social circle ☐ Stressors at home
☐ Stressors at work ☐ Self-medicating ☐ Enjoys getting high
☐ Other: _____

WHAT AREAS OF YOUR LIFE ARE AFFECTED DUE TO YOUR USE AND HOW DO YOU WANT YOUR LIFE TO BE BETTER:

_____

_____

Family History:

☐ Both biological parents deceased ☐ Adopted ☐ Caregiver of biological/adoptive children
☐ Children have been adopted ☐ Has children; minimal contact ☐ Loss of custody of children
☐ Family history of SA ☐ Family history of MH tx ☐ Family history of SA & MH overlap

Family History: ☐ Heart Disease ☐ Stroke ☐ Blood Pressure ☐ Diabetes ☐ Cancer

EXPLAIN ANY MARKED ABOVE:

_____

_____

Education History:

Military - Branch _____

Active or Non-Active Combat Service: _____

Last grade completed: GED: ___Yes ___No

☐ High School Diploma ☐ High School/College ☐ GED
☐ Degree ☐ Desire to further education ☐ Survivor of school bullying

Work History:

☐ Never worked
☐ Receiving disability
☐ Currently working

Amount: _____ For: ___ Medical ___ Mental Health
Current job: _____
Current weekly hours: _____
Pay Rate: _____ Check Stub Amount: _____
If you do not work, how or who supports you?
☐ FS ☐ UE ☐ FF ☐ CS If you pay child support, how much monthly? _____

WHAT DO YOU LIKE ABOUT YOUR JOB AND WHAT DO YOU DISLIKE:

_____

_____

Criminal History/Criminal Thinking:

☐ Juvenile Record ☐ Yes ☐ No ☐ Adult Record ☐ No Record
If yes, what for: _____

Year	Court	Charge	Guilty	Pending	Jail Time	Admits Responsibility	Denies Responsibility	Under Influence

☐ Probation Officer
☐ Sex Offender Registry ☐ Yes ☐ No Name:

Bio-Medical:

Weight: _____ Height: _____ Allergies: _____

Past Medical Issues: ☐ Cardiac ☐ COPD ☐ Stroke ☐ Cancer ☐ Diabetes

Primary Care Physician: _____

Your last visit was when and for which one? _____ ☐ Medical ☐ Eye ☐ Dental

Insurance: _____

Current Medical Condition(s): _____

Current Medical Medications: _____

☐ Compliant with medication ☐ Non-compliant with medication

Any overnight hospitalizations? ☐ Yes ☐ No For what? ☐ Births ☐ Surgeries ☐ Other: _____

In last 30 days, how many days have your medical issues caused you problems? _____ Stable with meds? _____

Have you ever made attempt to kill self or others? ☐ Yes ☐ No When/what? _____

Have you ever had thoughts or thoughts/plan BUT NO ATTEMPT to kill self or others? ☐ Yes ☐ No When/where? _____

How many pregnancies have you had? _____ How many births have you had? _____

How many children live with you? _____

How many of your children are removed by DCS? _____ Family placed by DCS ☐ With family NOT placed by DCS ☐

Do you smoke cigarettes?	☐ No	☐ Yes	How much? _____
Do you vape?	☐ No	☐ Yes	
Are you currently experiencing any medical issues?	☐ No	☐ Yes	
Do you need help getting in to see a physician?	☐ No	☐ Yes	
If yes, referred to:	☐ Rural Health Clinic	☐ Other: _____	

Mental Health Treatment History:

☐ **No history**

Age of 1st MH TX	Provider	Current or Past	Inpatient or Outpatient	Crisis Stay	Last Treated	Related to A/D Use?	Related to SI/HI	Precontemplation /Contemplation /Preparation/Action

☐ Compliant w/medication ☐ Non-compliant w/medication

Mental Health Medications:
Current Medical Medications: _____
Prescribed by: _____

HAVE YOU EVER BEEN GIVEN A MENTAL HEALTH DIAGNOSIS, IF SO WHAT AND BY WHOM?

_____

_____

WHAT AREAS OF YOUR LIFE HAVE BEEN AFFECTED BY YOUR MENTAL HEALTH ISSUES AND HOW YOU DO WANT YOU LIFE TO IMPROVE?

_____

_____

Alcohol/Drug Treatment History:

☐ No history

Date of A/D TX	Provider	Current or Past	IP/OP Length	Last Treated	Length of sobriety after tx	Left AMA	Did it help?	Why started back?	Did you have sponsor?

HOW WAS YOUR EXPERIENCE WITH TREATMENT (IN DETAIL):

Trauma History:

☐ Rape
☐ Prostitution
☐ Other: _____

☐ Sexual Assault
☐ Physical Abuse

☐ Death of: _____
☐ Emotional Abuse

EXPLAIN HOW THE TRAUMA AFFECTS YOU IN YOUR DAILY LIVING:

How did you cope?

☐ Isolation
☐ Anger/Acting Out

☐ Self-injury Behavior
☐ Other: _____

☐ Used A/D

DID YOU TELL ANYONE ABOUT THE TRAUMA AND IF SO WHAT WAS THEIR RESPONSE:

Prior to Onset of Symptoms Leisure Activities:

☐ Outside hunting/fishing
☐ Time with kids
☐ Gardening

☐ Family gatherings
☐ Sports
☐ Church

☐ School activities
☐ Working out
☐ Other: _____

WHAT BENEFIT IN YOUR DAILY LIVING DO THESE ACTIVITIES PROVIDE:

Belief/Faith (Optional):

☐ Belief in God
☐ Unsure

☐ Saved
☐ Does not want to answer

☐ No Belief

DOES YOUR BELIEF / FAITH BENEFIT YOU IN YOUR DAILY LIFE? IF SO, HOW:

Strengths/Weaknesses DETAILED:

Strengths: _____

Weaknesses: _____

Goals: NEED 4 DETAILED YOU WANT TO ACHIEVE WITHIN THE NEXT 6 MONTHS

Describe 4 goals in your (client's) own words in 6 months: _____

Describe 2 goals you want to achieve within the next year: _____

Driver's License Status:

☐ Suspended Why? _____ ☐ Revoked Why? _____ ☐ Current ☐ Never Had Driver License

Testing Instruments Used:

- ☐ Clinical Interview
- ☐ Trauma Hx Checklist
- ☐ Client Questionnaire
- ☐ Anxiety-Depression Assess
- ☐ Juvenile Disposition Assess
- ☐ Tx Intervention Inventory
- ☐ Beck Depression Inventory (Opt.)
- ☐ Adult Anger Control Survey (All)
- ☐ UDS Observed
- ☐ Adult OP Assessment
- ☐ Domestic Violence Inventory
- ☐ Offender Assessment Inventory
- ☐ Juvenile Tx Intervention Inventory
- ☐ Juvenile Anger Control Survey (Juvenile)
- ☐ Child/Adl. Consumer Questionnaire
- ☐ Anger-Aggression Violence Assessment
- ☐ Juvenile Domestic Violence Inventory
- ☐ Sexual Adjustment Inventory
- ☐ Victim Index (for Rape/Violence referrals)

Additional Comments:

- ☐ Married
- ☐ WM
- ☐ Referred By:
- ☐ GCJC
- ☐ Widowed
- ☐ WF
- ☐ Self
- ☐ Humboldt Circuit
- ☐ Divorced
- ☐ BM
- ☐ HGS
- ☐ Trenton Circuit
- ☐ Single
- ☐ BF
- ☐ TGS
- ☐ Milan City
- ☐ Separated
- ☐ Other: _____
- ☐ Trenton City
- ☐ Other: _____

What do you hope to gain by coming to treatment? _____
Do you feel you are addicted to alcohol and why? _____
Do you feel you are addicted to drugs and why? _____
Do you feel you are not stable with you mental health and why? _____
What situations stress you out the most? _____

TO BE FILLED OUT BY THERAPIST:

Primary Diagnosis on Assessment: _____
Secondary Diagnosis on Assessment: _____