CONSENT TO TREATMENT AND DIAGNOSTIC SERVICES

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the services received at Diversified Counseling and Consulting Services (DCCS) are based on currently accepted practice in the fields of mental health. I also understand that the outcome of treatment cannot be guaranteed in that services continue with my voluntary consent. I understand that I can withdraw my consent and discontinue treatment at any time.

**Confidentiality and Records Release**

I understand that my records or the records of my dependent are confidential under the law and may be released only as allowed under existing applicable statutes.

I understand that DCCS program staff may release client information without client consent under the following conditions:

* If the client threatens to harm themselves or others.
* If the staff suspect child or elder abuse or neglect.
* If we must call 911.
* To management and financial auditors.
* Under a court order or subpoena.

**Fees,** **Billing, Insurance and Self-Pay**

I understand that by signing this agreement that, for any applicable insurance, I also give DCCS permission to bill my insurance company for services rendered to me or my dependent and to release any information, such as diagnosis, treatment plans, and Protected Health Information, as necessary to obtain payment for services. I agree to disclose all relevant and current insurance information both completely and accurately, including any change to my insurance coverage and any updates. It is my responsibility to understand my insurance benefits, including limitations and exclusions, co-pays and year maximums. I understand that it is the policy of DCCS and the policy of my therapist, as an independent contractor who is not paid a salary, to charge me according to the policy outlined in the appointment section. **Insurance companies will not pay for any missed appointments.**

I understand that out of office expenses that are not covered by my insurance company are my responsibility to pay and, in certain situations, must be paid in advance. These billable tasks include school visits, letter preparation, court visits, copying records, telephone consultations over five minutes etc. A fee schedule for these expenses may be provided by my therapist.

**I understand that fee for services including co-pays are to be paid at the time of the appointment** unless other arrangements have been made. It is not DCCS policy to send out statements for unpaid co-pays. If my insurance company does not cover any fees or any portion of fees for the services that I or my dependent have received, I accept responsibility for these costs. If maximum insurance benefits have been reached, I will be fully responsible for any fees for services subsequently rendered to myself or my dependent. I understand that it is my responsibility to understand and obtain authorization if necessary. DCCS staff may assist with understanding my insurance benefits but are not responsible for my understanding of them.

I understand that many insurance companies do not cover two mental health appointments on the same day and that I will be charged directly for one of the two appointments if this occurs (i.e., meeting with the therapist and a psychiatrist on the same day). I understand that unpaid balances over $200 and/or over 90 days will automatically be transferred to the DCCS collection agency unless formal payment arrangements have been made with the DCCS billing department. I understand that defaulting on the payment arrangements will lead to my account going immediately back to a collection status.

I understand that DCCS shall not be obligated to send any report concerning my (or my dependent’s) treatment status to anyone unless the balance on my account is paid in full.

**Contact by DCCS**

I understand that it may be necessary for DCCS to contact me by mail or telephone during or after treatment services for the purpose of confirming or scheduling appointments, billing issues, completion of forms, conducting surveys and any other necessary follow-up. I understand that I have the right to request contact and confidential information by alternate means, at a different location, as specified in the Notice of Privacy Practices.

Email and texting interactions may not be secure and are subject to discovery and legal matters. Email and texting communications are not conducive to therapeutic effectiveness for several reasons including timeliness of receiving and responding to such communications. They are used by DCCS only for purposes of making general contact and communicating changes such as scheduling or office closure.

**Appointments**

I agree to provide accurate information for the development and achievement of treatment plan goals. I will keep my scheduled appointments. I’m aware that any appointment that is missed may be billed directly to me because insurance companies will not pay for missed appointments or late cancellations.

I understand that I will be billed the following: **1st missed appointment-Free**, **2nd missed** **appointment- $50.00**, **3rd missed appointment full fee of-$80.00**. Payment for a missed or late cancellation appointment is **due immediately**. If treatment or diagnostic evaluation is terminated by choice, or because of violation of program rules, I agree to pay all outstanding fees existing at the time of termination.

I understand that all **other Consultations in addition to my regular Therapy sessions (phone** **consultations, letters, additional paperwork for courts, lawyer’s, etc.)** will be billed to my insurance company. **However not all insurance companies** cover these additional costs so I will be responsible for this cost at the rate of **$30 for every fifteen minutes.**

**Additional Important Information**

I acknowledge that any violent or hostile behavior will result in discharge. I understand the possession of a weapon on DCCS property is prohibited. I realize that I will be refused any appointment on any day that I come to DCCS intoxicated. I also acknowledge that I’m aware that DCCS never uses seclusion or restraint. I understand that should custodial parents disagree regarding treatment, therapy may be suspended or concluded.

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services at DCCS for myself and/or my dependent. I recognize that I may refuse any aspect of treatment. I also accept that such refusal may, in some instances, result in termination of services by DCCS.

I acknowledge that the therapist is an independent contractor who is using the facilities, billing, and record-keeping on the premises of DCCS and the therapist is not an employee of DCCS.

My signature below acknowledges that I have read this Consent to Treatment and that I agree to abide by the policies and procedures of DCCS and have read the Notice of Privacy Practices. I have received a Client Orientation to DCCS. I also consent to be contacted to check on my overall functioning after completing my treatment at DCCS.

|  |  |
| --- | --- |
| Client Signature: | Date: |
| (or parent/guardian as identified) |  |
| Witness Signature: | Date: |

Release of Information to Primary Care Physician

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby **Do / Do Not** authorize Diversified

**(Client Name) (Check ONE)**

Counseling and Consultation Services to release information contained in my record to my Primary Care Physician (PCP) and for my PCP to release information to the service providers at DCCS. I understand that my consent to release information will include sending information to my PCP, including a summary of treatment provided, updates to that treatment, discharge information, and any other information deemed necessary to coordinate treatment at DCCS. I understand that this release also permits my PCP to send and communicate informtaion to DCCS.

If concent is provided, information will be released as follows:

1. Type of information to be disclosed: assessment and treatment information.
2. This consent is subject to revocation at any time except to the extent that the program making the disclosure has already done so in reliance upon this release (i.e. no responsibility for information released prior to revocation).

Physician’s name and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If consent is not revoked then this release will terminate on:

1. Event of 6 months after date of discharge from DCCS
2. Date and Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(or parent/guardian as identified)**

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release of Information

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Diversified Counseling and

**(Client Name)**

Consultation Services to release information contained in my record to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Name)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Client Name) (Name)**

to release information to Diversified Counseling and Consulting Services.

I understand that my consent to release information will include sending information to the specified recipients and will be limited to the information specified. I understand that this release may also permit the specified recipient to send and communicate information to DCCS.

If consent is provided, information will be released as follows:

1. Type of information to be disclosed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. This consent is subject to revocation at any time except to the exent that the program making the disclosure has already done so in reliance up on this release (i.e. no responsibility for information released prior to revocation). If consent is not revoked then this release will terminate on:
2. Event of 6 months after date of discharge from DCCS
3. Date and Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(or parent/guardian as identified)**

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIPAA Acknowledgement

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I have received notification of my

(print client name)

rights and responsibilities as described by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature/Parent or Guardian Date

Missed Appointment Fees

CO-PAYS, DEDUCTIBLES AND BALANCES ARE DUE PRIOR TO SERVICES BEING RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH THE ADMINISTRATIOR.

DCCS WILL BILL YOUR INSURANCE COMPANY FOR VISITS SEEN IN THIS OFFICE. BUT IT IS YOUR RESPONSIBILITY TO BE SURE THAT YOU ARE COVERED FOR ALL VISITS. DCCS PLLC, CAN NOT BILL INSURANCE COMPANIES FOR CANCELLED OR NO CALL NO SHOW APPOITMENTS THIS IS THE **CLIENTS SOLE RESPONSIBILTY** TO COVER THOSE CHARGES.

**1st CANCELLATION: NO CHARGE**

**2nd CANCELLATION: $50.00 CHARGE**

**3rd CANCELLATION: 80.00 CHARGE**

**\*\*Clients Must Fill out either the Credit Card form OR the Cash/Check forms. \*\***

Credit Card Form

Dear Patient,

You are required to provide your credit card information to DCCS’s billing department. This is to secure payment should you cancel your appointment, as stated in your “Consent for Treatment” document. As a reminder, each therapist works contractually, and therefore, does not get paid for their time should you cancel. Also, DCCS still has operating costs to keep the business open to meet your desired day and time for service.

Please be advised that your information is secure and confidential as mandated by **Michigan Law IDENTITY THEFT PROTECTON ACT 452 of 2004**.

**CARD HOLDER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CARD NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LAST 3 DIGITS ON THE BACK OF CARD: \_\_\_\_\_\_\_\_\_\_\_**

**ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **TODAY’S DATE** | **AMOUNT TO CHARGE** | **EXPIRATION DATE** |
| \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ |

Cash or Check Form

Dear Patient,

You are required to provide a cash or check deposit if you have not chosen to leave your credit card information with DCCS’s billing department. This is to secure payment should you cencel your appoint, as stated in your “Consent to Treatment” document. AS a reminder, each therapist works contractually, and thereforce does not get paid for their time should you cancel. Also, DCCS still has operating costs to keep the business opent ot meet your desired day and time for services.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have chosen not to leave my credit card on file with Diversified Counseling and Consulting Services. Instead, I will be paying in forward the $80.00 missed appointment fee, which will be reimbursed to me upon termination of services not utilized.

Cash in the amout of $80.00

Check in the amount of $80.00 made payable to DCCS. Check #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(or Parent/Guardian as identified)**

Clinician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Biopsychosocial Assessment – Adult (Age 18 and over)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this form is completed by somebody else, their name/relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Demographics**

**Ethnic Identification**

African American Caucasian Native American Hispanic

Latino Asian Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexual Identification**

Straight Gay/Lesbian Bisexual Other

**Gender Identity & Expression**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chief Compaint**

Why are you seeking treatemtn from DCCS:

Depression Anxiety Relationship problems

Homelessness Drug Problem  Domestic Violence/Abuse

Alcohol Problem Gambling Problem Job Problem

School Problem Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Presenting Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Constellation/Relationships**

**Marital Status**:

Single Married Partnered/Cohabitating Separated

Divorced Widowed Other

Who Lives or Stays with You?

Name Relationship Age Lives in Home Out of Home

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My relationships with my friends are:

Good Fair Poor

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I receive emotional support from friends/family

Yes No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a child, my relationship with my mother was:

Good Fair Poor

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a child, my relationship with my father was:

Good Fair Poor

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a child, my relationship with my friends were:

Good Fair Poor

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a significant friend or family member died within the last year?

Yes No

If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Mental Health**

Have any of your immediate family members had mental health problems (anxiety, depression, substance us, suicide, etc.)? Yes No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous relationships: Please list previous significant relationships (e.g., dissolved marriages, partnerships, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tools** Which of the following will help you in therapy?

Support from family (parents, children, others)

Support from spouse or significant other

Support from friends

Connection to self-help group (AA, NA, etc.)

Positive and supportive sponsor

Connection to church group or minister

Psychiatrist

Judge or probation officer

Employer

Permanent Residence

**Strengths:**

Motivated about treatment

Good interpersonal skills

Good emotion-management skills

Good reasoning and analytical skills

Recognizing my problems

Good self-esteem

Positive plans and goals for my future

Willingness to change

Good relationship with a higher power

Pleasurable things in life

Good work skills and experience

Education

**Needs:** What do you want from therapy?

Thorough understanding of problems

Improvement of interpersonal skills/relationships

Improvement of communication skills

Contact with supportive people

Emotion management skills

Anger management skills

Personal safety plan

Parenting skills

Education regarding my health

Relapse prevention

Coping skills

Referral to psychiatrist

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Personal History**

Have you been seen previously for treatment evaluation of psychological or psychiatric concerns?

Yes No

Check if applicable: Inpatient Residential Day Treatment/Partial Hospitalization

Outpatient Psychological Testing Substance Abuse Program Psychiatric Evaluation

Name of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor/Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problem Area/Diagnosis & Therapy Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was this helpful? Yes No

**Have you had (now or in the past):** Suicidal Thoughts Suicidal Plan Suicide Attempt(s)

Self-harm Behavior (cutting, etc.) Explosive Anger Homicidal Feelings No History

Therapist Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Abuse/Trauma:**

Where you ever the victim of:

Physical Abuse or Assault A life threatening event Sexual Abuse/Assault Neglect

Emotional or verbal abuse No history of abuse/neglect

Therapist Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Educational, Work, Military Service, Religion/Spirituality, Legal, Leisure**

**Education**

Are you currently enrolled in school/college/training? Yes No

If yes, Full-time Part-time

Highest grade you completed in school was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your school experience Good Fair Poor

Do you want to go back to school/training Yes No

List degrees, licenses, special training etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment:**

Current Employment

Full-time Part-time Unemployed Volunteer Work

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship with Coworkers: Good Fair Poor

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship with Supervisor: Good Fair Poor

Therapist Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Military**

Have you served in the Military? Yes No

If yes, which branch of service? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you in combat? Yes No

If applicable, please describe combat service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Honorable Discharge?Yes No

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Religion/Spirituality**

Presently active in religion/spirituality? Yes No

Do you have a spiritual or religious community that is important to you? Yes No

Are you satisfied with your religion/spirituality? Yes No

Therapist Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Legal**

Have you ever been arrested? Yes No

If yes, how many times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you (currently or in the past):

Had difficulty or contact with police?

Been convicted of a crime?

Been on probation?

No legal history

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Leisure Activities**

Please list your leisure activities (hobbies, activities used for stress relief, tasks you enjoy in your spare time): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you satisfied with these activities (e.g. frequency, enjoyment, etc.)? Yes No

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information**

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical/annual exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your health in general? ExcellentGoodFairPoorOther: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current on immunizations? Yes No

Are you pregnant? N/A Yes No

If yes, # of weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a/any miscarriage(s)? Yes No

Check any of the following that you have had or currently have:

Major accident/injury Blood pressure (high/low) Headaches Multiple Sclerosis

Hospitalization GI problems Hearing problem Parkinson’s Disease

Surgery Cancer Heart disease Speech/Language

Adverse med reaction Cerebral Palsy Hepatitis A, B, or C problem

Allergies Chronic fatigue Hypoglycemia Stroke

Anemia Dental problems Huntington’s Thyroid (hypo/hyper)

Angina Diabetes Kidney problems Ulcer

Arthritis Epilepsy Learning disability Vision problem

Asthma Fibromyalgia Liver problems Other (please list):

Birth defects Head trauma (loss of Lung disease

Bladder problems (consciousness YN) Menopause

Please provide additional detail about items checked above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any disabilities not noted thus far? Yes No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current prescribed and over the counter medications/supplements (if none check box )

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | Dosage | Prescribed By | Medication | Dosage | Prescribed By |
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If you listed any psychiatric medications above, do they seem to be helping?

No A little Moderately A lot

Please list any psychiatric medication you recall using in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychological Symptoms and History**

Please check any of the following that are currently bothering you:

Worrying too much Having to redo things or Food restriction

Feeling tense check things Problems with children

Feeling fearful Doing things very slowly to Difficulty making friends

Panic attacks make sure they are correct Withdrawing

Startle easily Unwanted thoughts Loneliness

Trauma/abuse Avoiding things I’m afraid of Work/school problems

Being scared for no reason Asking others for reassurance Financial problems

Worrying about what others Couples problems Sexual problems

think about me Family problems Infertility

Trouble concentrating Nightmares Hair-pulling

Memory problems Appetite change Skin-picking

Racing thoughts Self-injury Gambling

Procrastination Excessive spending Sexual addiction

Careless mistakes Impulsivity Internet addiction

Start but don’t finish tasks Hyperactivity Upset stomach

Irritability/easily annoyed Seeing/hearing things that Headaches

Sadness others don’t Chronic pain

Crying easily Feeling something is wrong Anger

Hopelessness with your mind Being violent

Worthlessness Feeling disoriented Homicidal thoughts

Low self-confidence Feeling high without being Other:

Feeling inferior on drugs

Low energy level Mood swings

Difficulty making decisions Feeling numb

Feeling confused Feelings easily hurt

Loss of interest/pleasure Difficulty controlling thoughts

Thoughts of suicide Difficulty controlling actions

Increased sleep Being suspicious of others

Decreased sleep Someone’s death

Problems falling asleep My weight **Please note: Substance use**

Problems staying asleep My eating **concerns are explored in detail**

Fatigue/feeling tired Purging **at the end of this packet.**

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Category of Substance | Current Use? | Ever Used? | Prescribed? | Amount & Frequency of us (e.g., 8 beers/day) | How often do you have a strong urge to use? (hourly, daily, etc.) | Use has led to problems (social, work, health, legal) | Don’t do what’s expected of me due to use | Others express concern about my use | Have tried to cut down or stop | Withdrawal symptoms? |
| Caffeine (coffee, soda, energy drinks, etc.) | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |
| Tobacco | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |
| Alcohol | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |
| Marijuana (pot, K2, salvia, etc.) | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |
| Hallucinogen (ecstasy, PCP, mushrooms, mescaline, DOM, ketamine/Special K, DMT, LSD, Robitussin, spices, etc.) | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |
| Inhalant (glues, fuels, paints, computer dusting spray, etc.) | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |
| Opioid (codeine, morphine, heroin, pain pills, oxycodone, Vicodin, etc.) | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |
| Anti-anxiety & sleeping medication (benzodiazepines such as Valium, Xanax, Klonopin, sleeping pills, such as Ambien, Sonata, etc.) | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |
| Stimulant (meth, cocaine, Ritalin, etc.) | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |
| Other (describe): | N  Y | N  Y | N  Y |  |  | N  Y | N  Y | N  Y | N  Y | N  Y |

\*\*\*\*\*\*\*\*\*\*\*\* END OF CLIENT PORTION \*\*\*\*\*\*\*\*\*\*\*\*



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Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_