CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION FOR CARE COORDINATION PURPOSES

Michigan Department of Health and Human Services

Providers or agencies receiving funding under the Violence Against Women Act, the Family Violence Prevention and Services Act, and the Victim of Crimes Act may not use this form. This form should be used with caution by other providers or organizations serving individuals with heightened safety and privacy concerns due to experiences with domestic violence, sexual assault, stalking, or other crimes. If use of this form is not appropriate, a separate consent form must be completed with the person or agency who provided services. (See FAQ at www.michigan.gov/bhconsent to determine if this restriction applies to you or your agency.)

First Name	Middle Initial	Last Name	Date of Birth	Zip Code	Individual's ID Number (e.g. Medicaid ID)

Under the Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code, a health care provider or agency can use and share most of your health information in order to provide you with treatment, coordinate your care, or receive payment for your care. However, your consent is needed to share other types of health information or for other reasons. You can give permission to share the following types of information with this form:

- Behavioral and mental health services (for reasons other than for treatment, payment, or coordination of care)
- Referrals and treatment for an alcohol or substance use disorder (e.g. drug test results, labs, claim history)

This information will be shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information. (See FAQ at www.michigan.gov/bhconsent).

SECTION 1: TO WHOM AND FROM WHOM

A. I consent to allow the following individuals and/or organizations to send and receive my information. (Please list the specific providers that may send or receive your information. You may include providers, third-party payers, family members, or other individuals and organizations.)

1. Region-10
2. CHR / I.M.P.A.C.T.
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

B. I consent for the following organizations that help transmit my information through electronic exchange of health information (e.g. Health Information Exchange, Health Information Organization, Health Information Network, etc.) to receive and re-disclose my health records.

1. Region-10
2. CHR/I.M.P.A.C.T.
3. ______
4. ______
5. ______
6. ______

C. By checking the box below, I consent to allow organizations that are listed under sub-section B to share my information with all of my past, current, and future treating providers who are members of the electronic exchange organization.

☐ All of my past, current, and future treating providers.

ADMINISTRATIVE USE ONLY

☐ Check this box if the individual has withdrawn their consent under Section 4. If this box is checked, behavioral health and substance use disorder information should not be shared with individuals and organizations that are listed on this form unless the sharing of this information is otherwise authorized under state and federal law.

SECTION 2: AMOUNT AND KIND

I consent to share:

☐ All of my behavioral health and substance use disorder information.

☐ All of my behavioral health and substance use disorder information except: (List types of health information you do not want to share below).

____

☐ Only the following records: (List types of health information you do not want to share below).

____

I understand that HIPAA and the Michigan Mental Health Code allows providers and other agencies to use and share much of my health information without my consent in order to provide me with treatment, receive payment for my care, and coordinate my care.

SECTION 3: OTHER IMPORTANT INFORMATION

By signing this form, I understand:

- I am giving consent to share my behavioral health and substance use disorder information as indicated in Sections 1 and 2. Behavioral health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.
- My information may be shared among each individual and organization listed in Section 1.
- My information will be shared to help diagnose, treat, manage, and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain treatment, payment for treatment, and health insurance or benefits.
- My health information may be shared electronically.
- Other types of my information may be shared with my behavioral health and substance use disorder information. HIPAA and the Michigan Mental Health Code allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and coordinate my care.
- This form allows me to choose to share my health information with past, current, and future treating providers under Sub-Section 1c. If I agree to share my health information in this way, I can request a list of all of the individuals and organizations who received my health information within the last two years. I must make this request to the organization(s) under Sub-Section B in writing. I can ask my provider for assistance if I am not sure how to contact the organization(s) under Sub-Section B.

- The sharing of my health information will follow state and federal laws and regulations.
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- I can withdraw or revoke my consent at any time. I understand that any information previously shared with or in reliance upon my consent cannot be taken back.
- I should tell all individuals and organizations listed on this form when I withdraw my consent.
- I can have a copy of this form.
- My consent will expire on the following date, event or condition unless I withdraw my consent. (If this field is left blank, the consent will expire 1 year from the signature date.)

Expiration Date, Event, or Condition:

____

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.			
Signature of person giving consent or legal representative			Date
Relationship to Individual			
☐ Self	☐ Parent	☐ Guardian	☐ Authorized Representative

SECTION 4: WITHDRAWAL OF CONSENT This section should only be completed if you are withdrawing consent to share your health information. I understand that any information already shared with or in reliance upon my consent cannot be taken back. I withdraw my consent to the sharing of my health information.			
Signature of person giving consent or legal representative			Date
Relationship to Individual			
☐ Self	☐ Parent	☐ Guardian	☐ Authorized Representative

VERBAL WITHDRAW OF CONSENT: This consent was verbally withdrawn.	
Signature of person giving consent or legal representative	Date
☐ Individual provided copy	☐ Individual declined copy

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations, 45 CFR Parts 160 and 164 as modified August 14, 2002, 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	

Veteran/Military Information

PLEASE CIRCLE 1 IN EACH CATEGORY

Veteran Status

Veteran Not a Veteran

Most Recent Military Service Era

WWII

Vietnam

Desert Storm

Post 9/11 (OIF/OEF/OND)

Peace Time Era

Not applicable for FY17 records summited in FY18

Not applicable-No Military Service

Branch Served In

Army

Army National Guard

Navy

Airforce

Air National Guard

Marines

Coast Guard

Not applicable for Fy17 records summited in Fy18

Not applicable-No Military Service

Family Military Service

Yes

No

Not applicable for FY17 records summited in FY18

Consumer/Family enrolled in/connected to VA/veteran resources/other Support & service organizations

Yes

No

Not applicable for FY17 record summited in FY18

EXHIBIT A

Region 10

SUBSTANCE USE DISORDER FINANCIAL INFORMATION AND PAYMENT AGREEMENT

The SUD Program Provider is a non-profit organization financed by consumer payments, funds from federal, state and local government and contributions. If you have insurance benefits, these sources must be billed in order to pay for part of the cost of the services you receive.

COMPLETION OF THIS FORM IS VOLUNTARY; however, if you choose to withhold the information requested, you will be responsible for paying the standard charge(s) for the service(s) you receive. The outpatient rate schedule is posted.

Program Name: ___________________________________

Consumer's Name	Case #	DOB:
Guarantor's (Responsible Party) Name:	Soc Security #	Relationship to Consumer:
Address:	DOB:	Telephone/Home:
City/State/Zip:		
Guarantor's Employer:		Telephone/Work:
Address:		
Name and age of dependents per Michigan Income Tax Return:		

INSURANCE INFORMATION We cannot bill your insurance company unless you provide Region 10 with your insurance information. (**Please attach a copy of your insurance card(s) front and back to this agreement**). All insurance benefits must be identified and used prior to using Medicaid benefits, as payer of last resort.			
Primary Insurance:		Policy/Contract Number:	
Name & DOB of Subscriber:		Group Number:	
Secondary Insurance:		Policy/Contract Number:	
Name & DOB of Subscriber:		Group Number:	
Tertiary Insurance:		Policy/Contract Number:	
Name & DOB of Subscriber:		Group Number:	

II.

☐ I certify that the above information is accurate, and I agree to notify Region 10 of any changes in this information during the course of my treatment.

☐ I authorize payment directly to Region 10 for any insurance benefits to which I am entitled and authorize the release of information needed to process insurance claims.

☐ I agree to endorse over to Region 10, within 10 business days, any insurance reimbursement checks that may be sent directly to me (subscriber). Failure to do so may result in me being charged the full cost of service and my account may be turned over to collections.

Copies of all insurance cards have been obtained and are attached: Yes ☐ No ☐

If not Medicaid eligible, proof of application and/or denial dated within the past 30 days has been provided:
Yes ☐ No ☐ Comments: ____

Consumers with current Medicaid, ABW, Healthy Michigan Plan or MI Child benefits will be assessed no fee for Substance Use Disorder services (Not to include Medicaid Spend Down, State Medical Program or Children's Special Health Care Services).

**Omit this box if consumer has already provided the necessary documents and proceed to section III.*

I do not have the needed document(s) to accurately assess my fee today. Failure to return the necessary documents needed to complete the fee assessment will result in monthly fee equal to full cost of all services provided. I will provide information within 14 days from the date signed below:

______________________________________ ____________________
Signature Date

III.

<u>Income (Michigan State Income Tax Return)</u>:

Copy of Michigan State Income Tax Return, W-2 or check stub(s), as well as unemployment income verification when applicable has been provided and is attached: Yes ☐ No ☐

If no, reason: ____

____

A) Consumer	$_____	Year: _____
B) Spouse	$ _____	Year: _____
C) Guarantor/Responsible Party	$ _____	Year: _____

Your assessed Ability to Pay for Substance Use Disorder services based upon your Michigan taxable income per the sliding fee scale (See page 4) is __________ per month, effective___________.

IV.

<u>Check as item is explained:</u>

☐ Payment is expected at the time of service. Failure to pay fees within 60 days from the date of service may result in the use of a collection agency/credit bureau or even result in the termination of services.

☐ A $20.00 processing fee will be charged for a non-sufficient funds check returned by the bank.

☐ If a Consumer/Responsible Party willfully fails to provide relevant insurance coverage information to the Substance Use Disorder services program or if a responsible party willfully fails to apply to have insurance benefits that cover the cost of services provided to the individual paid to Region 10, the responsible party's ability to pay shall be determined to include the amount of insurance benefits that would be available. If the amount of insurance benefits is not known, the responsible party's ability to pay shall be determined to be the full cost of services.

☐ An initial bill must be presented within 2 years from the date of service or the consumer/responsible party's financial obligation is waived. Statement balances owed may be provided monthly from Region 10.

My signature indicates that I have read and accept the assessed fee as noted on this binding agreement:

*Consumer/Guarantor (Responsible Party's) Signature	Date
Spouse's Signature (not required if spouse has no taxable income)	Date
Preparer's Signature	Date
Supervisor's Signature	Date

If you are not in agreement with the above assessed fee, you may request a "New Determination" (Full Financial Review). To do so, please notify your fee assessor that you would like request a New Determination and complete the "New Determination Request" form. Upon completing the new Determination Request form, you will be asked to submit proof of your assets and expenses within 30 days. If you fail to provide the necessary information within 30 days, you will be financially responsible for the above assessed fee.

My Signature below indicates that I am requesting a new determination of my assessed fee. I understand that my failure to provide the information necessary to complete the full financial review within 30 days will result in my financial responsibility of the above fee.

Consumer/Guarantor (responsible Party's) Signature	Date

The Center for Human Resources
Financial Policy and Agreement

Thank-you for choosing the Center for Human Resources as your service provider. We are committed to your treatment success. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

I agree to pay the established fee of ________ per session based on the rates listed below. I understand it is my responsibility to pay for services, CO-PAYS, OR DEDUCTABLES at the time of service (payment can be made directly or through an approved insurance carrier). I agree to pay or establish a payment plan for any portion of the treatment not covered by my insurance. I understand a sliding fee scale for services is available for individuals unable to cover the full cost for services.

Base Rate Schedule	
New Client Intake	$135.00
Individual Outpatient Session	$ 90.00
Family Outpatient Session	$ 90.00
Group Treatment Session	$ 27.00
General Assessments (substance abuse, ADHD, DLR)	$140.00
Psychiatric Assessments	$185.00
Medication Monitoring	$ 50.00

Regarding Insurance:

Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases, we file insurance claims as a courtesy to our patients. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company.) We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

CHECKS RETURNED FROM THE BANK

There will be a fee of $25.00 for each check returned from the bank due to non-sufficient funds, closed accounts, etc. You will be expected to bring in the full amount of the check plus the $25 **in cash.** Checks from you will no longer be accepted for payment to your account.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read, understand and agree with the above Financial Policy.

____ ____________________

Signature *Patient/ Responsible Party* *Date*

Authorizing Signatures.

I, ____, authorize the release of any information
Patient/ Responsible Party's Name
necessary to process medical claims and request payment of benefits to The Center for Human Resources, who accepts assignment of benefits.

____ ____________________

Signature *Patient/ Responsible Party* *Date*

A copy of this form must be given to Billing immediately after Intake

ADMISSION FORM IMPACT-CHR/LC3

Transaction Type: ○ **Start (A)** ○ **Update** ○ **End (D)** **Therapist's Name:**

Client Name: FIRST NAME LAST NAME	**Date of Birth:**	○ **Client** ○ **Co-Dependent**
Client SSN/ID:	**Medicaid ID #:**	
Is this a Medicaid Eligible client? ❍ Yes ❍ No	**Medicare ID #:** **MI Child ID #:**	
Admission Type: ❍ First Admission ❍ Re-Admission	**Agency Client ID#:**	
Admission Date (MM/DD/YYYY):	**Hispanic:** ○ **Yes** ○ **No (5)** **If Yes - #Below:**	

County of Residency:	**Referral Source: (i.e. DHS, MRS)**	**Service Category:** **Region 10 PIHP #: 2813624** **Outpatient - 11**
Sex: ❍ Male = 1 ❍ Female = 2	**Pregnant at Admission:** ❍Yes ❍No	**Military Service:** ❍Yes ❍ No

Current Employment Status:
01 = Employed; full-time (Competitive)
02 = Employed; part-time (Competitive)
03 = Unemployed (laid off, fired, seasonal, looking for work, etc.)
04 = Not in competitive labor force #____
98 = Not applicable to the person # ____
1:Disabled 2:Retired 3:SDA 4:SSI 5:SSDI

Education: 00-25 years (4 years of high school = 12 or GED) [ ]

Household Income: For all adults in the home [ ]

Number of hours in the past 2 weeks that the individual performed work/tasks specific to Employment Status: [ ]

Amount earned per hour in the past 2 weeks that the individual performed work/tasks specific to Employment Status: [ ]

Marital Status
01 = Never Married
02 = Married/Cohabitating
03 = Separated
04 = Divorced
05 = Widowed
97 = Not Collected

Are you a woman with dependent children? ❍ Yes ❍ No

Codependent Children? ❍Yes ❍ No

If yes, indicate the number of Dependent children: [ ]

Intellectually Disabled: ○ **Yes** ○ **No** ○ **Not Evaluated**
School Attendance Status/Education:
○ Yes = 1 ○ No = 2 ○ N/A = 6 ○ Not Collected = 7
Veteran Status: ○ Yes - Veteran = 1 ○ No - Not a Veteran = 2 ○ N/A = 6

Total Number of Dependents (+ You)
Dependent and living in the same home with you: [ ]

Race:
01 = Alaskan Native
02 = Native American
04 = African American/Black
05 = White
13 = Asian
20 =Other Single Race
21 = 2 or More Races
23 = Hawaiian / Pacific Islander
97 = Refused to Provide

Ethnicity:
1 = Puerto Rican
2 = Mexican
3 = Cuban
4 = Other Hispanic
5 = Not Hispanic
6 = Hispanic Origin Unknown
97 = Unknown or not specified

Priority Status:
0 = NA
1 = Pregnant IV Drug User
2 = Pregnant drug user
3 = IV Drug User
4 = Sub Ab Parents/Child at Risk
5 = Other

Living Arrangements:
01 = Homeless
02 = Dependent
03 = Independent

Arrest History	**Times Arrested, Last 30 Days**	**Times Arrested, Last 5 Years**
Total of All Arrests	______________	______________
Possession or Sale of Drugs/Alcohol	______________	______________
DUI / DWI	______________	______________

Corrections Related Status (please choose one):

01 = In prison 02 = In jail
03 = Paroled from Correction Facility
04 = Probation
05 = Tether
06 = Juvenile Detention Center
07 = Pre-Trial
08 = Pre-Sentencing or Pre-Distribution
09 = Post booking diversion
10 = Booking diversion
11 = Not under the jurisdiction of corrections or law-enforcement
97 = Not Collected at this co-located service
98 = Not Collected for this crisis only service

IMPACT – Clinical Services

Biopsychosocial Assessment Form

Client Name: Date of Birth: Today's Date:

Initial Identifying Information

1. Information was obtained from: Self: ☐ Family member/friend: ☐ (who): Name:
2. Primary spoken language: English ☐ Spanish ☐ Other:
3. Are any accommodations needed to complete this assessment: None ☐ List:
4. Please describe what brings you here today and your present concerns:

5. How long have these difficulties lasted? 30 days or less ☐ 1 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 5 years ☐ 5 years or more ☐

6. Please review the list below and check **all** of the symptoms you have experienced over the **past 90 days**:

(**None** = the symptomss were not present during this time. **Mild** = the symptoms have impacted my quality of life, but there is no significant impairment of day-to-day functioning. **Moderate** = there has been a significant impact on the quality of my life and/ day-to-day functioning. **Severe** = Profound negative impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed mood	☐	☐	☐	☐	Bingeing/purging	☐	☐	☐	☐	Guilt	☐	☐	☐	☐
Weight Problem	☐	☐	☐	☐	Laxative/diuretic abuse	☐	☐	☐	☐	Very elevated moods	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	Anorexia	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Agitation/irritability	☐	☐	☐	☐	Paranoid thoughts	☐	☐	☐	☐	Legal problems	☐	☐	☐	☐
Fatigue/low energy	☐	☐	☐	☐	Flashbacks	☐	☐	☐	☐	Medical problems	☐	☐	☐	☐
Nothing enjoyable	☐	☐	☐	☐	Racing thoughts	☐	☐	☐	☐	Medical treatment	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐	Delusions/False beliefs	☐	☐	☐	☐	Weight gain/loss	☐	☐	☐	☐
Thoughts of death	☐	☐	☐	☐	Hallucinations	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	Aggressive behaviors	☐	☐	☐	☐	Emotional trauma victim	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐	Behavioral problems	☐	☐	☐	☐	Physical trauma victim	☐	☐	☐	☐
Poor grooming	☐	☐	☐	☐	Uncontrolled crying	☐	☐	☐	☐	Sexual trauma victim	☐	☐	☐	☐
Suicidal thoughts	☐	☐	☐	☐	Self-mutilation (cutting)	☐	☐	☐	☐	Psychological pain	☐	☐	☐	☐
Suicide attempts	☐	☐	☐	☐	Extended Grief	☐	☐	☐	☐	Stomach Problems	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Panic attacks	☐	☐	☐	☐	Daily stress	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	Social isolation	☐	☐	☐	☐	Substance abuse	☐	☐	☐	☐
Compulsions	☐	☐	☐	☐	Generalized anxiety	☐	☐	☐	☐	Physical pain	☐	☐	☐	☐

7. At this time, do you require assistance or a referral to obtain any of the following services (**check all that apply**)? None ☐ Shelter ☐ Clothing ☐ Furniture ☐ Transportation ☐ Adaptive/Mobility Equipment ☐ Medical Equipment ☐ Personal Care Products ☐ Voter Registration ☐ Other ☐ Please List:

8. Do you require help linking or a referral to any of the following service organizations (**check all that apply**)? None ☐ Medical Services ☐ DHS ☐ Schools ☐ Social Security Administration ☐

Vocational Rehabilitation ☐ FIA ☐ Court System ☐ Legal Assistance ☐ Dental ☐
Immigration/Naturalization Service ☐ Religious or Spiritual Support ☐ Other ☐ Please List:

9. How have your current symptoms affected your level of functioning in any of the following areas?

	0=None	1=Mild	2=Moderate	3=Severe	N/A
Thinking and concentration	☐	☐	☐	☐	☐
Peer or family relationships	☐	☐	☐	☐	☐
Hobbies, interests, play, learning	☐	☐	☐	☐	☐
Activities of Daily Living	☐	☐	☐	☐	☐
Self-direction and self-control	☐	☐	☐	☐	☐
Personal hygiene or self-care	☐	☐	☐	☐	☐
School or work	☐	☐	☐	☐	☐
Accessing community services	☐	☐	☐	☐	☐
Language or speech	☐	☐	☐	☐	☐
Economic and self sufficiency	☐	☐	☐	☐	☐
Support from friends	☐	☐	☐	☐	☐

Mental Health and Substance Use History

10. Have you had prior outpatient or inpatient **mental health treatment**? Yes ☐ No ☐ (If yes please complete the questions below and list your most recent treatment events)

Provider's Name: Dates of service: from to
City State Zip Code
Reason for treatment:
Diagnosis (if known):

Provider's Name: Dates of service: from to
City State Zip Code
Reason for treatment:
Diagnosis (if known):

11. Have you had prior outpatient or inpatient **substance use disorder treatment**? Yes ☐ No ☐ (If yes please complete the questions below and list your most recent treatment events)

Provider's Name: Dates of service: from to
City State Zip Code
Reason for treatment:
Diagnosis (if known):

Provider's Name: Dates of service: from to
City State Zip Code
Reason for treatment:
Diagnosis (if known):

12. Has any family member received treatment for a mental health or substance use disorder? Yes ☐ No ☐
(If yes please describe):

13. Have you been prescribed a medication for your mental health or substance use disorder? Yes ☐ No ☐
(If yes please list all medications):

14. In the past, or currently have you used any alcohol or drugs? Yes ☐ No ☐ (If "No", skip to question 21)

15. In the past year, have you ever drank or used drugs more than you meant to? Yes ☐ No ☐

16. Have you ever felt you needed to cut down on your drinking or drug use in the last year? Yes ☐ No ☐

17. Has anyone objected or criticized your drinking or drug use? Yes ☐ No ☐

18. Have you ever used alcohol or drugs to relieve emotional discomfort such as sadness, anger, or boredom? Yes ☐ No ☐

19. Have you ever felt bad or guilty about your drug use? Yes ☐ No ☐

20. Have you ever used drugs first thing in the morning to steady your nerves or get rid of a hangover? Yes ☐ No ☐

21. List the drugs you have used in the past (more than a year ago) or that you currently (within the past year) use.

Substance Used	**Past**	**Current**
Alcohol	☐	☐
Amphetamines	☐	☐
Barbiturates	☐	☐
Benzodiazepine	☐	☐
Caffeine	☐	☐
Cocaine/Crack	☐	☐
Codeine	☐	☐
Hallucinogens	☐	☐
Marijuana	☐	☐
Inhalants	☐	☐
Opiates/Narcotic	☐	☐
Over The Counter Drugs	☐	☐
Psychotropic	☐	☐
Tobacco	☐	☐
Other:	☐	☐

Personal and Family Information

22. Are you currently involved in a significant relationship? Yes ☐ No ☐ If yes, how long?

23. Are you married? Yes ☐ No ☐ If yes, how long? Other marriages? Yes ☐ No ☐ #:

24. Please complete the following information regarding your immediate family:

	Present entire childhood	Present part of childhood	Not present at all	Family member's current marital status	Family member's current occupation	Check if member deceased	Current Relationship Status
Mother	☐	☐	☐			☐	
Father	☐	☐	☐			☐	
Stepmother	☐	☐	☐			☐	
Stepfather	☐	☐	☐			☐	
Sister /age:	☐	☐	☐			☐	
Sister /age:	☐	☐	☐			☐	
Brother /age:	☐	☐	☐			☐	
Brother/age:	☐	☐	☐			☐	
Other:	☐	☐	☐			☐	
Other:	☐	☐	☐			☐	

25. **If a female**, are you pregnant or suspect you may be pregnant? Yes ☐ No ☐ If yes, how long?

26. Do you have any children? Yes ☐ No ☐ If yes, how many? Please complete the brief table below.

Child(ren)'s Name	Date of Birth	Age	Sex	Residential Status (where?)	Special Concerns

27. What is your current living arrangement? Own home ☐ Rent ☐ With family ☐ With friends ☐ Foster care ☐ Halfway house ☐ Three quarter house ☐ Group Home ☐ Homeless ☐ Other:

28. Does faith or religion play a part in your life? Yes ☐ No ☐ If yes, are there any related questions you would like to express regarding your treatment with our agency?

29. Are there any cultural, ethnic, or language issues that influence your life and would affect your treatment with our agency? Yes ☐ No ☐ If yes, are there any related questions or special accommodations you require during your treatment with our agency?

Developmental and Childhood Information

30. During your childhood, did you experience any significant (other than normal) injuries, illnesses, or accidents that required special medical care or hospitalizations? Yes ☐ No ☐ If yes, please explain:

31. In your relationships, has there ever been: Verbal Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐ Neglect ☐ N/A ☐ Describe:

32. During school age (elementary or high school) did you experience any of the following difficulties (**check all that apply**): eating problems ☐ allergies ☐ sleep problems ☐ drug use ☐ alcohol abuse ☐ cigarette use ☐ extreme worry ☐ chronic lying ☐ hostile/angry mood ☐ self-harm ☐ stealing ☐ impulsive behavior ☐ violent temper ☐ easily distracted ☐ poor concentration ☐ hyperactivity ☐

often sad ☐ frequently tearfulness ☐ animal cruelty ☐ fire-setting ☐ assaults against others ☐
unusual daydreams ☐ ongoing conflicts with parents ☐ other ☐ Describe:

Education:

33. Highest level attended: Less than high school ☐ Completed high school, GED, or special education ☐ Some College ☐ Completed College ☐ Professional or Graduate School ☐

34. Are you currently in Training/Education? ☐ Yes ☐ No If yes: Trade School or Community College ☐ Four Year College ☐ Professional or Graduate School ☐ Other☐ Describe:

35. Have you ever had problems in school with the following? Expelled ☐ Suspended ☐ Poor Conduct ☐ Truancy ☐ Other ☐ None ☐ Explain:

36. How would you describe your school experience? Very Good ☐ Good ☐ Fair ☐ Poor ☐ Explain:

37. Are you interested in continuing your education? ☐ Yes ☐ No Explain:

Current Employment Status:

38. Please check off the item that best describes your current employment status:

☐ Employed full time (30 hours or more per week) competitively or self employed
☐ Employed part time (less than 30 hours per week) competitively or self employed
☐ Unemployed – looking for work, and/or on lay-off from job
☐ Not in the competitive labor force (homemaker, student age 18 and over, resident of an institution)
☐ Retired from work
☐ Sheltered workshop or work services participant in non-integrated setting
☐ **Not applicable to me (e.g., child under 18)**
☐ In supported employment only
☐ In supported employment and competitive employment

39. If employed, what is your occupation?

40. Earning less than $7.25 per hour at my current job: Yes ☐ No ☐ N/A ☐

Military:

41. Have you been involved in the military? Yes ☐ No ☐ If Yes, When did you serve?

42. Service Branch: Rank:

43. How would you describe your military experience? Very Good ☐ Good ☐ Fair ☐ Poor ☐

44. Discharge Status: Honorable ☐ Dishonorable ☐ Medical ☐ General ☐

45. Did you experience combat? Yes ☐ No ☐ Comments:

Current Stressors and Supports (strengths):

46. Please review the list below and check all of the items that current apply to you:

Living situation:
- ☐ housing adequate
- ☐ housing inadequate
- ☐ housing with family
- ☐ housing with friends
- ☐ living in a shelter
- ☐ homeless need assistance

Social support system:
- ☐ good support network
- ☐ a few friends - adequate
- ☐ no friends - problem
- ☐ good family support - adequate
- ☐ no family support - problem
- ☐ no support from others

Sexual Status:
- ☐ N/A or no sexual concerns or issues
- ☐ not sexually active
- ☐ sexually active with concerns
- ☐ would like help with this issue
- ☐ would like more information or a referral

Employment:
- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ can handle current job duties
- ☐ overwhelmed with duties
- ☐ coworker conflicts
- ☐ supervisor conflicts

Medical:
- ☐ I have a primary care physician
- ☐ no primary care physician
- ☐ date of last physical:
- ☐ no current medical problems
- ☐ current medical problems
- ☐ would like a medical referral

Recreation and Leisure Issues:
- ☐ no concerns regarding recreation or leisure activities
- ☐ concerns about recreational and social activities
- ☐ would like help improving my recreational activities
- ☐ would like referrals to recreational organizations
- ☐ currently engage in hobbies?

current activities:

Financial situation:
- ☐ no current financial problems
- ☐ current financial problems
- ☐ impulsive spending problems
- ☐ relationship conflicts over finances
- ☐ large indebtedness
- ☐ currently getting financial help
- ☐ would like a referral for help

Legal:
- ☐ no legal problems
- ☐ current legal problems
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court date pending
- ☐ sentencing pending
- ☐ incarceration pending

Spiritual Issues:
- ☐ no current religious concerns
- ☐ currently active in religious or spiritual activities
- ☐ formerly active in community spiritual activities
- ☐ would like to participate in spiritual activities?

General Comments:

47. Please let us know if there is any other information that would help us better serve you:

____ ________________

Client / Guardian's (parent) Signature Date

____ ________________

Staff's Signature Date

CONSENT FORM

THE CENTER FOR HUMAN RESOURCES

Consumer's Name:	Case #:

CONSENT FOR SERVICES

I am aware of the treatment process and voluntarily agree to receive services from The Center for Human Resources. I also understand that I may terminate services at any time for any reason (consumers under court order should review the order for consequences resulting from service termination). I understand that my social security number may be used as an identifying source, to be used solely for data reporting purposes.

I agree to treatment as offered by The Center for Human Resources for:

❑ Myself ❑ My Child ❑ The person for whom I am a legal guardian/custodian

CLIENT INFORMATION

1. I agree to call The Center for Human Resources in advance if I am unable to keep my scheduled appointment
2. I understand that I am not allowed to be on The Center for Human Resources premises under the influence of illicit drugs/alcohol.
3. I understand that I am not allowed to bring any items/weapons on The Center for Human Resources premises that would threaten or produce harm to staff, clients, friends and family members.
4. I have been informed that if I am Court ordered to attend counseling as part of my parole or probation program, my Court appointed officer (P.O.) will be notified by phone/mail **immediately** when I miss **<u>any scheduled</u>** individual, psychiatric or group session appointments. This may result in a violation of my probation/parole

EMERGENCY CARE, CONSENT, AND CONTACTS

I, ________________________________ authorize The Center for Human Resources to contact the individual and/or physician I have indicated below in the event I become incapacitated due to an emergency illness or accident while in treatment. I will assume the full responsibility of all incurred emergency treatment expenses.

Emergency Contact/Personal Representative		Primary Care Physician	
Name:	________________	Name:	________________
Address:	________________	Address:	________________
City, State, Zip:	________________	City, State, Zip:	________________
Home Phone:	________________	Phone:	________________
Work Phone:	________________		

CONSUMER RIGHTS INFORMATION

I received the brochure *Your Rights* and have had explained to me the agency's recipient rights policies. I understand I can contact a Recipient Rights Officer (985-8900) and seek their assistance. I understand that if I am not satisfied with services I am receiving, I can request a new therapist or request a referral to another treatment agency.

I understand that if I am not satisfied with the services that I have been offered, I may ask for a review by contacting Customer Services (1-888-225-4447). If I have Medicaid insurance, I can also ask for a review by a judge by calling 1-877-833-0870 or Customer Services and ask how to file for a Fair Hearing. I understand that there are specific timeframes for certain complaints, and I have received the Appeals Brochure to help me understand those timeframes. Customer Services can assist me with any appeal
I have received and understand the *Choices Brochure* that describes the *Person Centered Planning* process and understand that I can make decisions about the services I want and need.

The confidentiality of consumer records are protected under Federal Regulations governing confidentiality as defined by the Alcohol and Drug Abuse Records Act, CFR Part 2 and the regulations of the Michigan Department Community Health. I understand these records can not be disclosed without my written consent unless the release of such records is authorized through one of the following exceptions:

- The disclosure is allowed through a valid court order that complies with CFR Part 2
- There is evidence of child abuse or elder abuse
- There is a duty to warn a third party and the police because the consumer has a suicide plan or homicide plan
- The disclosure is made to medical personnel in a medical emergency.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND HAVE RECEIVED A COPY.

______________________	__________	______________________	__________
Consumer/Guardian Signature	Date	Staff Signature	Date

The Center for Human Resources

1001 Military Street Port Huron, MI 48060

Telephone #: 810-985-5168 Fax #: 800-248-1568

I, ______________________________________ with a birth date of _____/_____/______ and Social Security Number (last 4 only) of: XXX/XX/______ hereby authorize IMPACT / CHR, its Director or Designee to release or obtain information from the individual(s) or organization(s) listed below under the conditions that follow:

Name or title of persons or organizations which disclosure shall be made to or requested from:

			Legend
Region 10 PIHP - SUD Coordinating Agency	☐Release to ☐Obtain from	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7	1 = Medical
St Clair County Community Mental Health Authority	☐Release to ☐Obtain from	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7	2 = Legal
Parole/Probation Officer	☐Release to ☐Obtain from	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7	3 =Financial
Insurance Company - Name	☐Release to ☐Obtain from	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7	4 = Psychological
Physician	☐Release to ☐Obtain from	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7	5 = Substance Abuse History
Michigan Rehabilitation / Works	☐Release to ☐Obtain from	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7	6 = Attendance and Progress
Department of Health and Human Services / CPS	☐Release to ☐Obtain from	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7	7 = Not Available
Other	☐Release to ☐Obtain from	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7	

Specific information to be disclosed: **Any and all information related to authorization for financial reimbursement or the coordination of care.**

Purpose for Disclosure of Information: **To acquire authorization for services and to monitor program performance.**

I understand that my record(s) are protected under the federal privacy regulations governing confidentiality as defined by the Department of Mental Health and/or of Alcohol and Drug Abuse Patient records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in regulations. I understand that if the person or entity is not a "health care provider" that my information may be re-disclosed. I understand that I may refuse to sign this authorization and my refusal will NOT affect by ability to receive emergency treatment. I understand I may request and receive a copy of this authorization. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

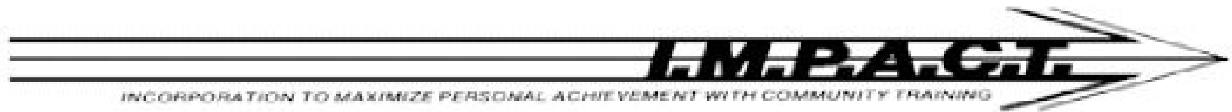
The date, event or condition of expiration: **one year from signature date or if revoked in writing by client.**

______________________________________ ______________

Signature of consumer, guardian, and/or parent of minor Date

______________________________________ ______________

Staff Signature Date



ACKNOWLEDGMENT OF THE RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

❑ I understand that as part of my healthcare, I.M.P.A.C.T. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

❑ I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the many health professionals who contribute to my care;
- a source of information for applying information to my bill;
- a means by which persons/agencies responsible for payment can verify that services billed were actually provided; and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

❑ I have received a copy of the *Notice of Privacy Practices for Protected Health Information* and have had full opportunity to read and consider the contents of the form.

Signature of Consumer/Guardian	Date
Relationship to Consumer/Guardian	Name of Consumer

Effective Date of Privacy Notice:

DRUG AND/OR ALCOHOL TESTING CONSENT FORM

AGREEMENT AND CONSENT TO DRUG AND/OR ALCOHOL TESTING

I hereby voluntarily agree and consent, to submit to scheduled and/or random "therapeutic" drug or alcohol testing and to furnish a sample of my urine and/or breathe for analysis as requested. I understand and agree that that the purpose of these tests is to promote my recovery, ensure my safety and health, and to improve the overall effectiveness of my treatment at IMPACT / The Center for Human Resources.

I also understand the results will only be used for treatment decisions within the clinic and the results will not be shared with any individual or agency without my specific consent.

I understand that only duly-authorized staff will have access to information obtained in connection with the tests; that the staff will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary within the clinic to make decisions regarding my treatment and progress.

I will hold harmless agency (IMPACT / CHR), its staff, and any laboratory that produces or interprets the tests results for therapeutic benefits. This means I will not sue or hold responsible such parties for any alleged harm to me that might result from such therapeutic alcohol or drug testing.

These alcohol or drug tests will not be used by the clinic for legal or criminal purposes and the results of the tests will be maintained in the confidential clinical records of the agency. As stated above, the results of the therapeutic alcohol or drug tests will only be released if I have given written consent to the release.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

I acknowledge I can withdraw this consent at any time for any reason. However, I also understand continued participation in a recovery program may require regular participation in alcohol or drug testing to promote my recovery and to protect my physical and psychological health.

____________________________________ ___________________

Signature of Client Date

____________________________________ ___________________

Signature of Witness Date

Outcome Questionnaire (OQ 45.2)

Instructions: Read each item carefully and circle the number under the category that best describes how you have been feeling over the last week. We are defining "work" as employment, school, housework, volunteer work, etc.

Name: ______________________ FMP/SSN: ______________________ Date: ______________________

	Never	Rarely	Sometimes	Frequently	Almost Always	SD	IR	SR
1. I get along well with others.	4	3	2	1	0			
2. I tire quickly.	0	1	2	3	4			
3. I feel no interest in things.	0	1	2	3	4			
4. I feel stressed at work/school.	0	1	2	3	4			
5. I blame myself for things.	0	1	2	3	4			
6. I feel irritated.	0	1	2	3	4			
7. I feel unhappy in my marriage/significant relationship.	0	1	2	3	4			
8. I have thoughts of ending my life.	0	1	2	3	4			
9. I feel weak.	0	1	2	3	4			
10. I feel fearful.	0	1	2	3	4			
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink mark "never")	0	1	2	3	4			
12. I find my work/school satisfying.	4	3	2	1	0			
13. I am a happy person.	4	3	2	1	0			
14. I work/study too much.	0	1	2	3	4			
15. I feel worthless.	0	1	2	3	4			
16. I am concerned about family troubles.	0	1	2	3	4			
17. I have an unfulfilling sex life.	0	1	2	3	4			
18. I feel lonely.	0	1	2	3	4			
19. I have frequent arguments.	0	1	2	3	4			
20. I feel loved and wanted.	4	3	2	1	0			
21. I enjoy my spare time.	4	3	2	1	0			
22. I have difficulty concentrating.	0	1	2	3	4			
23. I feel hopeless about the future.	0	1	2	3	4			
24. I like myself.	4	3	2	1	0			
25. Disturbing thoughts come into my mind that I can't get rid of.	0	1	2	3	4			
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable mark "never")	0	1	2	3	4			
27. I have an upset stomach.	0	1	2	3	4			
28. I am not working/studying as well as I used to.	0	1	2	3	4			
29. My heart pounds too much.	0	1	2	3	4			
30. I have trouble getting along with friends and close acquaintances.	0	1	2	3	4			
31. I am satisfied with my life.	4	3	2	1	0			
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	0	1	2	3	4			
33. I feel that something bad is going to happen.	0	1	2	3	4			
34. I have sore muscles.	0	1	2	3	4			
35. I feel afraid of open spaces or driving or being on buses, subways and so forth.	0	1	2	3	4			
36. I feel nervous.	0	1	2	3	4			
37. I feel my love relationships are full and complete.	4	3	2	1	0			
38. I feel that I am not doing well at work/school.	0	1	2	3	4			
39. I have too many disagreements at work/school.	0	1	2	3	4			
40. I feel something is wrong with my mind.	0	1	2	3	4			
41. I have trouble falling asleep or staying asleep.	0	1	2	3	4			
42. I feel blue.	0	1	2	3	4			
43. I am satisfied with my relationships with others.	4	3	2	1	0			
44. I feel angry enough at work/school to do something I may regret.	0	1	2	3	4			
45. I have headaches.	0	1	2	3	4			
					Subscale Totals			
Developed by Michael J. Lambert PhD and Gary M Burlinggame, PhD					TOTAL OQ45 Score:			

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Client Health History Questionnaire

It is important that you carefully complete every item on this health history questionnaire as thoroughly as possible for your provider to obtain a complete medical history.

Today's Date: ___________ Client's Name: ________________________________ Gender: **M** ☐ **F** ☐

Date of Birth: ________________ Social Security Number (last 4 only): ________

Primary Care (Family) Physician: ____________________________ Phone: ____________________

Name of Preferred Pharmacy: ______________________________ Phone: ____________________

Are you currently taking ANY kind of medication? (Include prescription, over-the-counter or herbal medications.)
Yes ☐ **No** ☐ If yes, please list below and include dosages. Please use separate sheet of paper if you need additional space.

Name of Medication	Dosage	How Often Taken

Are you ALLERGIC to any medications? **Yes** ☐ **No** ☐ If yes, please list below.

Name of Medication	Reaction

Are you ALLERGIC to anything in the environment such as pollens, dust, food, contrast dye, etc.? **Yes** ☐ No ☐
If yes, please indicate environmental allergen(s): ____
Are you allergic to latex? **Yes** ☐ **No** ☐ **Have you ever had an allergy test?** **Yes** ☐ No ☐

Have you ever been DIAGNOSED with any of the following conditions? (Please list the year of diagnosis.)

Cancer: (Type) ________________ Year ________

Ear: Infections **No** ☐ **Yes** ☐ Year ________
Hearing Loss **No** ☐ **Yes** ☐ Year ________
Dizziness **No** ☐ **Yes** ☐ Year ________

Nose and Sinus:
Nasal Allergies **No** ☐ **Yes** ☐ Year ________

Throat Condition: **No** ☐ **Yes** ☐ Year ________
Type ____________________________________

Heart and Blood Vessels:
Elevated Cholesterol **No** ☐ **Yes** ☐ Year ________
High Blood Pressure **No** ☐ **Yes** ☐ Year ________
Heart Valve Defect **No** ☐ **Yes** ☐ Year________

Blood and Lymph Nodes:
Anemia **No** ☐ **Yes** ☐ Year ________

Lungs and Respiratory:
Tuberculosis **No** ☐ **Yes** ☐ Year ________
Pneumonia **No** ☐ **Yes** ☐ Year ________

Stomach and Digestive:
Acid Reflux **No** ☐ **Yes** ☐ Year ________
Duodenal Ulcer **No** ☐ **Yes** ☐ Year ________
Stomach Ulcer **No** ☐ **Yes** ☐ Year ________

Kidney:
Renal Failure **No** ☐ **Yes** ☐ Year ________

Are You Currently Pregnant? **No** ☐ **Yes** ☐

Brain and Nervous System:
Stroke **No** ☐ **Yes** ☐ Year ________

Mental and Emotional:
Depression **No** ☐ **Yes** ☐ Year ________
Anxiety **No** ☐ **Yes** ☐ Year ________

Glands, Hormones and Blood Sugar Control:
Diabetes **No** ☐ **Yes** ☐ Year ________
Thyroid Disease **No** ☐ **Yes** ☐ Year ________

Allergies, Immune and Infectious Conditions:
Infectious Mononucleosis **No** ☐ **Yes** ☐ Year ________
HIV **No** ☐ **Yes** ☐ Year ________
Hepatitis B or C **No** ☐ **Yes** ☐ Year ________
Methicillin-Resistant
Staphylococcus Aureus **No** ☐ **Yes** ☐ Year ________
Other Drug-Resistant Infection **No** ☐ **Yes** ☐ Year ________
Type: ____________________________________

Other Conditions Previously Diagnosed:
____

MEDICATION SIDE EFFECTS, INPATIENT STAYS OR HOSPITALIZATIONS

Have you ever had any complications with PRESCRIBED medications? **No** ☐ **Yes** ☐
If yes, please list what sort of complications: ____

(Over)

Have you ever been hospitalized for a medical problem? **No** ☐ **Yes** ☐
If yes, list hospitalizations, the reason for, and dates of hospital admission: ____

____

Have you ever been hospitalized for a mental health or substance use problem? **No** ☐ **Yes** ☐
If yes, list list when and where: ____

FAMILY MEDICAL HISTORY (check all that apply)

Mental Health Problem: ______________________________
Mother ☐ Father ☐ Brother ☐ Sister ☐

Substance Use Problem: ______________________________
____
Mother ☐ Father ☐ Brother ☐ Sister ☐

Hearing Loss after age 20
Mother ☐ Father ☐ Brother ☐ Sister ☐

Nose and Sinus:
Nasal Allergies Mother ☐ Father ☐ Brother ☐ Sister ☐

Heart and Blood Vessels:
Heart Disease Mother ☐ Father ☐ Brother ☐ Sister ☐
High Blood Pressure Mother ☐ Father ☐ Brother ☐ Sister ☐

Lungs and Respiratory:
Athma Mother ☐ Father ☐ Brother ☐ Sister ☐
Lung Cancer Mother ☐ Father ☐ Brother ☐ Sister ☐
Tuberculosis Mother ☐ Father ☐ Brother ☐ Sister ☐

Brain and Nervous System:
Stroke Mother ☐ Father ☐ Brother ☐ Sister ☐

Blood and Lymph Node Conditions:
Bleeding/Clotting Problem
Mother ☐ Father ☐ Brother ☐ Sister ☐

Other: ______________________________
Mother ☐ Father ☐ Brother ☐ Sister ☐

SOCIAL HISTORY **Marital Status:** Single ☐ Married ☐ Divorced ☐ Widowed ☐
What is (or was) your occupation? ______________________________ **Check if you are retired** ☐
Have you ever used tobacco in any form? No ☐ **Yes** ☐

Type of Tobacco	From (Year)	To (Year)

Do you consume alcohol? No ☐ **Yes** ☐

Type of Alcohol	How Much	How Often

REVIEW OF CURRENT SYSTEMS: Mark Yes or No and CHECK any of the following you have recently had:

General Health Concerns **No** ☐ **Yes** ☐
Fever ☐ Sleeping Problems ☐ Unintentional Weight Loss ☐

Eye Problems **No** ☐ **Yes** ☐
Double Vision **No** ☐ **Yes** ☐
Itchy **No** ☐ **Yes** ☐

Ear Problems **No** ☐ **Yes** ☐
Ear Pain ☐ Ear Drainage ☐ Hearing Loss ☐ Dizziness ☐
Ringing ☐

Nose and Sinus Issues **No** ☐ **Yes** ☐
Chronic Congestion ☐ Hay Fever ☐ Sinus Drainage ☐
Sneezing ☐ Nose bleeds ☐

Mouth and Throat Problems **No** ☐ **Yes** ☐
Change in Voice ☐ Snoring ☐ Sore Throat ☐ Ulcers ☐
Difficulty Swallowing ☐

Heart or Circulation Issues **No** ☐ **Yes** ☐
Blacking Out or Fainting ☐ Chest Pain ☐ Leg Cramps ☐
Bluish Discoloration of Lips or Fingernails ☐
Irregular Heartbeat ☐ Swelling of Ankles ☐

Please provide childhood immunizations if under 18.

Lung or Respiratory Problems **No** ☐ **Yes** ☐
Frequent Nonproductive Cough ☐ Wheezing ☐
Frequent Productive Cough ☐ Shortness of Breath ☐

Stomach Conditions **No** ☐ **Yes** ☐
Abdominal Pain ☐ Diarrhea ☐ Heartburn ☐ Vomiting ☐

Musculoskeletal **No** ☐ **Yes** ☐
Neck Pain ☐ Other ☐ ______________________________

Brain or Nervous System Condition **No** ☐ **Yes** ☐
Numbness ☐ Seizures ☐ Severe Face Pain ☐ Weakness ☐

Problems with Glands or Hormones **No** ☐ **Yes** ☐
Increased Appetite ☐ Increased Fatigue ☐ Always Feel Cold ☐
Neck Has Enlarged ☐ Feel Warm When Others Do Not ☐
Undesired Weight Change ☐ Increased Appetite ☐
Increased Fatigue ☐

Problems with Blood or Lymph Nodes **No** ☐ **Yes** ☐
Bleeding Excessively After Injury ☐ Bruise Easily ☐

Problems with Allergies **No** ☐ **Yes** ☐
Food Intolerances ☐ Frequent Sneezing ☐ Hives ☐
Post Nasal Drainage ☐ Severe Reaction to Insect Bites ☐

Please list the main reason you are seeking services through The Center for Human Resources: ______________________________
____

The above information is accurate to the best of my knowledge. ______________________________
(Signature of Client/Legal Guardian)

The following section is to be completed by the Therapist

Substance Abuse History:

	Drug Code (Choose from list below)	Route of Admin. (Choose from list below)	Age at First Use	Frequency of Use when they were using (Choose from list below)	Initially a Prescription?
Primary Drug					○Yes ○ No ○ N/A
Secondary Drug					○Yes ○ No ○ N/A
Tertiary Drug					○Yes ○ No ○ N/A

Drug Codes

01 = None
02 = Alcohol
03 = Cocaine/Crack
04 = Marijuana/Hashish
05 = Heroin
06 = Methadone (Non-prescription)
07 = Synthetic and Other Opiates
08 = PCP
09 = Hallucinogens
10 = Methamphetamines
11 = Other Amphetamines
12 = Other Stimulants
13 = Benzodiazepine
14 = Other Tranquilizers
15 = Barbiturates
16 = Other Sedatives/Hypnotics
17 = Inhalants
18 = Over the Counter Medication
20 = Other Drugs

Route of Admin.

01 = Oral
02 = Smoking
03 = Inhalation/Intranasal
04 = Injection
20 = Other
96 = Not Applicable

Frequency of Use

01 = No Use in the Past Month
02 = Used 1-3 Days in Past Month
03 = Used 1-2 Days in Past Week
04 = Used 36 Days in Past Week
05 = Daily Use
96 = Not Applicable

Date of last substance use: ____ /____ /____

Has the client injected drugs in last 30 days? ○ No – 2 ○ Yes - 1

Attendance at Self-Help Programs (in past 30 days): ○ 01=No Attendance ○ 02= Less than 1 Times/week ○ 03= Once /week ○ 04=2-3 times/week ○ 05= At least 4 times/week ○ 98=Not collected

Integrated SUD & MH Treatment: ○ **Yes** ○ **No** **Primary ICD-10 Diagnosis:**

Other ICD-10 Diagnoses:

Service Start Date (MM/DD/YYYY): ___ / ___/ ___

Medication Assisted Treatment (Buprenorphine or Methadone): ○ Yes =1 ○ No = 2 ○ N/A

Number of Previous Substance Abuse Treatment Admissions (Anywhere, anytime):

Time Waiting to Enter Treatment (days since request made):
Explain delays in comments section.

Indication of Mental Health Issues (MI, SMI, SED)? ○ No – 2 ○ Yes - 1

SUD Disability Designation

○ **Yes** (self-report) ○ **No** SUD ○ Not evaluated for SUD
○ 1 or more SUD dx codes active or in partial remission within past year
○ 1 or more SUD dx codes with all SUD dx codes in full remission
○ Results from screening suggest SUD

Co-occuring Disorder/Integrated Substance Use and Mental Health Treatment:

○ Yes, client with co-occuring SUD/MH has integrated Tx plan.
○ No, client not co-occurring SUD/MH and no integrated Tx plan.
○ Client with co-occurring SUD/MH DOES NOT have integrated Tx plan.

Comments:

National Outcome Measures – Status Charts

Client Name: Date:

Please circle one item in each box to rate the client's current status.

Abstinence Status (any alcohol or illegal or non-prescribed medication)	
10	No use for the past 180 days or more
9	No use for the past 91 to 179 days
8	No use for the past 31 to 90 days
7	No use for the past 30 days
6	Occasional use of 1 use in the past month
5	Occasional use of 2 to 3 times in the past month
4	Regular use 1 to 2 times per week
3	Regular use 3 to 5 days per week
2	Regular daily use
1	Regular multiple uses every day

Mental Health Morbidity / Global Assessment of Functioning	
10	Superior functioning in a wide range of activities 91-100
9	Absent or minimal symptoms, good functioning in all areas 81-90
8	If symptoms are present they are transient and expectable reactions to psychosocial stresses 71-80
7	Some mild symptoms OR some difficulty in social, occupational, or school functioning 61-70
6	Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning 51-60
5	Serious symptoms OR any serious impairment in social, occupational, or school functioning 41-50
4	Some impairment in reality testing or communication OR major impairment in several areas 31-40
3	Behavior is considerably influenced by delusions or hallucinations OR inability to function in all areas 21-30
2	Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene 11-20
1	Persistent danger of severely hurting self or others OR persistent inability to maintain hygiene 1-10

Employment Status	
10	*Employed Full-Time (30 hours or more per week) or fully retired with social security and other benefits*
9	*Employed part-time (less than 30 hours per week)*
8	*Unemployed and actively looking for work*
7	*Unemployed because of a layoff and waiting to return to work*
6	*Unemployed and currently in a vocational training program*
5	*Participating in a workshop or day activity program*
4	*Not in the competitive workforce by choice (student, homemaker, etc.)*
3	*Unemployed and seeking permanent disability*
2	*Unemployed and on permanent disability*
1	*Unemployed and not seeking work*

Educational Status	
10	Completed college
9	Completed some college or vocational school
8	Completed high school or GED (or special education program)
7	Currently full-time student (academic or training program)
6	Currently part-time student (academic or training program)
5	Currently in special education program
4	Completed less than high school grade and no current academic interests
3	Completed less than 9th grade and no current academic interests
2	Completed less than 6th grade and no current academic interests
1	No formal education and no academic interest

Crime and Criminal Justice / Legal Status	
10	Never under the jurisdiction of any law enforcement program
9	Past but not under the current jurisdiction of any law enforcement program
8	Not on parole or probation but awaiting trial for a criminal offense
7	Not on parole or probation but awaiting sentencing for a criminal offense conviction
6	On parole or probation with no outstanding warrants or arrests – living independently
5	On parole or probation with no outstanding warrants or arrests – living in ½ or ¾ house
4	On parole or probation with 1 arrest or outstanding warrant within the past 90 days
3	On parole or probation with 2 to 3 arrests or outstanding warrants within the past 90 days
2	On parole or probation with 4 or more arrests or outstanding warrants within the past 90 days
1	Currently incarcerated in prison, jail, or detention center

Stability in Housing / Housing Status	
10	Residing independently in a house or apartment
9	Residing in a private residence with natural family or foster family
8	Residing in a specialized residential home or nursing facility
7	Residing in transitional housing and awaiting permanent housing (motel, hotel, etc.)
6	Existing housing unstable because of expected eviction within the next 90 days
5	Existing housing unstable because of expected eviction within the next 30 days
4	Unstable transient housing (staying with family or friends temporarily)
3	Residing in a prison, jail or detention center
2	Currently residing in a shelter for the homeless
1	Homeless on the street with no residential supports

Social Connectedness Status	
10	A stable, supportive social network with 4 or more family members or friends are consistently available
9	A stable, supportive social network with 2 to 3 family members or friends are consistently available
8	A stable, supportive social network with 1 family member or friend is consistently available
7	A moderately supportive social network of family or friends is frequently available (75%)
6	A mildly supportive social network of family or friends is frequently available (75%)
5	A moderately supportive social network of family or friends is available occasionally available (50%)
4	A mildly supportive social network of family or friends is available occasionally available (50%)
3	A moderately supportive social network of family or friends is available rarely available (25%)
2	A mildly supportive social network of family or friends is available rarely available (25%)
1	No supportive network is ever available (0%)

Perception of Care (for persons saved)	
10	Extremely satisfied with current services and supports
9	Very satisfied with the current services and supports
8	Satisfied with current services and supports
7	Somewhat satisfied with the current services and supports
6	Neutral satisfaction with the current services and supports
5	Somewhat dissatisfied with the current services and supports
4	Dissatisfied with the current services and supports
3	Very Dissatisfied the current services and supports
2	Extremely dissatisfied the current services and supports
1	Refused any further participation in services and supports

Staff Signature: ____