LEGACY COUNSELING
AND WORKFORCE CONNECTIONS

Patient Registration Form

PATIENT INFORMATION **If any information does not apply to you, please write "N/A" on the field. **

Last Name: _____ **First Name**: _____ **Middle Initial**: _____

Gender: ☐Male ☐Female ☐Non-binary ☐Transgender ☐Prefer not to say ☐Other: _____

Date of Birth: _____/_____/_____ **Social Security**: _____

Phone Number: (_____) _____ ☐Home ☐Cell ☐Work **Phone Number #2**: (_____) _____ ☐Home ☐Cell ☐Work

Email Address: _____

Address: _____ **Appt/Suite #**: _____ **Homeless**: ☐ No ☐Yes

City: _____ **State**: _____ **Zip Code**: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Engaged ☐Other: _____

Sexual Orientation: ☐Straight/Heterosexual ☐Lesbian/Gay/Homosexual ☐Bisexual ☐Other: _____

Ethnicity: _____ **Race:** _____ **Religion**: _____

Native American: ☐No ☐Yes **Veteran**: ☐No ☐Yes **Disability**: ☐No ☐Yes: _____

Employment Status: ☐Full-time ☐Part-time ☐Self-employed ☐Unemployed ☐Disabled ☐Retired

Highest Education: ☐Elementary/Middle ☐Some HS ☐HS Graduate/GED ☐Some College ☐College Graduate ☐N/A

INSURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance**: _____

Member Name: _____ **Member Name**: _____

Member ID/Policy: _____ **Member ID/Policy**: _____

Group Number: _____ **Group Number**: _____

EMERGENCY CONTACT ** An ROI will be required! OR please write "N/A" if we will NOT be contacting emergency contact. **

First Name, Last Name: _____ **Relationship to Patient**: _____

Phone Number: _____ **Email**: _____

Last Revised: August 15, 2025

Adults Patient's Rights

As the patient of a program for treatment of abuse of/or dependency upon alcohol or other drugs, your rights include, but are not limited to, the following:

1. If the program receives funds from the Substance Abuse Prevention and Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether or not you can afford to pay for it, and the program is prohibited from imposing any fee or contract, which would be a hardship for you or your family.

2. You have the right to be provided treatment appropriate to your needs.

3. If you are transferred to another treatment provider, you have the right to be given an explanation of the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.

4. You have the right to be informed of all program services, which may be of benefit to your treatment.

5. You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.

6. You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of staff involved in your treatment.

7. You have the right to be informed of our diagnosis, treatment plan and prognosis.

8. You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimated cost of treatment, and a description of the alternatives to treatment.

9. You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.

10. You have the right to examine your bill for treatment and to receive an explanation of the bill.

11. You have the right to be informed of the program's rules for your conduct at the facility.

12. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.

13. You have the right to receive respectful and considerate care.

14. You have the right to receive continuous care: To be informed of our appointments for treatment, the names of program staff available for treatment, and of any need for continuing care.

15. You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so.

16. You have the right to safe, healthful and comfortable accommodations.

17. You have the right to confidential treatment. This means that, other than exceptions defined by law, such as those in which public safety takes priority, without your explicit consent to do so the program may release no information about you, including confirmation or denial that you are a patient.

18. Waiver of any civil or other right protect by law cannot be required as a condition of program services.

19. You have the right to freedom from emotional, physical, intellectual, or sexual harassment or abuse.

20. You have the right to attend religious activities of your choice, including visitation from a spiritual counselor, to the extent that such activities do not conflict with program activities. The program shall make a reasonable accommodation to your chosen religious activities. Attendance at and participation in any religious activity is to be only on a voluntary basis.

21. You have the right to grieve actions and decisions of facility staff, which you believe are inappropriate, including but not limited to actions and decisions, which you believe violate your rights as patient. The facility is obligated to develop a grievance procedure for timely resolution of complaints from patients and to post such a procedure in a place where it shall be immediately available to you. You have the right to freedom from retaliation or other adverse consequence as the product of filling a grievance.

22. You gave the right to file a complaint with the State of Nevada if the facility's grievance procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution or other adverse consequences as the product of filing a complaint. Such complaints may be addressed in writing or by telephone to: Substance Abuse Prevention and Treatment Agency, 4126 Technology Way, 2nd Floor, Carson City, Nevada 89706. Phone: 1-775-684-4190.

23. You have the right to be informed of your rights as a patient. The foregoing are to be posted in the facility in a place where they are immediately available to you, and you are to be informed of these rights and given a listing of them as soon as is practically possible upon you beginning treatment.

ACKNOWLEDGMENT OF RECEIPT OF ADULTS PATIENT'S RIGHTS

I have read, understand, and have been provided a copy of the above Patient's Rights

_____ _____

Client Name (Print) Date

_____ _____

Client Signature Date

NOTICE OF PRIVACY

Effective: _____ Name: _____ Date of Birth: _____

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how tour provider may use and disclose tour PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 42 CFR Part 2, your provider is required to maintain the privacy of PHI and to provide you with notice of his or her legal duties and privacy practices with respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. New Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1966 (HIPAA), 45 CFR, Ports 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year after signing.

HOW YOUR PROVIDER MAY USE AND DICLOSE HEALTH INFORMATION ABOUT YOU

FOR TREATMENT: Your PHI may be used and disclosed by those who are involved in your care for the purposed of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization.

FOR PAYMENT: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only disclose the minimum amount of PHI necessary for purposes of collection will be disclosed.

FOR HEALTH CARE OPERATIONS: Your provider may use or disclose, as needed, your PHI in order to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided, we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be used to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

REQUIRED BY LAW: Under the law. Your provider must make disclosures of your PHI to you upon your request. In addition, disclosures must be made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.

WITHOUT AUTHORIZATION 42 C.F.R PART 2: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations.
- When there is a patient medical emergency
- Required by Court Order
- When there are communications from substance abuse, part 2, program personnel to law enforcement agencies or officials directly related to a patient's commission of a crime on the premises of the substance abuse program or against substance abuse program personnel, or to a threat to commit such a crime.
- When an individual determined by the substance abuse program to be qualifies to conduct an audit or evaluation of the program, or another lawful holder, is conducting an audit or assessment that encompasses record review
- When communications between a substance use program and a qualified service organization are needed by the qualifies service organization to provide services to the program.
- Necessary to prevent or lessen a serious an imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

VERBAL PERMISSION: Your provider may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Users and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider.

RIGHT OF ACCESS TO INSPECT AND COPY: In most cases, you have the right to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Your provider may charge a reasonable, cost-based fee for copies.

RIGHT TO AMEND: If you feel that the PHI your provider has about you is incorrect or incomplete, you may ask for it to be amended, although your provider is not required to agree to the amendment.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. Your provider is not required to agree to your request.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION: You have the right to request that your provider communicate with you about medical matters in a certain way or at a certain location.

RIGHT TO A COPY OF THIS NOTICE: You may ask your provider for a paper copy of this notice at any time

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with the federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the Federal Government, contact:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
(202)619-0257

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on wats my provider may use or disclose personal health information to provide service.

_____ _____
Client Name (Print) Date

_____ _____
Client Signature Date

_____ _____
Name and Relationship of person if other than client Date

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name: _____ Date of Birth: _____ Date: _____

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following a Mental Health Assessment, Evaluation, and a thorough discussion with me. (A Mental Health Assessment consists of an Initial Assessment with a therapist followed by an Evaluation with a Psych Services Provider, for a more thorough Assessment.) The goal of the Mental Health Assessment and Evaluation process is to determine the best course of treatment for me. Typically, Treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment.) I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentially can be broken under certain circumstances of danger to myself and others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentially and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations and discuss with your provider any questions or concerns you may have.

By my Signature below, I voluntarily request and consent to Behavioral Health Assessments, Evaluations, Care Treatment, or Services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment form, I acknowledge that I have both read and understand the terms and information contained herein. Ample opportunity has been offered to me to ask question and seek clarification of anything unclear to me.

ACKNOWLEDGMENT OF RECEIPT OF INORMED CONSENT FOR ASSESSMENT AND TREATMENT

_____	_____
Client Name (Print)	Date
_____	_____
Client Signature	Date
_____	_____
Name and Relationship of person if other than client	Date
_____	_____
Witness	Date

MEDICATION MANAGEMENT AGREEMENT FOR PSYCHIATRIC SERVICES

Psychiatric services are the provision of medical care under a Nevada licensed Medical Doctor, Doctor of Osteopathic Medicine, Certified Registered Nurse Practitioner of Physician Assistant for mental health diagnosis and the provision of medication for mental health diagnoses. Psychiatric prescribers have a broad clinical experience in treating children, adolescents, adults and geriatric patients using psychotropic medication.

Psychiatric prescribers working at Legacy Counseling and Workforce Connection ae credentialed by the Nevada Board of Nursing as a Psychiatric Mental Health Nurse Practitioner. The provider has received the required training and experience to provide excellent and competent care. By reviewing this document and signing the accompanying informed consent, the patient acknowledges in order to provide the best psychiatric care, there will be an agreement between patient and psychiatric mental health nurse practitioner. By reviewing and signing the document and the accompanying informed consent, the patient agrees to the following terms and conditions.

The main treatment goal in receiving prescription medications is to improve my overall function in life which includes ability to have and maintain interpersonal relationships, ability to work ability to care for self. In consideration of these goals, I agree to help myself by following a better health habit including but not limited to excising, following a health balanced diet and avoiding the use tobacco, alcohol, and illicit substances. Furthermore, it is our expectation that you will resume liability for not: following recommendations, participation in treatment in a cooperative and respectful manner, complying with treatment in a recommendation and/or failed/missed appointments. Clinicians reserve the right to terminate the relationship in the condition of this agreement are not adhered to.

As the patient I am responsible for my controlled substance medications. If the prescription medication is lost, stolen or if it needs refill sooner than prescribed, I understand it will NOT be replaced. Furthermore, I am responsible for safe storage of all my medication in a location that is safe for medication life as well as safe from the reach of children or other unauthorized person. The patient also agrees to not shared, trade or sell medications and understand failure to comply with this will result in immediate discharge from this office. In addition, the patient understands that driving a motor vehicle may not be allowed at times while taking a controlled substance or any medication that may cause drowsiness and it is your responsibility to comply with the laws of the state and I agree to not hold the prescribing provider responsible for not adhering to this.

As the patient I agree to not accept medication of the same class form any other physician/prescriber while I am receiving medication from this office. The patient will disclose to the best of their knowledge all the medications they are taking.

Refills of medication will only occur at the scheduled medication management appointments. Refills of medication will not occur over the phone unless otherwise arranged with your prescriber. In some cases, it may take up to 3 business days for prescriptions to be send to the pharmacy. Refills will not be authorized early because of vacations or personal plans. Psychotropic medications are prescribed to you because the medical provider has weighed that the benefits of treatment outweigh the risk associated with their use. Risk of the use of psychotropic medications include but are not limited to: side effects, adverse effects, black box warnings, extrapyramidal symptoms neuroleptic malignant syndrome, and serotonin syndrome. Education regarding your medications will be provided to you. In additions, it is strongly encouraged that you speak with you pharmacist about your medications.

If a medication in not covered by your insurance and preauthorization is required, this can take up to 14 days or longer for this to be processed.

ACKNOWLEDGMENT OF RECEIPT OF MEDICATION MANAGEMENT AGREEMENT FOR PSYCHIATRIC SERVICES

By signing this agreement, I as the Patient agree to comply with these terms & conditions set forth within this agreement.

_____ _____

Client Name (Print) Date

_____ _____

Client Signature Date

_____ _____

Name and Relationship of person if other than client Date

CLIENT GRIEVANCE REPORT AND PROCEDURE FORM

LEGACY COUNSELING AND WORKFORCE CONNECTIONS
6600 WEST CHARLESTON BLVD SUITE 111
LAS VEGAS, NV 89146

It is the policy of Legacy Counseling and Workforce Connections to treat all clients with fairness and professionalism and to strive for excellence in providing services to clients. Legacy Counseling and Workforce Connections' policy allows clients and their families or legal guardians to express problems or grievances related to the quality of services. If you feel you have been treated unfairly or unprofessionally, or your rights have been breached, the following procedure should be used.

The Legacy Counseling and Workforce Connections Grievance Procedure is designed to provide a means for those applying for Legacy Counseling and Workforce Connections services and clients receiving services to bring a grievance to the attention of Legacy Counseling and Workforce Connections and reach a speedy resolution. Legacy Counseling and Workforce Connections has a strict policy prohibiting retaliation against anyone who files a grievance. A grievance is any situation or condition a client thinks is unfair, unjust, or inequitable. In addition, if a client states they are being treated unfairly or unprofessionally, a grievance should be completed. Under this Client Grievance Procedure, you should submit a grievance in the following sequence; in-house as follow:

1) If you have a grievance, the concern can be discussed with a Legacy Counseling and Workforce Connections staff. If you decide to speak to a Legacy Counseling and Workforce Connections staff and an agreement cannot be reached, you should proceed to the next step of this grievance procedure.
2) You can file a grievance without discussion and proceed to the next step. Grievance forms can be found at the following:
   a) The lobby/front desk of Legacy Counseling and Workforce Connections site
   b) You can request the form from any Legacy Counseling and Workforce Connections staff
   c) Call (702)763-7443 ext. 8008 to request a form
3) If the matter has not been resolved satisfactorily, you may discuss your concerns with any supervisor without fearing reprisal.

Once notified in writing, Legacy Counseling and Workforce Connections will initiate an investigation withing three (3) business days and provide an acknowledgement to you within seven (7) business days.

Legacy Counseling and Workforce Connections will report the outcome of the complaint investigation to you within fourteen (14) business days of receiving the complaint. Suppose it has not been possible to gather the necessary information to lead to a resolution by fourteen (14) days; in that case, you will be notified and given a new date, up to thirty (30) days, by which a resolution or determination will be made. If, for any reason, you are unsatisfied with the results, you may contact Legacy Counseling and Workforce Connections. A supervisor not involved with the case will review the matter and respond to you in writing within ten (10) business days.

Level of Care will comply with all laws following the Medicaid Chapters 100 and 400 guidelines. You can also fill a grievance with:

State of Nevada Substance Abuse Prevention and Treatment Agency (SAPTA)
https://dpbh.nv.gov/Programs/ClinicalSAPTA/Home_-_SAPTA/

Division of Public and Behavioral Health (DPBH)
4150 Technology Way
Carson City, NV 89706
Phone: 775-684-4200 | Fax: 775-687-7570
Email: dpbh@health.nv.gov
Business Hours: 8 AM to 5 PM

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue
Washington, DC 20530
Hotline Number: 888-848-5306

_____ _____
Client Name (Print) Date

_____ _____
Client Signature Date

_____ _____
Witness Date

LCWC's MEDICAID INSURANCE LATE POLICY & PROCEDURES

1.) If a client is unable to attend an appointment at LCWC, the Client will need to give a 24-Hour Notice, for any Late Cancellations and Reschedules. No-Shows are subject to LCWC's Late Policy.

- For unforeseen circumstances such as being sick, car breaking down, etc., Client's appointments will be excused. Clients must inform LCWC Staff about any cancellations and/or reschedules of their appointments. Failure in doing so will be penalized with an immediate mark.
- No-Shows are subject to an immediate mark. Clients will be reached out to reschedule their No-Showed appointment. Clients that have repeating appointments, if the No-Showed Appointments continue, repeating appointments will be affected.

2.) For any Reschedules, No-Shows and late Cancellations, without any prior notification, will earn a mark. After the **THIRD** mark, clients are subject for potential discharge.

- Marks earned, will linger for a 90 Day Period.
- All marks will be expunged after the 90-Day Period. Clients that have services over 90 Days, marks will be expunged every Quarter.

3.) Clients that earn THREE marks within a 90-Day Period are subject to a potential discharge. Clients that are discharged will be referred out to another agency, if applicable. Clients that have separate parties, parties will be informed of the client's potential discharge.

By signing, I have read & understood the policy written above. I am responsible for any marks accumulated as well as any action taken because of those marks.

Signature: _____ Date: _____

**** IF NOT MEDICAID OR MEDICARE INSURED, PLEASE REVIEW AND SIGN THE REVERSE SIDE!! ** ---------->**

LCWC's COMMERCIAL INSURANCE & SLIDING FEE SCALE LATE POLICY & PROCEDURES

1.) If a client late Cancels, Reschedules or No-Shows their appointment, without any prior notification, the client is subject to a mark and will be charged a fee of $25.

- Any client that accumulates an outstanding balance of $100 or more, appointments will cease and no new appointments will be scheduled (emergencies excluded). Until the full accumulated balance has been paid off, no further appointments will be made.
- Legacy offers payment plans for clientele that have issues with paying off any accumulated balance for services provided (Contact Front End Staff).

2.) If a client is unable to attend an appointment at LCWC, the Client will need to give a 24-Hour Notice, for any Late Cancellations and Reschedules. No-Shows are subject to LCWC's Late Policy.

- For unforeseen circumstances such as being sick, car breaking down, etc., Client's appointments will be excused. Clients must inform LCWC Staff about any cancellations and/or reschedules of their appointments. Failure in doing so will be penalized with an immediate mark.
- No-Shows are subject to an immediate mark. Clients will be reached out to reschedule their No-Showed appointment. Clients that have repeating appointments, if the No-Showed Appointments continue, repeating appointments will be affected.

3.) For any Reschedules, No-Shows and late Cancellations, without any prior notification, will earn a mark. After the **THIRD** mark, clients are subject for potential discharge.

- Marks earned, will linger for a 90-Day Period.
- All marks will be expunged after the 90-Day Period. Clients that have services over 90 Days, marks will be expunged every Quarter.

4.) Clients that earn THREE marks within a 90-Day Period are subject to a potential discharge. Clients that are discharged will be referred out to another agency, if applicable. Clients that have separate parties, parties will be informed of the client's potential discharge.

By signing, I have read & understood the policy written above. I am responsible for any marks accumulated as well as any action taken because of those marks.

Signature: _____ Date: _____

**** IF NOT USING A COMMERCIAL INSURANCE OR UNDER A SLIDING FEE SCALE, PLEASE REVIEW AND SIGN THE REVERSE SIDE!! * ---------->**

CLIENT PSYCHOTHERAPY INTAKE FORM

Please provide the following information and answer the questions below. ***Please note: Information you provide here is protected as confidential information.***

****If any information does not apply to you or if you are unsure, please write "N/A" in the field. ****

GENERAL INFORMATION

Name: _____
(Last) (First) (Middle Initial)

Birth Date: ____/_____/_____ Gender: _____ Preferred Pronoun: _____

Nevada Resident? ☐ Yes ☐ No If yes, how long have you lived in Nevada? _____

Referred to our agency? ☐ Self ☐ Court Mandated ☐ Doctor ☐ Other: _____

Have you previously received any mental health services? ☐ Yes ☐ No
If yes, please answer the following:

Previous Therapist/Practitioner: _____ How Long: _____

Have you ever been prescribed Psychiatric Medications? ☐ Yes ☐ No
If yes, please list medication(s), and provide dates used:

_____

_____

PHYSICAL / MENTAL HEALTH INFORMATION

Last Physical Exam Date: _____

How would you rate your current physical health?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Explain: _____

Are you experiencing any of the following issues **(Please circle any that apply):**

☐ High Blood Pressure ☐ Diabetes ☐ HIV ☐ Cholesterol ☐ None

Are you experiencing any weight loss or gain? ☐ Yes ☐ No

Please list any specific health problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____ ☐ I don't exercise
What type(s) of exercises or physical activities do you participate in?

_____

Do you smoke cigarettes/vape? ☐ Yes ☐ No ***IF YES, FOR HOW LONG*** _____

HOW MANY CIGARETTES/VAPES DO YOU SMOKE PER DAY? _____

IF QUIT, PLEASE EXPLAIN: _____

How would you rate your current sleeping habits?
☐ Very Poor ☐ Poor ☐ Good ☐ Great **How many Hours do you sleep?** _____

If you feel that the amount or quality of your sleep is not good, briefly explain why you feel this way:

_____

If applicable, please list any difficulties you're experiencing with your appetite or eating patterns:

_____

Are you currently experiencing sadness, grief, or depression? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Have you ever contemplated or attempted suicide? ☐ Yes ☐ No

If yes, when was the last time: _____
If yes, please explain:

_____

_____

Have you recently or ever experienced any anxiety or panic attacks? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Do you drink alcohol more than once a week? ☐ Yes ☐ No ☐ I don't drink

If yes, what type of alcohol do you consume? _____

If yes, please explain how many times per week you consume alcohol: _____

If yes, when was your last DUI? If no DUI, write "N/A": _____

Do you use **ANY** form of cannabis in any form? ☐ Yes ☐ No

Are you currently experiencing any chronic pain? ☐ Yes ☐ No

If yes, where? _____ ***How long? (Daily/Weekly):*** _____

Do you gamble? ☐ Yes ☐ No Is gambling an issue? ☐ Yes ☐ No

Are you currently in a romantic relationship? ☐ Yes ☐ No **If yes, For How Long?** _____

On a Scale of 1 – 10, with 1 being very unhealthy, how would you rate your relationship? _____

FAMILY HISTORY

Please provide the names and ages of your birth, adoptive, foster parent, or primary caregivers.
Circle: Birth / Adoptive / Foster / Caregiver

_____
(Last) (First) (Middle Initial) (Age)

_____
(Last) (First) (Middle Initial) (Age)

Any sibling? ☐ Yes ☐ No Do you keep in touch with family? ☐ Yes ☐ No

IN THE SECTION BELOW, IDENTIFY AND CHECK FAMILY HISTORY THAT YOU ARE AWARE OF REGARDING THE CONDITIONS LISTED. PLEASE CHECK OFF ANY THAT APPLY TO THEM.

	Mother	Father	Sister	Brother	Aunt	Uncle	Grandmother	Grandfather
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Drugs	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Domestic Violence	☐	☐	☐	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Obsessive Compulsive Disorder (OCD)	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐	☐	☐	☐
Smoke/Vape	☐	☐	☐	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐	☐	☐	☐

ADDITIONAL INFORMATION

What is your highest educational level completed? _____

Have you ever been convicted of domestic violence? ☐ Yes ☐ No

Have you suffered a domestic violence offense? ☐ Yes ☐ No

If yes to any of the previous two questions, please explain:

_____

_____

Are you currently employed? ☐ Yes ☐ No

If yes or no, please explain:

_____

_____

Do you enjoy your work? ☐ Yes ☐ No

If no, why not? Please explain:

_____

Is there anything stressful about your current job or business? ☐ Yes ☐ No

If yes, please explain:

_____

Do you have any Spiritual or religious beliefs? ☐ Yes ☐ No

If yes, please explain:

_____

What do you consider to be some of your strengths (ex: patient)?

_____

What do you consider to be some of your weaknesses (ex: impatient)?

_____

GOALS

What would you like to accomplish from your time in therapy?

_____

_____

PATIENT HEALTH QUESTIONNAIRE AND GENERAL ANXIETY DISORDER (PHQ-9 AND GAD-7)

Over the ***Last 2 Weeks***, how often have you been bothered by any of the following problems?
Please check off your answers.

PHQ-9	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless.	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much.	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy.	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating.	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	☐ 0	☐ 1	☐ 2	☐ 3
ADD THE SCORE FOR EACH COLUMN				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? **(Check One)**

☐ **Not Difficult at all** ☐ **Somewhat Difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**

Over the ***Last 2 Weeks***, how often have you been bothered by any of the following problems?
Please Circle you answers.

GAD-7	Not at all sure	Several Days	Over half the days	Nearly Every Day
1. Feeling nervous, anxious, or on edge.	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control.	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things.	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing.	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still.	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable.	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen.	☐ 0	☐ 1	☐ 2	☐ 3
ADD THE SCORE FOR EACH COLUMN				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? **(Check One)**

☐ **Not Difficult at all** ☐ **Somewhat Difficult** ☐ **Very Difficult** ☐**Extremely Difficult**

ALCOHOL SCREENING QUESTIONNAIRE (USAUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz Beer  5 oz. Wine  1.5 oz liquor (One Shot)

1. How often do you have a drink containing alcohol?	Never ☐	Less than Monthly ☐	Monthly ☐	Weekly ☐	2-3 times a week ☐	4-6 times a week ☐	Daily ☐
2. How many drinks containing alcohol to you have on a typical day when you are drinking?	1 drink or None ☐	2 drinks ☐	3 drinks ☐	4 drinks ☐	5-6 Drinks ☐	7-8 drinks ☐	10+ drinks ☐
3. How often do you have "X" or more drinks on one occasion? ("X" being 5 for all men; 4 for women & men over the age of 65)	Never ☐	Less than Monthly ☐	Monthly ☐	Weekly ☐	2-3 times a week ☐	4-6 times a week ☐	Daily ☐
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never ☐	Less than Monthly ☐	Monthly ☐	Weekly ☐	Daily/almost Daily ☐		
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never ☐	Less than Monthly ☐	Monthly ☐	Weekly ☐	Daily/almost Daily ☐		
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavily drinking session?	Never ☐	Less than Monthly ☐	Monthly ☐	Weekly ☐	Daily or almost Daily ☐		
7. How often during the last year have you had feeling of guilt or remorse after drinking?	Never ☐	Less than Monthly ☐	Monthly ☐	Weekly ☐	Daily/almost Daily ☐		
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never ☐	Less than Monthly ☐	Monthly ☐	Weekly ☐	Daily/almost Daily ☐		
9. Have you or someone else been injured because of your drinking?	No ☐		Yes, but not in the past year ☐		Yes, In the past year ☐		
10. Has a relative, friend, doctor, or other Health care worker been concerned about your drinking or suggested you cut down?	No ☐		Yes, but not in the past year ☐		Yes, In the past year ☐		
	0	1	2	3	4	5	6

Have you ever been in treatment for alcohol use? (**Check One**) ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-7	8-15	16-19	20+
Or age >65:	0-6	7-15	16-19	20+

DRUG SCREENING QUESTIONNAIRE (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Check any that apply to you:

☐ Methamphetamines (Speed, Crystal)
☐ Cannabis (marijuana, pot)
☐ Inhalants (paint thinner, aerosol, glue)
☐ Tranquilizers (valium)
☐ Cocaine
☐ Narcotics (heroin, oxycodone, methadone, etc.)
☐ Hallucinogens (LSD, mushrooms)
☐ Other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost Daily

1. Have you used drugs other than those required for medical reasons?	☐ No	☐ Yes
2. Do you abuse more than one drug at a time?	☐ No	☐ Yes
3. Are you always able to stop using drugs when you want to?	☐ No	☐ Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	☐ No	☐ Yes
5. Do you ever feel bad or guilty about your drug use?	☐ No	☐ Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	☐ No	☐ Yes
7. Have you neglected your family because of your use of drugs?	☐ No	☐ Yes
8. Have you engaged in illegal activities in order to obtain drugs?	☐ No	☐ Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐ No	☐ Yes
10. Have you had medical problems as a result of your drug use (Ex: memory loss, hepatitis, convulsions, bleeding)?	☐ No	☐ Yes

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

Name: _____

ID#: _____ DOB: _____

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score

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

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

2. Did a parent or other adult in the household often…
   Push, grab, slap, or throw something at you?
   OR
   Hit you so hard that you had marks or were injured? ☐Yes ☐No

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

4. Did you often feel that…
   No one in your family loved you or thought you were important/special?
   OR
   Your family didn't look out/feel close/support for each other? ☐Yes ☐No

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

6. Were your parents ever separated or divorced? ☐Yes ☐No
7. Was your mother or stepmother…
   Often pushed, grab, slapped, or had something thrown at her?
   OR
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   OR
   Ever repeatedly hit over at least a few minutes or threated with a gun or knife? ☐Yes ☐No
8. Did you live with anyone who was a problem drinker or used street drugs? ☐Yes ☐No
9. Was a household member depressed, mentally ill, or attempted suicide? ☐Yes ☐No
10. Did a household member go to prison? ☐Yes ☐No

YOUR ACE SCORE: _____