Consumer Name _____

Identifier _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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Consumer Orientation Checklist

Name: _____ ☐ MH ☐ SA

☐ Transfer of Services / Consent for Treatment Form

☐ Right to Name Treatment Advocate

☐ Consent for Release of Confidential Information

☐ Consumer Handbook and Acknowledgement of Receipt

☐ Bio-Psychosocial Assessment

☐ Hope Revealed Behavioral Health Center Pamphlet

☐ If substance abuse diagnosis then ASAM and AOD CM Form

Has Consumer been educated about the availability of an Advance Directive? ☐ Yes ☐ No

Did the Consumer utilize the Advance Directive? ☐ Yes ☐ No

Is Hope Revealed collaborating with another agency or LBHP provider regarding this consumer?
☐ Yes ☐ No
If Yes, who? _____

After your intake is completed, we will develop a treatment plan using the information you give us about your preferences and needs. Your therapist will go over this plan with you, including the discharge criteria, when it is ready to sign.

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for all benefits, for services rendered and for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

SIGNATURE: _____ DATE: _____

GUARDIAN: _____ DATE: _____

WITNESS: _____ DATE: _____

Consumer Name _____

Identifier _____

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Consent for Release of Confidential Information

Name_____ DOB_____ SSN_____

I, _____ authorize Hope Revealed Behavioral Health Center, Inc., and the following agencies, entities, or people to release and disclose to one another the following types of information:

Information released or disclosed will be used to coordinate, evaluate, plan and/or continue appropriate treatment or program, determine eligibility for benefits or program, case review, and/or update files. Released information may be subject to re-disclosure by the recipient, resulting in the information no longer being protected.

This consent is valid from:(One year period) start date:_____ end date:_____

Name and address of agency, entity, or person to release to or obtain information from:

❑DHS ❑ OJA ❑Doctor ❑Family ❑School ❑Redwood Toxicology Lab ❑Other: _____

Type of document(s) to be released or obtained:

❑Behavioral Information ❑ Psychological reports and results ❑ Medical Reports ❑Treatment Plans ❑Test Results ❑Summary Reports

I understand my medical records and all clinical information are confidential and are protected under the provisions of 43A OS & 1-109. I understand medical records and all communications between consumer and doctor or psychotherapist are privileged and confidential; with such information limited to persons or agencies actively engaged in my treatment or related to administrative tasks. I understand privileged and confidential information shall not be released without my written, informed consent. I understand that treatment is not contingent upon or influenced by my decision to permit this information release. My consent is given freely and voluntarily. **The information authorized for release may include records, which may indicate the presence of a communicable or non communicable disease, or venereal disease, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). (63 O.S. sec. 1-1502(B)). If any criminal proceeding is involved, disclosure is bound by federal laws and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C. #290DD-2; 42 C.F.R., Part 2) and recipients of the information may receive and disclose it only in connection with their official duties with respect to the particular criminal proceeding and may not use the information in other proceedings, for other purposes, or with respect to other individuals.** I understand that I may revoke this consent in writing at any time by signing and dating the revocation line at the bottom of this page, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year following the date I stopped receiving services from QUEST. Revocation must be submitted to the Antlers office. However, if any criminal proceeding is involved, this consent is irrevocable until final disposition of the proceeding, and expires upon final disposition of the proceeding.

Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Legally authorized Representative:_____ Date:_____

I hereby revoke this consent:_____ Date:_____

Witness Signature:_____ Date:_____

Consumer Name _____

Identifier _____

HOPE REVEALED

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Consent for Treatment

Application is hereby made by the undersigned for voluntary admission to the services of Hope Revealed Behavioral Health Center, Inc., as a voluntary consumer under the provision of OS 43A Section 9-101.

I certify that I am eighteen (18) years of age of over. Voluntary admission may be made for any person eighteen (18) years of age or over on his/her own signature. Any person at least sixteen (16) years of age may be admitted with the consent of such person and the consent of the person's parent or guardian, OS 43A 5-304.

I have read, or had read to me, the following information about my rights.

All persons receiving services from this facility shall retain the rights, benefits, and privileges guaranteed by the laws and constitutions of the State of Oklahoma and the United States of America, except those specifically lost through due process of law. OS 43A, Section 1-103(h).

All persons shall have the rights guaranteed by the Substance Abuse Consumer's Bill of Rights, unless an exception is specially authorized to these standards or an order of a court of competent jurisdiction.

I have been given a summary or full copy of my rights as a consumer and fully understand the content of this document.

I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate services delivered.

I understand that OS 43A, Section 4-201 requires that each consumer of the agency be charged for care and treatment provided. An individual will not be refused needed treatment because of inability to pay, OS 43A, Section 4-202.

Date of Birth: _____ Social Security: _____ ☐Male ☐Female Race: ☐White

Address: _____ County: _____ ☐Black/African American

City, State, Zip: _____ ☐American Indian

Referred by: _____ ☐Asian

Parent, Self, Other

Guardian Name: _____ ☐Native Hawaiian/Pacific Islander

Guardian Phone number: _____ Relationship to Consumer: _____ Ethnicity:

☐Hispanic/Latino

Name and credentials of clinician(s) that will be providing services: _____

I, _____, wish to transfer counseling services from all other mental health agencies to Hope Revealed Behavioral Health Center, LLC.

_____ _____

Signature of Consumer Date

_____ _____

Signature and printed name of Parent or Guardian if Consumer is under 18 Date

_____ _____

Signature of Witness (Clinician) Date

Consumer Name _____

Identifier _____

HOPE REVEALED

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Right to Name a Treatment Advocate

All adult mental health consumers being served by a licensed mental health professional have the right to designate a family member or other concerned individual as a Treatment Advocate. The choice to name an advocate is the consumer's alone. In the event an advocate is chosen, the level of involvement of the advocate is to be determined by the consumer and no limitation may be imposed on a consumer's right to communicate by phone, mail or visitation with the established Treatment Advocate. The Treatment Advocate may participate in the treatment planning and discharge planning of the person being served to the extent consented to by the consumer and permitted by law.

Would you like to name a Treatment Advocate? ☐ Yes ☐ No

Please list the name and phone number of the person you wish to choose as a Treatment Advocate:

Name: _____ Phone: _____

Please indicate the level of involvement the identified Treatment Advocate shall have:

☐ Should the advocate be present during intake?

☐ Would you like the advocate to help you with the treatment planning?

☐ Do you want the written treatment plan information provided to the advocate?

☐ Should we notify the advocate only if there are changes to the treatment plan?

☐ Would you like the advocate to be present at all of your sessions?

☐ Other: _____

_____ _____

Signature of Consumer Date

For the Treatment Advocate:
I intend to serve as Treatment Advocate for the above named consumer. I have received a copy of the Hope revealed Behavioral Health Center confidentiality standards and I agree to serve according to the consumer's specifications and comply with all standards of confidentiality.

_____ _____

Signature of Treatment Advocate Date

The consumer may revoke the designation of a treatment advocate at any time and for any reason.

Signature of person entering this form in consumer chart: _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime
☐	Actual suicide attempt	☐
☐	Interrupted attempt	☐
☐	Aborted or Self-Interrupted attempt	☐
☐	Other preparatory acts to kill self	☐
☐	Self-injurious behavior ***without*** suicidal intent	☐

Suicidal Ideation Check Most Severe in Past Month	
☐	Wish to be dead
☐	Suicidal thoughts
☐	Suicidal thoughts with method (but without specific plan or intent to act)
☐	Suicidal intent (without specific plan)
☐	Suicidal intent with specific plan

Activating Events (Recent)	
☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)
Describe:	
☐	Pending incarceration or homelessness
☐	Current or pending isolation or feeling alone

Treatment History	
☐	Previous psychiatric diagnoses and treatments
☐	Hopeless or dissatisfied with treatment
☐	Non-compliant with treatment
☐	Not receiving treatment

Other Risk Factors	
☐	
☐	
☐	

Clinical Status (Recent)	
☐	Hopelessness
☐	Major depressive episode
☐	Mixed affective episode (e.g. Bipolar)
☐	Command hallucinations to hurt self
☐	Highly impulsive behavior
☐	Substance abuse or dependence
☐	Agitation or severe anxiety
☐	Perceived burden on family or others
☐	Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Homicidal ideation
☐	Aggressive behavior towards others
☐	Method for suicide available (gun, pills, etc.)
☐	Refuses or feels unable to agree to safety plan
☐	Sexual abuse (lifetime)
☐	Family history of suicide (lifetime)

Protective Factors (Recent)	
☐	Identifies reasons for living
☐	Responsibility to family or others; living with family
☐	Supportive social network or family
☐	Fear of death or dying due to pain and suffering
☐	Belief that suicide is immoral; high spirituality
☐	Engaged in work or school

Other Protective Factors	
☐	
☐	
☐	

Describe any suicidal, self-injurious or aggressive behavior (include dates)

Consumer Name _____

Identifier _____

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CASE MANAGEMENT ASSESSMENT

Name:_____ **Address:**_____

Phone Number:_____

A. Daily Structures/Activities of Daily Living:

Living situation (circle all the apply) None/Homeless Shelter Permanent House/Apartment Temporary House/Apartment Jail Residential Program Doubled Up Subsidized Other_____

Who do you live with (circle all that apply) Alone Friends/Roommate(s) Spouse/Lover/Partner Children Parents Relatives Other_____

Do you pay rent? Yes No If so, how much?_____ Is it affordable? Yes No

Is your housing situation safe and stable? Yes No Any housing concerns?

_____

Nutritional Needs:

Obtaining enough food to eat? Yes No Any food assistance utilized? Yes No

What kind? Food Stamps Food Pantry Home Delivered Congregate Food Voucher Other__

Any nutritional concerns?

_____

Daily Living:

Do you need help with any daily living needs? _____

Clothing: Do you have appropriate clothing for the season? Yes No Any clothing concerns?

_____

B. Financial/Insurance/Legal Issues (Probation, fines, etc.):

Are you employed? Yes No If so, how much are you working? Full-Time Part-Time Seasonal

Consumer Name _____

Identifier _____

Monthly income-work_____ Other income (SSI, SSDI, Unemployment, etc.)_____

Total Household Income _____ Are you using any financial resources? Yes No

If so, which ones? SSI SSDI Unemployment TANF Food Stamps Other_____

Do you have medical insurance? Yes No Any financial or medical concerns?_____

Do you have any legal issues? (Examples: arrests, incarcerations, probation, parole, fines) Yes No

If yes, explain_____

C. Educational/Vocational

Educational/Vocational History

_____

Are in interested in going back? Yes No Any educational concerns?

_____

D. Social Supports/Family/Friends

Family Make-Up

_____

E. Mental Health/Substance Abuse/Addiction Disorders

Do you take any medications? Yes No If so, any side effects with these medications? Yes No

Do you take you medications as prescribed? Yes No

Do you smoke or use other tobacco products? Yes No If so, interested in stopping? Yes No

Do you or someone in your family feel that you have a problem with substance abuse or another addiction? Yes No Any mental health/substance abuse/addiction disorders concerns?

_____

F. Health/Medical:

Do you have a current doctor? Yes No Do you have a current dentist? Yes No

Do you see them on a regular basis? Yes No Do you have any current health issues? Yes No

If yes, please explain_____

When was your last physical/check-up_____

Well woman/mammogram_____ Prostate_____

Consumer Name _____

Identifier _____

Are you or your partner pregnant? Yes No If so, are you/they receiving prenatal care? Yes No

Do your children need a check-up or immunizations? Yes No

Any health/medical concerns?_____

What would you like to work on?_____

Case Manager Signature_____ Date_____

Consumer Signature_____ Date_____

Consumer Name:_____

Identifier:_____

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Brief Health Information Form

A. Identification

Client's name:_____Case #:_____Date:_____

B. History

1. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical con-dition you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List all medications, drugs, or other substances you take or have taken in the last year–prescribed, over-the-counter vitamins, herbs, and others.

Medication/drug	Dose (how much)	Taken for	Prescribed and supervised by

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

Consumer Name _____

Identifier _____

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get?

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? Which?

3. Do you try to restrict your eating in any way?
How?

Why?

4. Do you have any problems getting enough sleep? ☐ No ☐ Yes. If yes, what problems?

E. For women only

At what age did you start to menstruate (get your period): _____

1. Menstrual period experiences:

a. How regular are they?

b. How long do they last?

c. How much pain do you have?

d. How heavy are your periods?

e. Other experiences during periods?

Consumer Name _____

Identifier _____

2. Please list all of your pregnancies: What happened with this pregnancy?

Your age Miscarriage Abortion Child born Problems?

_____

_____

_____

_____

3. Menopause:

a. If your menopause has started, at what age did it start? _____

b. What signs or symptoms have you had?

_____

_____

_____

_____

F. Other

Do you use tobacco ☐ No ☐ Yes. If yes, how many cigarettes/cigars/other do you use each day? _____

Have you ever injected drugs? ☐ Yes ☐ No Ever shared needles? ☐ Yes ☐ No Have you had HIV testing in the last 6 months? ☐ Yes ☐ No. If yes, results: _____ Are there any other medical or physical problems you are concerned about?

_____

_____

_____

Would you like to receive more information regarding HIV/AIDS/STDs? ☐ Yes ☐ No.

Consumer Name _____

Identifier _____

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Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ☐ I have no problem or concern bringing me here
- ☐ Abuse–physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use–prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems–overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income

Consumer Name _____

Identifier _____

- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Housework/chores–quality, schedules, sharing duties
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Pain, chronic
- ☐ Panic or anxiety attacks
- ☐ Parenting, child management, single parenthood
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems (with friends, with relatives, or at work)
- ☐ School problems (see also "Career concerns ...")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care

Consumer Name _____

Identifier _____

- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- ❑ Other concerns or issues:

_____

_____

_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

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Dear Client,

Would you please help us to improve our work by answering some questions? We are interested in your honest opinions (whether they are positive or negative), and we welcome your comments and suggestions.

All your answers are completely confidential because your name will not be used on this form. To ensure confidentiality, please do not write your name on this survey. None of your responses will be included in your treatment records. Completing this survey will be regarded as giving your informed consent to participate in the survey. You can choose to withdraw from this research at any time and refuse to answer any questions. Doing this will not affect the care you receive in the future from us. If answering any of these questions makes you feel uncomfortable, please skip the question.

Thank you for taking the time to provide us with your feedback. We really appreciate your help.

Sincerely.

Hope Revealed Behavioral Health Center

HOPE REVEALED

BEHAVIORAL HEALTH CENTER LLC

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Behavioral Health Services Pre Treatment Survey

Please complete this form by filling in the bubbles on each question

About Mental Health

1. Have you ever received mental health services before?
   - o Yes
   - o No

2. If yes, how would you rate your overall experience?
   - o Excellent
   - o Very Good
   - o Fair
   - o Poor
   - o Not Applicable

3. Who may we thank for your referral?
   - o Medical Doctor:_____
   - o Family Member/Friend:_____
   - o DHS Worker Name:_____
   - o OJA Worker Name:_____
   - o School:_____
   - o Other:_____

c. How would you rate your experience in making an appointment in our office?
   - o Excellent
   - o Very Good
   - o Fair
   - o Poor

d. How would you rate your experience in finding our office?
   - o Excellent
   - o Very Good
   - o Fair
   - o Poor

e. How would you rate the timeliness of your first appointment?
- o Excellent
- o Very Good
- o Fair
- o Poor

f. How would you rate the friendliness of our office staff?
- o Excellent
- o Very Good
- o Fair
- o Poor

g. After visiting with a staff clinician, do you feel hopeful that we will be able to assist you in finding tools to help you cope with your present situation?
- o Very Hopeful
- o Hopeful
- o Somewhat Hopeful
- o Not Hopeful

Additional Comments: