Consumer Name ___________

Identifier ___________

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

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 ___________

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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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
BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

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

BEHAVIORAL HEALTH CENTER INC.

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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: ______________________

Consumer Name ___________

Identifier ___________

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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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____________

Suicide Risk **Screening Tool**

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ○ Yes ○ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ○ Yes ○ No
3. **In the past week, have you been having thoughts about killing yourself?** ○ Yes ○ No
4. **Have you ever tried to kill yourself?** ○ Yes ○ No

   If yes, how? ______________________________

   ____

   ____

   When? ______________________________

   ____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ○ Yes ○ No

   If yes, please describe: ______________________________

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.** Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed.** Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Consumer Name ________

Identifier ____________

THIS PAGE IS TO BE RETAINED BY HOPE REVEALED AND PLACED IN THE CONSUMER RECORD.

J. CONSENT FOR FOLLOW-UP

Upon termination of services from this program, we may want to contact you regarding your status and for you to answer some questions concerning satisfaction regarding services received. The purpose of this information is to assure the continuity of care and to provide HOPE REVEALED with pertinent statistical information. You may revoke permission for follow-up at any time by giving this agency a written notice or by refusing to participate in any follow-up questionnaire. Follow up will be the same with all persons served regardless of referral status.

CONSENT: I hereby GIVE DO NOT GIVE (Please circle one) permission to HOPE REVEALED to contact me by telephone or letter for follow-up and to answer questions concerning my satisfaction with services and my current status.

K. ACKNOWLEDGEMENT OF RECEIPT OF CONSUMER HANDBOOK

Please initial to verify receipt of the following

- ______ Code of Ethics
- ______ Consumer Bill of Rights
- ______ Confidentiality of Consumer Records
- ______ HIPAA Notice
- ______ Complaint/Grievance Procedure
- ______ Orientation Information
- ______ Consumer Expectations
- ______ HIV/AIDS/STD Education Session
- ______ HIV/AIDS/STD Referral Information

Do you or significant other wish to receive: ☐ Yes ☐ No

HIV/AIDS/STD Education	HIV/AIDS/STD Testing	HIV/AIDS/STD Counseling
☐ Self	☐ Self	☐ Self
☐ Significant Other	☐ Significant Other	☐ Significant Other
☐ Both	☐ Both	☐ Both

Do you want to receive the full Bill of Rights? Yes ☐ No ☐

Is consumer under the age of 21? Yes ☐ No ☐

If yes, does HOPE REVEALED have permission to see him/her at school? Yes ☐ No ☐

Does HOPE REVEALED have permission to transport child for the purpose of receiving services? Yes ☐ No ☐

In the event that a medical emergency occurs while my child is with a HOPE REVEALED representative, and it is not possible for me to consent to medical treatment, I hereby authorize any HOPE REVEALED representative to seek appropriate medical treatment for my child. I also give permission for attending personnel to execute on my behalf, permission forms or other medical documents, and to act on my behalf if I am unable to do so.

The undersigned has read the above consent and release and acknowledges that this document has been signed voluntarily.

HOPE REVEALED BEHAVIORAL HEALTH CENTER INC. is a Medicaid fee for service provider and all fees are covered by Medicaid if consumer is eligible.

On occasion it may be necessary for a licensed person to reassess and/or update clinical information regarding your plan of treatment. Your signature below acknowledges your permission for this licensed person to see you.

The undersigned acknowledges that he/she has received a copy of the Consumer Handbook which has been communicated to him/her in a meaningful way. Furthermore, he/she has read and understands this document in its entirety and further certifies that he/she agrees to the terms and provisions stated herein.

Consumer Name: ____________________ Medicaid #: ______________

____________________ Signature of Consumer ______________ Date

____________________ Signature of Parent or Guardian ______________ Date

____________________ Witness ______________ Date

Consumer Name ____________

Identifier ________________

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

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 ____________

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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Child Developmental History Record

A. Identifications

1. Child's name: ______________________ Birthdate: ____________ Age: ________
Person(s) completing this form: ______________________ Today's date: ____________

2. Mother's name: ______________________ Birthdate: ________ Home phone: ____________
Address: ____
Currently employed: ☐ No ☐ Yes, as: ______________________ Work phone: ____________

3. Father's name: ______________________ Birthdate: ________ Home phone: ____________
Address: ____
Currently employed: ☐ No ☐ Yes, as: ______________________ Work phone: ____________

4. Parents are currently ☐ Married ☐ Divorced ☐ Remarried ☐ Never married
☐ Other: ____________
Child's custodian/guardian is: ______________________________

5. Stepparent's name: ______________________ Phone: ____________
Address: ____
Currently employed: ☐ No ☐ Yes, as: ______________________ Work phone: ____________

6. Other adult family members?
____
____

B. Development

Please fill in any information you have on the areas listed below.
1. Pregnancy and delivery, prenatal medical illnesses, and health care:
____
____

Was the child premature? ☐ No ☐ Yes. Weight and height at birth: ________ pounds ______ inches
Any birth complications or problems?
____
____

Consumer Name ____________
Identifier ________________

2. The first few months of life were they breast-fed? If so, for how long? Any allergies?

Sleep patterns or problems:

Personality:

3. Milestones: At what age did this child do each of these?

Sat without support: ________ Crawled: ___________ Walked without holding on: ___________
Helped when being dressed: _________ Tied shoelaces: _________ Buttoned buttons: __________
Ate with a fork: __________ Stayed dry all day: _______ Didn't soil his or her pants: ________
Stayed dry all night: ____________

4. Speech/language development
Age when child said first word understandable to a stranger: ____________
Age when child said first sentence understandable to a stranger: ____________
Any speech, hearing, or language difficulties?

C. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

D. Residences

1. Homes

Dates From	Dates To	Location	With whom	Reason for moving	Any problems?

2. Residential placements, institutional placements, or foster care

Dates From	to	Program name or location	Reason for placement	Problems?

E. Schools

School /Daycare(name, district,)	Grade	Age	Teacher

May I call and discuss your child with the current teacher? ❑ Yes ❑ No

F. Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.:

G. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Consumer Name ___________

Identifier ___________

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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Child Checklist of Characteristics

Name: ______________________________ Date: ____________ Age: _____

Person completing this form: ______________________ Relationship: ____________

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first please mark all of the items that apply to your child on the "Adult Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

- ❑ Affectionate
- ❑ Argues, "talks back," smart-alecky, defiant
- ❑ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- ❑ Cheats
- ❑ Cruel to animals
- ❑ Concern for others
- ❑ Conflicts with parents over rule breaking, money, chores, homework, grades, choices in music/clothes/hair/ friends
- ❑ Complains
- ❑ Cries easily, feelings are easily hurt
- ❑ Dawdles, procrastinates, wastes time
- ❑ Difficulties with parent's paramour/new marriage/new family
- ❑ Dependent, immature
- ❑ Developmental delays
- ❑ Disrupts family activities
- ❑ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ❑ Dropping out of school
- ❑ Drug or alcohol use
- ❑ Eating–poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ❑ Exercise problems
- ❑ Extracurricular activities interfere with academics

- ❑ Failure in school
- ❑ Fearful
- ❑ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ❑ Fire setting
- ❑ Friendly, outgoing, social
- ❑ Hypochondriac, always complains of feeling sick
- ❑ Immature, "clowns around," has only younger playmates
- ❑ Imaginary playmates, fantasy
- ❑ Independent
- ❑ Interrupts, talks out, yells
- ❑ Lacks organization, unprepared
- ❑ Lacks respect for authority, insults, dares, provokes, manipulates
- ❑ Learning disability
- ❑ Legal difficulties--truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ❑ Likes to be alone, withdraws, isolates
- ❑ Lying
- ❑ Low frustration tolerance, irritability
- ❑ Mental retardation
- ❑ Moody
- ❑ Mute, refuses to speak
- ❑ Nail biting
- ❑ Nervous
- ❑ Nightmares
- ❑ Need for high degree of supervision at home over play/chores/schedule
- ❑ Obedient
- ❑ Obesity
- ❑ Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- ❑ Oppositional, resists, refuses, does not comply, negativism
- ❑ Prejudiced, bigoted, insulting, name calling, intolerant
- ❑ Pouts
- ❑ Recent move, new school, loss of friends
- ❑ Relationships with brothers/sisters or friends/peers are poor--competition, fights, teasing/provoking, assaults

- ❑ Responsible
- ❑ Rocking or other repetitive movements
- ❑ Runs away
- ❑ Sad, unhappy
- ❑ Self-harming behaviors--biting or hitting self, head banging, scratching self
- ❑ Speech difficulties
- ❑ Sexual--sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ❑ Shy, timid
- ❑ Stubborn
- ❑ Suicide talk or attempt
- ❑ Swearing, blasphemes, bathroom language, foul language
- ❑ Temper tantrums, rages
- ❑ Thumb sucking, finger sucking, hair chewing
- ❑ Tics--involuntary rapid movements, noises, or word productions
- ❑ Teased, picked on, victimized, bullied
- ❑ Truant, school avoiding
- ❑ Under-active, slow-moving or slow-responding, lethargic
- ❑ Uncoordinated, accident-prone
- ❑ Wetting or soiling the bed or clothes
- ❑ Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics:

___

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with and circle it.

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

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

"Healing yesterday, giving hope for tomorrow"

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:

____

____

____

____

____

____

____

____

____