

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 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 42A Section 9-101.

I certify that I am eighteen (18) years of age or 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 42A 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 42A, 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 42A, 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 42A, 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

Guardian Name: _____
Parent, Self, Other

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 continuing 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 _____



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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 _____



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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: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	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

FOR OFFICE CODING 0 + + +
=Total Score:

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

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Consumer Name _____

CASE MANAGEMENT ASSESSMENT

Name: _____ Address: _____

Phone Number: _____

A. Daily Structures/Activities of Daily Living:

Living situation (circle all that 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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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?
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D. Residences

1. Homes

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

Consumer Name _____

Identifier _____

2. Residential placements, institutional placements, or foster care

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

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 _____

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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, blasphemous, 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, workaholic/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.

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 condition 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
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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 _____

2. Please list all of your pregnancies:

Your age	Miscarriage	Abortion	Child born	What happened with this pregnancy?	Identifier	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.



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Young Adult Information Form

Note: Unless there is a serious risk of injury to you or someone else, the information on this form is confidential. It will not be discussed with your parents without your consent.

Your name: _____

Nickname? _____

Today's date: _____ Your age: _____

Your phone #: _____

Your address: _____

Health

How tall are you? _____ What do you consider your ideal weight? _____ Has your weight changed more than 10 pounds in the last year? No Yes How much? _____

Why? _____

What physical or medical problems do you have now, or have you had in the past?

Family

Birth parents' names: _____ and _____

Address: _____

Phone # _____

Present parents'/guardians' names: _____ and _____

Address: _____

Phone # _____

How would you describe your parents' relationship?

What kinds of problems are you having with:
Parents/stepparents/guardians?

Parents' live-in friends or boyfriends/girlfriends?

Brothers or sisters (or stepbrothers or stepsisters)?

School

Which school do you go to? _____
Grade level/year: _____

How are your grades?

Problems in school?

Work

Do you work? No Yes If so, How many hours a week? _____
What do you do? _____

Problems there?

Friends

Who are your close friends (names and ages)?

Do you have a serious one-on-one relationship now? No Yes

Do you party? _____

If so, when and where? _____

Previous counseling

With whom? _____

When? _____

For what? _____

With what results? _____

2. With whom? _____

When? _____

For what? _____

With what results? _____

Concerns

Would you like information or answers on: Sex (of any kind) Birth control Alcohol Drugs

Relationships Other concerns: _____

How important is religion to you and/or your family? _____

If so, in what ways? _____

What worries or upsets you?

What makes you happy?

Why do you think you are here? Please tell me in your own words.

What would you like to see happen or change because of this counseling?

What would you like me to let your parents know?

What else is important for me to know?

What would you like me to ask you about?

Signed: _____
Date: _____



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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?
 - Yes
 - No

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

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

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

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

e. How would you rate the timeliness of your first appointment?

- Excellent
- Very Good
- Fair
- Poor

f. How would you rate the friendliness of our office staff?

- Excellent
- Very Good
- Fair
- 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?

- Very Hopeful
- Hopeful
- Somewhat Hopeful
- Not Hopeful

Additional Comments:
