Counseling & Recovery
SERVICES OF OKLAHOMA
Certified Sanctuary Community

Steps of Intake

- Filling out business paperwork
- 2 hour assessment and 1 hour treatment plan with therapist
- First time doctors visit, if wish to receive medication

Client will ***NOT*** be able to schedule a doctor's appointment or receive medication until steps above have been completed.

Please make sure to fill each page out completely

Child Outpatient Information Sheet

Client Name: ____________________________ Date: _____/_____/______

Age: ________________________ Sex:_______________ Race: _______________

Birthdate: _____/_____/______ Social Security Number: _______-_____-________

Client Address: ____

City: ________________________ State:______________ Zip: ____________

Guardian's Phone Number: (____)-_____-______

Is this a cell phone? YES NO Can we text you? YES NO

E-mail address: ____________________________________

Guardians Name: _____________________________________

Are you the legal guardian? YES NO

If NO, who is? Name:________________________ Phone Number:(____)-_____-______

Insurance Insurance Medicaid Medicare Self-Pay

Member ID/Policy Number: ____________________________________

Primary Care Physician

Name: __________________________ Medical Center: _________________________

Phone Number: (____)-_____-______ Fax Number: (____)-_____-______

Address: ____

City: ________________________ State:______________ Zip: ____________

Emergency Contact Information

Name: __________________________

Phone Number: (____)-_____-______ Relationship: ________________

Address: ____

City: ________________________ State:______________ Zip: ____________

Was child a previous client? YES NO When was child seen here: _______ to _______

Is child currently having suicidal thoughts? YES NO

Is child currently having homicidal thoughts? YES NO

Previous suicidal/homicidal thoughts? YES NO

Number of attempts: _____ Date of Most Recent Attempt: _____/______/_______

How: _______________________________________

Counseling&Recovery
SERVICES OF OKLAHOMA
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Well/**CHILD**

Child/Youth Health Risk Appraisal

Name: ______________________________ Date: ______________

Date of Birth: ____________ Age: ________ Location: ____________________

Client Medicaid Member ID: ______________

Who is completing this form? ☐Self ☐Parent/Guardian ☐Other: ______________

1. Do you have any concerns about your child's general health, development or behavior?

   ☐ Yes ☐ No

2. Does your child/youth have any of the following medical conditions?

   ☐Asthma ☐Diabetes ☐Seizure Disorder

   ☐Heart Disease ☐High Cholesterol ☐High Blood Pressure

   Please list any other physical health condition (including surgeries) that you feel is important for us to know: ____

   ____

3. Does your child need any of the following:

Primary Care Physician	☐Has	☐Need	**Eye Doctor**	☐Has	☐Need
Dentist	☐Has	☐Need	**Audiologist**	☐Has	☐Need
Medical Equipment	☐Has	☐Need	**Other Specialist**	☐Has	☐Need

PCP Name and Telephone Number: ______________________________

Specialist Name and Telephone Number: ______________________________

Any other healthcare providers: ______________________________

4. Has your child had a **physical examination** in the last 12 months? ☐Yes ☐ No ☐ Unknown
5. Has your child had an **eye exam** in the last 12 months? ☐Yes ☐ No ☐ Unknown
6. Has your child had a **dental exam** in the last 12 months? ☐Yes ☐ No ☐ Unknown
7. Does your child have any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)? ☐Yes ☐ No ☐ Unknown

Client ID: ______________ Client Name: ______________________________

Well/**CHILD**

Child/Youth Health Risk Appraisal

8. Does your child have any allergies (food, medication, latex, etc.)? ☐Yes ☐ No ☐ Unknown
9. Does your child take any medications? ☐ Yes ☐ No

   If yes, please list. Include vitamins, supplements, and over-the-counters (daily or occasional)

   ____

   ____

   ____

   ____

10. In the last 12 months has your child experienced any difficulty with wheezing or excessive night coughing? ☐Yes ☐No ☐Unknown
11. In the last 12 months, has your child experienced any noticeable weight loss or weight gain, or excessive thirst or urination? ☐ Yes ☐No ☐Unknown
12. Does your child use any special medical equipment in the home? ☐Yes ☐No
13. Does your child use any mobility tools to help him/her walk/move? ☐Yes ☐No
14. Has your child been to an Emergency Room within the last 3 months? ☐Yes ☐No

    If yes, where and what reason?____

15. Has your child been **admitted to the hospital** in the last 3 months? ☐Yes ☐No

    If yes, where and what were the reasons?____

16. Does your child see more than one doctor? ☐Yes ☐No

    If yes, please list: ____

17. Does your child need immunizations? ☐Yes ☐No ☐Unknown
18. Has your child had a lead screen? ☐Yes ☐ No ☐Unknown

Client ID: ____________________ Client Name: ____

Child/Youth Health Risk Appraisal

19. Is your child around cigarettes/cigars/pipes on a regular basis? ☐ Yes ☐ No
20. Is your child around drugs and alcohol on a regular basis? ☐ Yes ☐ No
21. How many hours of sleep does your child usually get each night? ______ hours
22. Does your child snore? ☐Yes ☐ No
23. Does your child mouth breathe? ☐Yes ☐ No
24. How many **days** per week does your child usually get exercise? _________ days
25. How many **hours** per day does your child usually get exercise? _________ hours
26. How many hours of screen time (computer/smart phone/tablet/gaming systems/television) does your child have a day? _________ hours
27. On a typical day, how many servings of fruits and/or vegetables does your child eat? (1 serving= 1 cup fresh or ½ cup cooked vegetables) ____________ servings per day
28. Does your child drink plenty of water every day? ☐ Yes ☐ No
29. How many sodas or energy drinks does your child drink in a day? ___________ drinks
30. Is your child sexually active? ☐ Yes ☐ No
31. Does your child take a multivitamin? ☐ Yes ☐ No
32. Does your child put on sunscreen before spending extended time outside? ☐ Yes ☐ No
33. Does your child always fasten his/her seatbelt when in a car? ☐ Yes ☐ No
34. In general, would you say your child's physical health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

____ _______________________

Signature of person completing form Date

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver.4.0.1

What is your name? a.__________________________ b. ____ c. ____________________________________
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|__| / |__|__| / 20 |__|__|

The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

IDScr 1. **When was the last time** that you had **significant** problems with…

a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
e. thinking about ending your life or committing suicide?	4	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0

EDScr 2. **When was the last time** that you did the following things **two or more times**?

a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
d. Had a hard time waiting for your turn.	4	3	2	1	0
e. Were a bully or threatened other people.	4	3	2	1	0
f. Started physical fights with other people	4	3	2	1	0
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0

2h. When was the **last** time, if ever, you were treated for a mental, emotional, behavioral or psychological problem by a mental health specialist or in an emergency room, hospital or outpatient mental health facility, or with prescribed medication?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

SDScr 3. **When was the last time that...**

	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
a. you used alcohol or other drugs weekly or more often?	4	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0
f. you received treatment, counseling, medication, case management or aftercare for your use of alcohol or **any other drug**? Please do not include any emergency room visits, detoxification, self-help or recovery programs	4	3	2	1	0

CVScr 4. **When was the last time** that you…

	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
a. had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b. took something from a store without paying for it?	4	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0
f. were involved in the criminal justice system, such as jail or prison, detention, probation, parole, house arrest or electronic monitoring?	4	3	2	1	0

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) .... Yes 1 / No 0

   v1. ____

   ____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

   v1. ____

6a. Which races, ethnicities, nationalities or tribes best describe you? (Any others?) (**Please record and select all that apply**)

   v1. ____

   ____

Please select at least one race.

	MENTIONED Yes	No
1. Alaskan Native **(Please record tribe in 6a1)**	1	0
2. Asian	1	0
3. African American/Black	1	0
4. Caucasian/White	1	0
5. Hispanic, Latino or Chicano	1	0
a. Puerto Rican	1	0
b. Mexican	1	0
c. Cuban	1	0
e. Dominican	1	0
f. Other Central American	1	0
g. Other South American	1	0
z. Other **(Please record tribe in 6a1)**	1	0
6. Native American **(Please record tribe in 6a1)**	1	0
7. Native Hawaiin	1	0
8. Pacific Islander	1	0
99. Some other group **(Please record tribe in 6a1)**	1	0

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Chestnut Health Systems

GAIN GLOBAL APPRAISAL OF INDIVIDUAL NEEDS Coordinating Center

Staff Use Only

8. Site ID: ____________________________ Site name v. ____

9. Staff ID: ___________________________ Staff name v. _______________________________________

10. Client ID: _________________________ Comment v. ____

11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered

13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: ________________________

15. Referral comments: v1. ____

Scoring

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				

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GAD-7 Anxiety

Pre: ______ Mid: _____ Post: _______

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "**X**" to indicate your answer")*	Not at all	Several days	More than 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 worrying	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 is 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
Column totals:	___ +	___ +	___ +	___

= ***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
☐	☐	☐	☐

Clinician: ______________________________

Client ID: _____________________ Client Name: ____

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

PHQ-9 Depression

Pre: ______ Mid: _____Post: _______

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

Column totals ___ + ___ + _____ + ___

= ***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**
☐	☐	☐	☐

Clinician: ____________________________

Client ID: ____________________ Client Name: ______________________________________

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

COMMUNICABLE DISEASE INFORMATION

COUNSELING AND RECOVERY SERVICES OF OKLAHOMA is committed to identifying and addressing needs of the client beyond the emotional. Often other health issues may affect a client.

Would you like referrals for services for the **testing of communicable diseases** (to include but not limited to HIV, AIDS, STDs, Hepatitis C, Tuberculosis)?

For yourself/client ☐ YES ☐ NO Your Initial ________
For your partner ☐ YES ☐ NO ☐ Not Applicable Your Initial ________
For a family member ☐ YES ☐ NO ☐ Not Applicable Your Initial ________

FOR OFFICE STAFF USE ONLY

If yes, **staff** will list referral agencies that will provide testing services

.____

____

Would you like **education to be provided about** any of the above **communicable diseases**(to include but not limited to HIV, AIDS, STDs, Hepatitis C, Tuberculosis)?

For yourself/client ☐ YES ☐ NO Your Initial ________
For your partner ☐ YES ☐ NO ☐ Not Applicable Your Initial ________
For a family member ☐ YES ☐ NO ☐ Not Applicable Your Initial ________

FOR OFFICE STAFF USE ONLY

If yes, **staff** will list referral agencies that will provide education.

____

____

Would you like **counseling** to be provided **about how to cope with** having any of the above **communicable diseases** (to include but not limited to HIV, AIDS, STDs, Hepatitis C, Tuberculosis)?

For yourself/client ☐ YES ☐ NO Your Initial ________
For your partner ☐ YES ☐ NO ☐ Not Applicable Your Initial ________
For a family member ☐ YES ☐ NO ☐ Not Applicable Your Initial ________

FOR OFFICE STAFF USE ONLY

If yes, **assessment clinician** will enter how this will be accomplished – either at this agency or provide referral to agencies in the community.

____

____

SIGNATURE OF THE PERSON COMPLETING THIS FORM:________________________________
DATE:______________________