Adult Intake

- ✓ **Fill out business paperwork packet**

- ❑ **Meet with Intake Coordinator and complete Initial Evaluation**: Review client information, discuss income and client rights, talk about services offered

- ❑ **Meet with Therapist to complete the Assessment and Comprehensive Care Plan**: Three-hour assessment with therapist to complete service plan and substance abuse assessment (as needed)

- ❑ **Schedule appointment with doctor**: Once these steps have been completed, we will schedule an appointment with the doctor for you

You must complete these steps before you are able to see the doctor and receive medication.

Please make sure to fill out each page completely.

Adult Outpatient Information Sheet

Date: _____ / _____ / _____

Client Name: _____Maiden Name:_____

Age: _____ Sex: _____ Race: _____

Birthdate: _____ /_____ /_____ Social Security Number: _____-_____-_____

Client Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____-_____

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

Work Phone Number: (____) _____-_____ ext: _____

E-Mail Address: _____

Insurance Insurance Medicaid Medicare Self-Pay

Member ID/Policy Number: _____

Primary Care Physician

Name: _____

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

Medical Center: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information

Name: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Were you a previous client: YES NO When were you seen here: _____ to _____

Are you currently having suicidal thoughts? YES NO

Are you currently having homicidal thoughts? YES NO

Previous suicidal/ Homicidal thoughts? YES NO

Number of attempts: _____ Most Recent Attempt: _____ / _____ / _____

How:_____

Adult Health Risk Appraisal

Client Name: _____ Appraisal Date: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Medicaid Client ID: _____

Source of Information: ☐ Client ☐ Parent/Guardian ☐ Caretaker ☐ PCP

☐ Other, specify: _____

1. Do you have any of the following medical conditions?

☐ Diabetes ☐ Emphysema/COPD ☐ Asthma

☐ High Blood Pressure ☐ Heart Disease ☐ High Cholesterol

☐ Drug and/or environmental allergies

Please list any other physical health challenges that you feel is important for us to know:

_____

_____

_____

2. Do you have or need any of the following:

Primary Care Physician: ☐Has ☐Needs **Dentist**: ☐Has ☐Needs

Eye doctor: ☐Has ☐ Needs **Audiologist:** ☐Has ☐Needs

Medical Equipment: ☐Has ☐Needs

Other Specialist: _____ ☐Has ☐Needs

PCP Name and Telephone Number: _____

Specialist Name and Telephone Number: _____

Any other healthcare providers: _____

3. Are you on 4 or more medications? ☐Yes or ☐No
4. Are you on medications that are not prescribed at this agency? ☐Yes or ☐No

Adult Health Risk Appraisal

5. Do you use any special medical equipment in your home? ☐Yes or ☐No

6. Do you use any mobility tools or assistive devices (This would include things such as hearing aids and CPAP machines for apnea)? ☐Yes or ☐No

7. Have you been to an emergency room within the last 3 months? ☐Yes or ☐No

8. Have you been in the hospital in the last 3 months? ☐Yes or ☐No

9. Do you see more than one doctor other than us? ☐Yes or ☐No

10. Do you smoke or use other tobacco products? ☐Yes or☐ No

11. Do you want help to quit? ☐Yes or ☐No

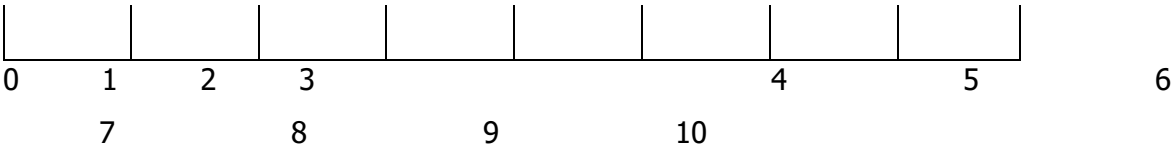
12. Do you worry that you use too much alcohol or drugs? ☐Yes or ☐No

13. Has a doctor ever told you that you are overweight? ☐Yes or ☐No

14. Do you want help to lose weight? ☐Yes or ☐No

How would you rate your satisfaction with your overall health and wellness?

(0 = not at all; 10 = completely satisfied)



_____ _____

Signature of person completing form Date

Client ID: _____ Client Name: _____

Chestnut Health Systems

GAIN
GLOBAL APPRAISAL OF INDIVIDUAL NEEDS
Coordinating Center

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...**

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…

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

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				

NAME: _____ ID#: _____ DATE: _____

Adverse Childhood Experience (ACE) Questionnaire

This Questionnaire will be asking you some questions about events that happened during your childhood, specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:		If yes enter 1
1. Did a parent or other adult in the household <u>often:</u> Swear at you, insult you, put you down, or humiliate you? **Or** Act in a way that made you afraid that you might be physically hurt?	☐ Yes ☐ No	_____
2. Did a parent or other adult in the household <u>often:</u> Push, grab, slap, or throw something at you? **Or** Ever hit you so hard that you had marks or were injured?	☐ Yes ☐ No	_____
3. Did an adult or person at least 5 years older than you <u>ever:</u> Touch or fondle you or have you touch their body in a sexual way? **Or** Attempt or actually have oral, anal, or vaginal intercourse with you?	☐ Yes ☐ No	_____
4. Did you <u>often</u> feel that: No one in your family loved you or thought you were important or special? **Or** Your family didn't look out for each other, feel close to each other, or support each other?	☐ Yes ☐ No	_____
5. Did you <u>often</u> feel that: You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	☐ Yes ☐ No	_____
6. Were your parents <u>ever</u> separated or divorced?	☐ Yes ☐ No	_____
7. Were any of your parents or other adult caregivers: <u>Often</u> pushed, grabbed, slapped, or had something thrown at them? **Or** <u>Sometimes or often</u> kicked, bitten, hit with a fist, or hit with something hard? **Or** <u>Ever</u> repeatedly hit over at least a few minutes or threatened with a gun or knife?	☐ Yes ☐ No	_____
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?	☐ Yes ☐ No	_____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	☐ Yes ☐ No	_____
10. Did a household member go to prison?	☐ Yes ☐ No	_____
ACE SCORE (Total "Yes" Answers): _____		

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: _____

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 <u>any</u> problems, how <u>difficult</u> 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: _____

PCL – 5

_____ Many difficult or stressful things sometimes happen to people. Please read through the following instructions and initial if you feel none of these questions and initial if you feel none of the questions apply to you.

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so):

_____

_____

_____

_____

_____

How long ago did it happen? _____ (please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

_____ Yes _____ No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe:

_____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____ Accident or violence

_____ Natural Causes

_____ Not applicable (the event did not involve the death of a close family member or close friend)

INSTRUCTIONS: Below is a list of the problem that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem **in the PAST MONTH.**

Second, below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. **In the past month, how much were you bothered by:**	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "super alert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

COMMUNICABLE DISEASE INFORMATION

Counseling and Recovery Services of Oklahoma is committed to identifying and addressing the needs of our clients beyond just your emotional needs; often other health issues may affect a client.

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

For yourself/client YES NO Your Initial _____
For your partner YES NO Your Initial _____
For a family member YES NO Your Initial _____

FOR STAFF USE ONLY

If yes, STAFF will list referral agencies that will provide testing services at

_____
_____

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

For yourself/client YES NO Your Initial _____
For your partner YES NO Your Initial _____
For a family member YES NO Your Initial _____

FOR STAFF USE ONLY

If yes, STAFF will list referral agencies that will provide educational services at

_____
_____

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

For yourself/client YES NO Your Initial _____
For your partner YES NO Your Initial _____
For a family member YES NO Your Initial _____

FOR 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 person completing this form: _____ Date: _____

S:forms/medical record forms/business/Communicable Disease Questions