Client Information

_____ _____
Full Name Date

_____ _____
Address City

_____ _____ _____ _____ _____ _____
State Zip Home Phone# Mobile Phone# Age Sex

In case, we need to call either of the two phone numbers above, may we leave a message? ☐Yes ☐No

_____ _____ _____
Marital Status _ Date of Birth SPN #

_____ _____
Employer _ E-Mail

Enrolled in A Court Counseling Program: Total Cost: $_____

☐Alcohol/Drug Evaluation ☐Anger Management ☐BIPP ☐IOP ☐SOP ☐ Anti-theft ☐Cognitive Skills Development ☐ Marijuana Education ☐Think for a Change Program

_____ $_____
Program Director, Michael Yeager B.A, LCDC, C.ht, CAS, SAP Fee Paid

Comments:_____

_____

Referral Information

Referred by (Check One): ☐Probation Officer ☐CPS ☐DPS ☐Judge ☐Attorney ☐Other: _____

Name: _____

Address: City, State Zip:_____

E-mail: _____

Phone: _____

Emergency Contact Information

Emergency Contact _____ Relationship:_____

Emergency Contact's Phone: _____ Alt. Phone: _____

Basic Agreements for IOP, SOP and BIPP Clients

1. Attend **1**☐ **2** ☐ **3**☐ Twelve Step or SMART Recovery Meetings a week beginning _____.

2. Locate a 12 step Temporary Sponsor or SMART Recovery Member by _____ to help you understand the program and to help you write out the first 5 steps of the 12 step model or write out 6 SMART Recovery ABC processes to be turned in every 3 weeks for review.

3. Have a meeting sign in sheet signed weekly and turned in weekly for review.

4. Pay fees weekly or as otherwise agreed:
   - ☐ I will pay the total cost of the program (including admission fee) in the amount of $_____
   - ☐ I will pay admission fee in the amount of $_____
   - ☐ I will pay program fees every group
   - ☐ I will pay program fees every other week on pay day _____
   - ☐ Each payment will be a minimum of: $_____

5. Fee payment is to be made in **CASH ONLY** no money orders, no checks or credit cards.

6. The only excused absence is your death. There are only 2 absences allowed during the program and they are to be called in to **713-461-3279** or **832-407-2958** - 24 hours in advance. If not called in they are an unexcused absence and you will be charged for the class and have to make it up later as well and pay for the make-up class.

7. If you miss more than 2 classes for any reason you will be discharged from the program. A start over is possible only with new requirements and fees.

8. If you test positive for drugs/alcohol you will be discharged from the program you are in and have to restart a/the program after another evaluation has been completed at $50.00. New requirements may apply to the program activities.

9. In the case of BIPP clients reoffending you will be discharged from the program and another evaluation is required and new program requirements will apply exceeding the 18 week weekly group commitment.

I _____ have read the above and agree to these conditions.
(Name / Please Print)

_____ _____
Signature of Client Date

_____ _____
Signature of ACCP Representative Date

CONSENT FOR DISCLOSURE OF INFORMATION FOR COURT AGENCIES

I hereby authorize A Court Counseling Program to disclose records concerning,

_____, to:
Name of Client

☐ Probation Officer ☐Parole Officer
☐ Courts of Law ☐ Child Protective Services ☐ Attorney

_____ _____
Client's Initial Date

I understand that such disclosure will be made for the purposes of information exchange, progress reports, coordination of services and referrals and facilitating victim safety.

Disclosure is limited to information regarding attendance, participation, information exchange, coordination of services and referrals & facilitating victim safety.

I understand that I may revoke this consent at any time and that my request for revocation must be in writing. If not earlier revoked, this consent for disclosure of information shall expire 1 year after my completion of or termination from A Court Counseling Program.

ACCP is allowed to share confidential information about me in the way described above.
Release of information is voluntary, I understand I have a right to refuse ACCP request for this disclosure.

_____ _____
Signature of Client Date

_____ _____
Signature of ACCP Representative Date

NOTIFICATION

Initial Contact & Appointment

Date: _____

To: _____

This form is to notify you that _____

SS#/ Tracer#/ SPN# _____

Contacted _____for an appointment on _____and appeared for

the Intake/ Orientation session on _____.

Participant has completed the required documents checked below:

___ Completed ACCP Intake/Orientation
___ Completed Anger Management Intake/Orientation
___ Completed Parenting Intake/Orientation
___ Completed Supportive SA Intake/Orientation
___ Completed Intensive SA Intake/Orientation
___ Completed SA Education/Awareness Intake/Orientation
___ Completed the Aggression Questionnaire
___ Completed the Anger Management Assessment
___ Completed a Parenting Scale/Questionnaire
___ Completed the SA Assessment (SASSI)
___ Completed the SOGS/SACODA Assessment
___ Completed the Alcohol and Drug Questionnaire

Cost for this program service is checked below:

	Attended 1st Session		**Paid for 1st Session**	
BIPP $_____for 36 hours	☐Yes	☐No	☐Yes	☐Yes
Anger Management Program $_____for 4, 8 or 12 hours	☐Yes	☐No	☐Yes	☐No
Parenting Program $_____for 4 to 8 hours	☐Yes	☐No	☐Yes	☐No
Supportive Substance Abuse Program $_____for 12 weeks	☐Yes	☐No	☐Yes	☐No
Intensive Substance Abuse Program $_____for 18 weeks	☐Yes	☐No	☐Yes	☐No
Substance Abuse Education/Awareness Program $_____for 4 hours	☐Yes	☐No	☐Yes	☐No
SALCE, SASSI, MAST Assessment $_____for 50 minutes	☐Yes	☐No	☐Yes	☐No

Participant will attend the program group sessions at the following location:_____

_____

Comments: _____

_____

Sincerely,

_____
Program Director

Individualized plan

Admission Date: _____ Discharge Date: _____ SPN#: _____

Name: _____

Assessment Results: _____

Presenting Problem: _____

_____

Goal:_____

_____

Referral Source To: _____For:_____

(Substance Abuse, Psychiatric Disorders and Specialized Interventions for Perpetration of Child Abuse and/or Sexual Assault)

Referral Source To: _____For:_____

(Additional interventions in response to intake information or observed participation in groups)

Services/Strategies: Group program sessions 'include written assignments, workbooks, videos, role modeling, homework assignments and/or case management. Videos are shown to illustrate the abusive behavior targeted for change. The program is instructive and confrontational.

The IOP meets 2 times a week for 2 hours each time for 18/22 weeks**. The SOP** Meets once a week for 2 hours each group for 12/16 weeks. **The BIPP Program** is 18 weeks /36 hours in duration and meets once a week for two hours. **The Anti-Theft** group meets 4/8 hours. **The Parenting** group meets weekly for up to 12 weeks. **The Cognitive Therapy Decision Making** group meets 4/8 hours. The Anger Management education program is 4 hours.

We offer other group activities and their times may be gotten from talking with staff. The group procedure consists of: (1) check-in for reporting recent behavior, homework assignments and problem areas; (2) role playing, group exercise, video viewing, or written classroom work for promoting participation; and (3) wrap-up to provide closure to de-escalate heightened emotions. Facilitators confront instances of denying, blaming, minimizing, justifying, and rationalizing.

Intervention/Approaches, CBT, Voice Dialogue, EFT, Kinesiology, SMART Recovery, 12 Step, Hypnosis, Parts Therapy, Addiction Educational Videos.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

ACCP GOALS

1. The safety and self-determination of all family members.
2. Accepting responsibility for and stopping their drinking, violence and other abuses, including emotional, financial, sexual abuse, as well as threats of abuse and violence.
3. Seeing and accepting the point of view of the persons witnessing and/or victimized by violent and intoxicated abusive behavior.
4. Learning to use new skills to stop using violence and the threat of using violence.
5. Agreeing to change attitudes and beliefs that lead to using violent and abusive behavior and to explore how they control others.
6. Learning to live in relationships that are not only violence and addiction free, but mutually respectful, mutually satisfying and growth-promoting.
7. Assuming social responsibility by passing on the benefits received from participation in ACCP

WHAT WE EXPECT FROM YOU

I AGREE TO: _____ Initials

1. be non-abusive (psychologically, physically, sexually, or verbally) to my partner, children or Family Support Services staff.
2. be honest and direct, reporting any past and present use of violence (psychological, sexual, verbal, and physical).
3. be no more than 5 minutes late for group. If late, I understand I will not be allowed to stay for that session which will be considered an absence with payment due.
4. miss no more than two (2) group sessions and pay for the missed sessions. I understand that missing more than two (2) group sessions may result in being terminated from the program. I understand that I still must attend _____ groups to complete the program. And I understand that I must notify my facilitator if unable to attend a session by calling 713-461-3279 and leave a message if the facilitator is not in.
5. regularly participate in group including sharing experiences, insights and feelings as related to my past or present use of violence or chemicals as well as role-playing and homework.
6. know my fee and pay with cash each week for each group I am scheduled to attend whether I am there or not. This fee also applies to orientation sessions.
7. follow through on referrals made by my ACCP facilitator for other evaluations or treatment (e.g. chemical abuse or counseling).
8. comply with any provisions of a court order, including child support. I also agree not to engage in any criminal behavior.
9. to comply with court order concerning the use of alcohol and not use alcohol the day of group which could result in termination from the program or an absence.
10. to always use my (ex)partner's name. Slang terms will not be allowed.
11. to avoid side talking in group. Disruptions could mean being asked to leave group for the evening.

I understand that not meeting the above expectations and/or violating any of the above rules and guidelines could result in termination from the program. If appropriate, referral to other services may be offered. I understand that, If terminated, I must wait 30 days before being considered for reentry into the program AND must begin at Week 1 and a reentry orientation may be required. Entry into the program after a second termination will not be allowed. I also understand that my referring agent determines any reentry into the program.

_____ _____

Signature Date

A Group Agreement of Program Rules

The overall goal for each individual in counseling or treatment at COC Program and other services is to experience a profound change in behavior and attitude of one's self. This change shall be accomplished by learning (1) to arrest the destructive behavior and lifestyle of alcohol/drug abuse/addiction, anger and violence one has created through power and control, (2) to fulfill one's personal needs in a more effective, productive, and nonviolent way, and (3) to change one's irrational thinking and belief system. Your admission into the COC Program acknowledges your agreement to keep the following contract as a means of beginning to accomplish this end.

Commitment to Nonviolence

I, _____ agree to abide by the following program rules contract:

1. **I agree not to** use physical, emotional, verbal, or sexual violence toward others, including Victim/partner, or myself
2. **I agree not to** use verbal and mental abuse toward others, including all threats of violence or suicide, name-calling, or intimidation.
3. **I agree not to** physically, sexually, verbally, or emotionally abuse my children.
4. **I agree not to** injure or destroy pets or property as a means to hurt or control others.
5. **I agree not to** engage in the abuse of drugs or alcohol, and will not in other ways inflict harm upon myself. As a condition of my program at_____. I may be required to abstain from alcohol and/or drug use or to participate in some form of alcohol/drug evaluation or treatment. While I am attending I agree not to drink alcohol or use drugs at all, unless this drug is a medication prescribed by a licensed physician for an ongoing health problem
6. **I agree** I will earnestly try to find ways to stop controlling other people. I will not follow, harass, or attempt to hold on to a person who has expressed a wish to be free of me
7. **I agree not** to withhold child support or withhold access to my children. I will not involve myself in legal actions toward my current or ex-partners where the main goal is to hurt, harass, humiliate, or control his / her behavior.
8. **I agree** that the purpose for my being in this program is to become nonviolent. **I agree** I will act accordingly both in the program and in my personal life. **I agree** I will participate openly, honestly, and actively; that is, being honest with thoughts and feelings and confronting my fellow group peers irresponsible behavior if that occurs. I will abide by all program rules and regulations, and complete all assignments that are given to me by my group leaders.
9. **I agree** that if I break any of the above agreements for ending my violence, I will report this immediately to and will openly talk about the problem in-group. f will accept the consequences of my behavior, including possible having my participation with extended, being terminated from the program, or other interventions.

Duration of Counseling

10. I agree and understand that satisfactory completion of the ACCP Program requires a minimum of (1) two hour sessions per week for 18 weeks or 36 sessions for satisfactory completion. Any excused and unexcused absences will extend my time in program during my first nine weeks in the program will evaluate my suitability for the remainder of the program.
11. I agree and understand that I may choose either ***The I8-week IOP Program***, ***The 12/16 week SOP Program***, ***The 4-8 hour Anti-Theft Program***, ***The up to 12 hour Parenting Program***, ***The 4/8 hours Cognitive Thinking Program*** or ***The _____Program***, I agree that if I choose to do so, day and time of sessions must be consistent for all weeks thereafter, unless otherwise changed.

Attendance and Fee Requirements

_____ Initials 12. **I agree** to attend and be **on time** for every meeting, and be **on time** for all regularly scheduled program functions, including group sessions, films, or other activities, if scheduled. I am more than 15 minutes late I understand this will be counted as an unexcused absence.

_____ Initials 13. **I agree** to pay 30.00 per hour / session, unless otherwise changed. I may pay as I go. I may be allowed to attend if I do

not bring payment, although I will be charged for that session. I agree I must continue in the ACCP education group sessions, I agree I will not receive a satisfactory discharged nor will I receive a certificate of completion from the ACCP program until all fees have been paid in full.

_____ Initials 14. **I agree** and understand that one half of my program fees must be paid by halfway of the program or I may be terminated from the program.

_____ Initials 15. **I agree** to give at least 24 hours' notice for any missed sessions (except in case of emergency). I agree to abide by the decision of and my group leaders on whether a missed session is excused or unexcused. I agree I am expected to make-up for all missed sessions of excused or unexcused absence. I agree to personally pay a regular fee of $30.00 per hour/session, unless otherwise changed, for all excused and unexcused absences. I agree and understand that I will be terminated from the program after a third unexcused absence.

_____ Initials 16. **I agree** to pay 5.00 f or each new certificate made when I fail to complete the program on my completion date.

Recording of Meetings (Group Sessions)

17. **I agree** and understand that some meetings may be recorded of observed for supervisory, monitoring, or training purposes. I understand that I will be informed whenever a meeting is being recorded or observed.

Waiver of Confidentiality

18. **I agree** and understand that ACCP is providing me with an educational service and will not be offering medical or psychological diagnosis or prognosis.
19. **I agree** that if related personal problems exist or surface, such as alcohol or drug abuse, or mental health problems, I will seek appropriate treatment as a condition of my continued involvement with ACCP. I agree I will cooperate with measures to asses such problems, if so requested by
20. **I agree** and understand that I may be terminated from if I do not abide by this agreement, and will be liable for all fees and expenses which incur to collect whatever fees I owe.

I have read, understood, agreed with and will receive a copy of this agreement if requested.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

Code of Conduct

COURT ORDERED COUNSELING of Texas is committed to maintaining good working relationships among all personnel. In dealing with co-workers, clients, and individuals from outside the organization, employees are expected to conduct themselves in a manner that reflects our philosophy as well as respect for the rights and well being of others. All employees and client shall act in compliance with all organizational policies and procedures.

1. Refrain from illegal, unethical, or unprofessional conduct on the premises.
2. Cease and avoid engaging in any outside professional activity and/or financial interactions with a staff and/or client which is a conflict of interest
3. Refrain from sexual contact with staff and/or client or engaging in conversation of flirtatious nature or involving sexual innuendo.
4. Refrain from being high on any drug or alcohol.
5. No gambling on company property.
6. No smoking in unauthorized areas. Staff and clients are not to smoke together.
7. Soliciting or accepting tips, gifts, or donations.
8. Theft, fraud, misappropriation of funds, neglect or deliberate destruction of property on premises regardless of ownership.
9. Solicitation, distribution, or sale of any type while on company property.
10. Falsification or unauthorized alteration of any company record.
11. Possession of firearms or weapons of any type while on company property.
12. The making or publishing, of false or malicious statements concerning any employee, supervisor, or the organization.
13. Fighting or committing any act of violence, or threatening an act of violence.
14. Violating any COURT ORDERED COUNSELING of Texas policy, practice, or procedures.
15. Improper use of COURT ORDERED COUNSELING of Texas property, including but not limited to its computer systems.
16. Have no current use of illicit drug; no abuse of either illicit or prescription drugs or alcohol.
17. Refrain from all types of harassment
18. No unlawful discrimination against people based on race} gender, sexual orientation, socioeconomic status, language, ethnic group identification, culture, natural origin, religion or spiritual beliefs, age, mental or physical disability in receiving program services. A client who believes s/he has been unlawfully discriminated against in receiving program services is directed to file her/his grievance with either the Program Director or DSHS.
19. The Federal and State regulations regarding the confidentiality of mental health records will be made available to all where all agree to follow the policies stated therein.
20. Each person on premises is to have secured on transportation as it is not the policy of COURT ORDERED COUNSELING of Texas to provide transportation to and/or for persons accessing treatment services.
21. Refrain from the appearances of dual relationships and enmeshment. All persons are to maintain clear, professional boundaries while on premises.

_____ _____

Participant Signature Date

_____ _____

Staff Signature Date

Client Grievance Procedures

The following procedures were designed for the participant of the A Court Counseling Program to be followed step-by-step to get full satisfaction in the event he/she thinks has been treated unfairly; if a problem with staff, interns or other clients arises, you should:

Step 1. Talk with the person you are having a problem with and try to settle it between you in a Violent-free manner.

Step 2. Request a meeting with the counselor to discuss your problem and see if assistance can be provided.

Step 3. If the situation is not resolved, request a meeting with the COC Coordinator.

Step 4. If the situation is not resolved, you may request a meeting with the Program Director.

Step 5. If you are still dissatisfied, you may request a meeting with the Executive Director.

Anytime you approach the ACCP Coordinator, Program Director, or Executive Director with a problem or grievance, they will also meet with the staff or clients involved before any decisions are made.

_____ _____

Participant Signature Date

YOUR RIGHTS

A COURT COUNSELING PROGRAM does not permit discrimination because of race, color, sex, age, handicap, national origin, religion or political preference.

_____ _____

Participant Signature Date

_____ _____

ACCP Program Director, Michael Yeager B.A, LCDC, C.ht, CAS, SAP Date

FIREARMS AND KNIVES

We **REQUIRE** that all firearms be removed from your home by the time you enter the group program, and that they remain outside the home until completion of the program as a safety precaution. Firearms and knives are not permitted in this facility. My signature below indicates that I will comply with this requirement.

_____ _____

Signature Date

WHAT YOU CAN EXPECT FROM US

1. Respect your dignity and confidentiality as defined in this document, and to give you a copy of this document-for your records.
2. Be honest with you in all aspects of your work here.
3. Provide you with referrals/recommendations in response to additional needs you may have that we are unable to help you meet.

CONFIDENTIALITY

Confidentiality means keeping private your identity and the information you share with your counselor and other group members. On occasion, other Family Support Services employees or interns will have access to your file for agency teaching, supervision, research, and administrative purposes. Interns or agency staff will also, on occasion, observe group. Furthermore, your records may also be accessed by auditors from outside A Court Counseling Program. Any person observing your group or your file is required to sign a statement which requires them to respect your confidentiality.

EXCEPTIONS TO CONFIDENTIALITY

1. Your records could be subpoenaed by a court of law
2. We must report perceived threats of potential immanent physical injury, suicide or homicide (We will contact the police and/or the potential victim in every case where we have reason to fear for the safety of yourself or someone else).
3. We must report suspected neglect or abuse of children, the disabled or the elderly (We are required by law to notify the appropriate protective service (DFPS). We encourage you to report any incidents personally
4. We must send reports to referring agents from the legal system (e.g., judge, district or county attorney, probation officer, or child protective services caseworker).
5. We will attempt to notify your wife/partner where you complete the program or if you are terminated. An attempt will also be made to contact your wife/partner when you begin the program in .order to provide information about services available to her.

You may refuse to disclose any information you are not comfortable disclosing unless it is important to your program. <u>However you will be required to discuss past and present use of violence, specifically describing any emotional, verbal, physical or sexual abuse.</u>

You have the right to look at or obtain access to anything in your file.

_____ _____

Signature Date

NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES

NOTICE THIS NOTICE DESCRIBES HOW MEDICAL/ PROTECTED EALTH INFORMATION ABOUT ME MAY BE USEDAND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE RIEW IT CAREFULLY.

PRIVACY IS IMPORTANT TO ALL OF US.

You have privacy rights under a federal law that protects your health-information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected.

WHO MUST FOLLOW THIS LAW?

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health careproviders
- Health insurance companies, HMOs, most employer group health plans
- Certain government programs mat pay for health care, such as Medicare and Medicaid

PROVIDERS ANDHEALTH INSURERS WHO ARE REQUIREDTO FOLLOW THIS LAW MYST COMPLY WITH YOUR RIGHT TO...

Ask to see and get a copy of your health records

You can ask to see and get a copy of your medical record and other health information. You may not be able to get all of your information in a few special cases. For example, if your doctor decides something in your file might endanger you or someone-else, the doctor may not have to give this information to you.

- In most cases, your copies must be given to you within 30 days, but this can be extended for another 30 days if you are given a reason.
- You may have to pay for the cost of copying and mailing if you request copies and mailing

HAVE CORREOIONS ADDED TO YOUR HEALTH INFORMATION.

You can ask to change any wrong Information in your file or add information to your file if it is incomplete. For example, if you and your hospital agree that your file has the wrong result for a test, the hospital must change it. Even if the hospital believes the test result Is correct, you still have the right to have your disagreement noted in your file.

- In most cases the file should be changed within 60 days, but the hospital can take an extra 30 days if you are given a reason.

RECEIVE A NOTICE THAT TELLS HOW YOUR HEALTH INFORMATION IS USED AND SHARED.

You can learn how your health information is used and shared by your provider or health insurer. They must give you a notice that tells you how they may use and share your health information and how you can exercise your rights. In most cases, you should get this notice on your first visit to a provider or in the mail from your health insurer, and you can ask for a copy at any time.

DECIDE TO GIVE YOUR PERMISSION BEFORE YOUR INFORMATION CAN BE USEDOR SHARED; FORCERTAIN PURPOSES.

In general, your health Information cannot be given to your employer, used or shared for things like sales calls or advertising, or used or shared for many other purposes unless you give your permission by signing an authorization form. This authorization form must tell you who will get your Information and what your information will be used for.

GET A REPORT ON WHEN AND WHY YOUR HEALTH INFORMATION WAS SHARED. Under the law, your health Information may be used and shared for particular reasons, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area, or making required reports to the police, such as reporting gunshot wounds. In many cases, you can ask for and get a list of who your health information has been shared with for these reasons.

- You can get this report for free once a year
- In most cases you should get the report within 60 days, but it can take an extra 30 days if you are given a reason.

ASK TO BE REACHED AT DIFFERENT PLACES OTHER THAN HOME.

You can make reasonable requests to be contacted at different places or in a different way. For example, you can have the nurse call you at your office instead of your home, or send mall to you. in an envelope instead of on a postcard. If sending information to you at home might put you in danger, your health Insurer must talk, call, or write to you where you ask and in the way you ask, if the request is reasonable.

ASK THAT YOUR INFORMATION NOT BE SHARED

You can ask your provider or health Insurer not to share your health information with certain people, groups, or companies. For example, if you go to a clinic, you could ask the doctor not to share your medical record with other · doctors or nurses in the clinic. However, they do not have to agree to do what you ask.

FILECOMPLAINT

If you believe your Information was used or shared in a way that is not allowed under the privacy law, or if you were not able to exercise your rights, you can file a complaint with your provided or health insurer. The privacy notice you receive from them will tell you who to talk to and how to file a complaint. You can also file a complaint with U.S. Government

You also can learn more, including how to file a complaint with the U.S. Government, at the website at: www.hhs.gov/ocr/hipaa/

Acknowledgement of Receipt of Notice

I, _____understand that A Court Counseling Program may share my health information for treatment, billing and healthcare operations according to **Texas Health & Safety Code Chapter 611,Federal (42 CFR Part 2)**, and/or State Confidentiality Regulations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand the organized healthcare arrangement has the right to change this notice at any time; I may obtain a current copy by contacting the human resource agency office.
My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

Successful Discharge

1. Successful discharge is defined as:
    a. completion of intake and assessment (if applicable)
    b. Completion of the prescribed number of sessions as directed by the program,
    c. Payment of fees
    d. Completion of goals identified on Individualized Plan (if applicable)
    e. Compliance with program rules governing appropriate participation.
2. Unsuccessful discharge is defined as:
    a. Discontinuance of the program (e.g., more than 2 absences)
    b. Receipt of an additional charge for which admission was necessary
    c. Failure to work towards established goals on Individualized Plan (if applicable)
3. Termination decisions are to be consistent, objective, and predictable; thus, will address the following:
    a. Continued using alcohol, drug and other addictive behavior
    b. Attendance
    c. Inappropriate use of intervention techniques in accordance with program principles
    d. Non-compliance with other intervention conditions or provisions that are part of the participant's written agreement, such as involvement in a recovery program
    e. Non-compliance with fee payment
    f. Violation of group rules to include frequent and/or continued use of manipulation or disruptive behavior during group sessions.
    g. Violation of any provisions of court order, including child support, particularly when the participant is court-mandated to intervention.

_____ _____

Participant Signature Date

_____ _____

Staff Signature Date

Orientation Checklist

I _____, have been informed of the following information in A Court Counseling Program orientation packet and will initial to verify that this information has been explained to me upon my enrollment:

☐ Program services will be provided in understandable terms for greatest comprehension by participants.

☐ Group day and time information has been provided upon my enrollment into the program which is verified by the Consent to Participate in A Court Counseling Program.

☐ Notice of change in time and/or day that group is to be held on will be made a minimum of two weeks prior to change.

☐ Anti-discrimination laws and applicable state and federal laws have been explained to me as verified by the Grievance Procedure.

☐ Referring agency and/or its representatives will be made aware of my participation to include compliance or lack thereof monthly throughout the course of program in the form of a Monthly Progress Report which has been verified on the Release of Confidential Information.

☐ Referring agency and/or its representatives will be made aware of any acts of violence or violation of laws within 24 hours of A Court Counseling Program being informed.

☐ Discharge Summary. Report will be forwarded to referring agency and/or its representatives within 24 hours of termination from program or successful completion as verified in Release of Confidential Information and discharge Criteria.

☐ Copies of all orientation documentation that I have signed during my enrollment into the program will be provided to me.

☐ A Court Counseling Program will make every effort to provide fair and humane treatment to participants.

_____ _____

Participant Signature Date

_____ _____

ACCP Program Director, Michael Yeager B.A, LCDC, C.ht, CAS, SAP Date

PSYCHOSOCIAL ASSESMENT

Name _____ Admission Date _____

Age: _____ Date of Birth _____ SS# _____

Home Address _____

Phone _____ Cell _____

Email Address _____

Emergency Contact _____ Phone _____

1. **Describe why you came for Treatment. (Be specific)**

_____

_____

_____

2. **How has your addiction affected your life? (Be Specific)**

_____

_____

_____

3. **Describe your addictive history.**

What is your "drug of choice"? _____

What do you suspect are triggers that perpetuate your drug/alcohol use or any other addictive behavior?

_____

_____

What do you hope to gain from this treatment?

_____

_____

Please answer the following questions by circling a Yes or No answer.

Have you ever tried to cut back on your consumption? Yes No

Would you consider total abstinence from all mood/mind-altering chemicals? Yes No

Are you ever angry when criticized or confronted about your drug/alcohol use? Yes No

Do you ever feel guilty after "using"_____? Yes No

Have you ever experienced any of the following symptoms?

Loss of control?	Yes	No
Compulsion?	Yes	No
Hangovers?	Yes	No
Seizures?	Yes	No
Blackouts?	Yes	No
Overdose?	Yes	No
Sleep disturbance?	Yes	No
Assaults?	Yes	No
Suicidal Impulse?	Yes	No
Relationship Conflicts?	Yes	No
Binges?	Yes	No
Job loss?	Yes	No
Arrests?	Yes	No

Cannot not use despite adverse consequences? Yes No

Other: _____

Have you begun to "use" and/or "drink" at times when you previously had not allowed yourself to indulge, i.e. mornings, at work, while operating a vehicle or equipment, or at any time that you considered to be taboo?
Yes No

Has your drug and/or alcohol use caused you to break any other rules or vows you have set for yourself?
Yes No

Have you ever experienced any of the following as a result of decreased use of alcohol and/or drugs?

Shakes	Yes	No
Seizures	Yes	No
Convulsions	Yes	No
Hallucinations	Yes	No
Hangovers	Yes	No

Do you believe you have a problem with drugs and/or alcohol? Yes No

Please explain: _____

_____

Please explain the consequences of your drug/alcohol use.

_____

_____

Do you believe that someday you may be able to use drugs and/or alcohol without consequences? Yes No

Please explain: _____

_____

Starting at your earliest age, detail your drug/alcohol history:

Substances Used	First Use Age	Last Use Age	Current Use	Frequency/ Amount
Alcohol				
Amphetamines				
Barbiturates				
Caffeine				
Cocaine				
Crack cocaine				
Hallucinogens				
Inhalants				
Marijuana or hashish				
Nicotine				
PCP				
Sedatives				
Ecstasy				
Opiates				
Prescription Drugs:				
Other:				

Please answer the following questions by circling a <u>Yes</u> or <u>No</u> answer.

<u>Alcohol</u>

When you have a drink with friends, yon usually drink more than they do. Yes No

Your drinking causes problems with your family or friends. Yes No

Your drinking causes problems with your work. Yes No

After you have been drinking, you cannot remember things that happened. Yes No

After yon have been drinking, you get the shakes. Yes No

When you are drinking, you have three or fewer drinks. Yes No

You drink to calm your nerves or make yourself feel better. Yes No

Yon drink when you are alone. Yes No

You drink so much that you go to sleep or pass out. Yes No

Your drinking interferes with obligations to your family or friends. Yes No

Yon have one or more drinks when things are not going well for you. Yes No

Yon have one or more drinks before noon. Yes No

Your friends avoid you when you are drinking. Yes No

Your personal life gets very troublesome when you drink. Yes No

You drink 3 to 4 times a week. Yes No

Your family or friends tell you that you drink too much. Yes No

You feel that you drink too much alcohol Yes No

After you have had one or two drinks, it is difficult for you to stop drinking. Yes No

You feel guilty about what happened when you have been drinking. Yes No

When you go drinking you get into fights. Yes No .

Your friends think you have a drinking problem. Yes No

It is hard for you to stop drinking when you want to. Yes No

Your friends think your level of drinking is acceptable. Yes No

You get mean and angry when you drink. Yes No
You avoid drinking to excess. Yes No

Prescription and/or Illegal Drug Use

You take drugs to calm your nerves or make you feel better. Yes No
When you take drugs with friends, you usually take more than they do. Yes No
Your drug use causes problems with your family or friends. Yes No
Your drug use causes problems with your work. Yes No
You take drugs when you are alone. Yes No
Your drug use interferes with obligations to your family or friends Yes No
You take drugs when things aren't going well for you. Yes No
Your friends avoid you when you take drugs. Yes No
Your personal life gets very troublesome when you use drugs. Yes No
You take drugs several times a week. Yes No
Your family or friends tell you that you take to many or too much drugs. Yes No
You feel that you use too much drugs. Yes No
After you have begun using drugs, it is difficult for you to stop. Yes No
You do not use drugs. Yes No
You feel guilty about your use of drugs. Yes No
When you do drugs, you get into fights. Yes No
After you have been using drugs, you cannot remember things that happened. Yes No
After you have been using drugs you get the shakes. Yes No
Your friends think you have a drug problem. Yes No
You do drugs so much that you pass out. Yes No
You can stop using drugs whenever you want to. Yes No
You do drugs before noon. Yes No
Your friends think your level of drug use is acceptable. Yes No
You avoid excessive use of drugs. Yes No
You get mean and angry when you do drugs. Yes No

What do you know about 12 Step Program? _____

_____

Have you ever been involved in the 12 Step Program and to what extend? _____

_____

What is your attitude about 12 Step Program? _____

_____

_____

4. Describe the other addictions that you have.

Do you think you have another addiction besides drugs and alcohol? Yes No

If YES, which one (s)

☐ Gambling ☐ Spending Money ☐ Internet Addiction ☐ Eating Disorder ☐ Sexual Addiction

Please answer the following questions by circling either a yes or no.

Gambling

Did you ever lose time from work due to gambling? Yes No
Has gambling ever made your home life unhappy? Yes No
Did gambling affect your reputation Yes No
Have you ever felt remorse after gambling? Yes No
Did you ever gamble to get money with which to pay debts or solve financial difficulties? Yes No
Did gambling cause a decrease in your ambition or efficiency? Yes No
After losing did you feel you must return as soon as possible and win back your losses? Yes No
After a win did you have a strong urge to return and win more? Yes No
Did you often gamble until your last dollar was gone? Yes No
Did you ever borrow to finance your gambling? Yes No
Have you ever sold anything to finance gambling? Yes No
Were you reluctant to use "gamble money" for normal expenditures? Yes No
Did gambling make you careless of the welfare of yourself and your family? Yes No
Did you ever gamble longer than you had planned? Yes No
Have you ever gambled to escape worry or trouble? Yes No
Have you ever committed, or considered committing an illegal act to finance gambling? Yes No
Did gambling cause you to have difficulty in sleeping? Yes No
Do arguments, disappointments or frustrations create within you an urge to gamble? Yes No
Did you ever have an urge to celebrate any good fortune by a few hours of gambling? Yes No

Spending Money

Do you start out thinking that you deserve a reward and then end up feeling shame and guilt? Yes No
Does your spending cause strife between; yourself and a significant other? Yes No
Do you go shopping to change your mood? Yes No
Do you shop when you are depressed? Yes No
Do you shop when you are happy and then become depressed? Yes No
Have you ever maxed out your credit cards? Yes No
Have you ever asked yourself why you buy things you don't need? Yes No
Have you ever spent money for bills on things for yourself? Yes No
Have you stolen money from a friend, family member, employer pp of business? Yes No
Have you ever used one credit card to pay the bill of another? Yes No
Do you shop to impress others? Yes No
Do you hide things that you buy from others? Yes No
Do you give things away to others to help relieve the Do you give things away to others to help relieve the pain caused by spending? Yes No
Have you ever sought help for a spending/shopping problem? Yes No
Have you ever wished your life was different? Yes No

Internet Addiction

Do you spend more time than you think you should surfing the "Net"? Yes No
Do you feel you have a problem limiting the time you spend on the "Net"? Yes No

Have any of your friends or family members complained about the time you spend at your computer? Yes No
Do you find it hard to stay away from the "Net" for several days at a time? Yes No
Has either your work output or your personal relationships suffered as a result of spending too much time on the "Net"? Yes No
Are there particular areas of the "Net" or types of files, you find hard to resist? Yes No
Do you have trouble controlling your impulses to purchase products or services on the "Net"? Yes No
Have you tried, unsuccessfully to control your use of the "Net"? Yes No
Do you derive much of your pleasure and satisfaction in life from being on the "Net"? Yes No

Eating Disorder

You are terrified about being overweight? Yes No
You avoid eating when you are hungry? Yes No
You find yourself preoccupied with food? Yes No
Yon have gone on eating binges where you feel that you may not be able to stop? Yes No
You cut your food into small pieces? Yes No
You are aware of the calories content of foods that you eat? Yes No
You particularly avoid food with high carbohydrate content? Yes No
You feel that others would prefer if you ate more? Yes No
You vomit after you have eaten? Yes No
You feel extremely guilty after eating? Yes No
You are preoccupied with a desire to be thinner? Yes No
You think about burning up calories when you exercise? Yes No
Other people think that you are too thin? Yes No
You are preoccupied with the thought of having fat on your body? Yes No
You take longer than others to eat your meals? Yes No
You avoid foods with sugar in them? Yes No
You eat diet foods? Yes No
You feel that food controls your life? Yes No
Yon display self-control around food? Yes No
You feel that others pressure you to eat? Yes No
You give too much time and thought to food? Yes No
You feel uncomfortable after eating sweets? Yes No
You engage in dieting behavior? Yes No
You like your stomach to be empty? Yes No
You enjoy trying new rich foods? Yes No
You have the impulse to vomit after meals? Yes No

Sexual Addiction

You frequently fantasize or think about sex? Yes No
You have made promises to yourself or others to change or stop some of your sexual behavior and then have broken these promises? Yes No
Your sexual desire causes you to associate with people you would not normally be with or do things you would not usually do? Yes No
Frequenting sex sites on the internet for sexual stimulation have become a habit for you? Yes No
You frequently engage in sexual chat in sexually oriented chat rooms on the internet? Yes No

Masturbation is a frequent activity for you? Yes No
You have or have had an extensive collection of pornography or other X-rated material? Yes No
You have gotten rid of a pornography collection and then started collecting it again? Yes No
With some regularity you rent or buy X-rated videos? Yes No
You like to "channel cruise" on TV to find sexually stimulating scenes or have subscribed to cable in order to view sexually explicit programs? Yes No
You are attracted to phone sex? Yes No
You frequent topless dubs? Yes No
You frequent modeling studies for sex? Yes No
You go to massage business where you are able to obtain sexual massages? Yes No
You frequent adult bookstores for sexual excitement or sexual activity? Yes No
You frequent or have frequented X-rated movie theatres? Yes No
You frequent other sexually-oriented businesses? Yes No
Your regular sex partner frequently complains about the amount of sex or type of sex that you desire with him/her? Yes No
You have violated your marriage or other relationship by having or sex or affairs with others? Yes No
You are especially excited by sexual behavior that includes a risk of being caught? Yes No
You get a sexual thrill from your private body parts to unsuspecting onlookers? Yes No
You have a habit of trying to get forbidden looks at people that give you sexual excitement? Yes No
You frequently indulge in anonymous sex with others? Yes No
You take advantage of opportunities to touch people sexually that you find attractive by touching them in a way that makes it seem accidental? Yes No
You are an adult who engages in sexual activity with children? Yes No
You are an adult who forces other adults to have sex with you against their will? Yes No
You have been arrested because of some of your sexual behavior? Yes No
Some of your sexual activity causes you to have a secret life hidden from significant others? Yes No
Your sexual behavior or fantasy-sometimes makes you feel hopeless or depressed! Yes No
Yon have been told by someone that your sexual behavior is excessive or in appropriate or out of control? Yes No

5. TREATMENT HISTORY

Briefly describe events leading up to this treatment episode. _____

_____

_____

_____

Is there any family, legal or employment pressure for you to seek treatment? Yes No
If yes, please explain: _____

_____

_____

_____

List all past treatment program and/or therapists that you have seen in the past:

Treatment Center or Therapist Name Dates Type of Discharge

_____

_____

_____

List all prescribed medications and the illnesses for which they are prescribed:

Medication Diagnosis

_____

_____

_____

What were your past treatment goals and objectives? _____

_____

6. MEDICAL HISTORY

Describe your current physical health: ☐Good ☐Fair ☐Poor

Have you ever been hospitalized for a physical condition? Yes No

If so, what were you hospitalized for: Yes No

If so, where were you hospitalized and when: _____

Do you currently have any major illnesses? Yes No

If so, what major illnesses do you have _____

List any medications that you are currently taking: _____

7. CURRENT LIVING SITUATION

Where do you currently reside? _____

_____

With whom do you currently reside? _____

_____

Describe the atmosphere of your current living situation? _____

_____

_____

_____

Is anyone in your current residence abusing drugs and/or alcohol? Yes No

If yes, please explain: _____

_____

_____

_____

8. INTIMATE RELATIONSHIPS AND MARRIAGE

Marital Status:

☐ Single, never married
☐ Engaged _____months
☐ Married for _____years
☐ Divorced for _____years
☐ Separated for _____months
☐ Divorce in process _____months
☐ Live in for _____years
☐ Had prior marriages _____number

Are you currently married or involved in a relationship with another? Yes No

If yes, please explain: _____

_____

_____

If yes, how do you feel about this marriage or relationship? _____

_____

_____

List past marriages and reasons for dissolution: _____

_____

_____

List all the children, their age, and with whom they reside: _____

_____

_____

Are any of your children experiencing school, discipline or emotional problems? Yes No

If so, please explain _____

_____

_____

Describe any past or current significant issues in any of your intimate relationships: _____

_____

_____

_____

9. PEER GROUP

Are any of members of your group involved in alcohol and drug use? Yes No

If so, please explain _____

_____

_____

What do you like about your friends? _____

_____

What do you dislike about your friends? _____

_____

What are your future goals with your friends? _____

_____

_____

10. CHILDHOOD AND FAMILY HISTORY

Place of birth _____

Childhood family experience: Please check one:

☐ Outstanding home environment

☐ Normal home environment

☐ Chaotic home environment

☐ Witnessed physical/verbal/sexual abuse toward others

☐ Experienced physical/verbal/sexual abuse from others

Were you raised by both parents: Yes No

If no, please explain _____

_____

_____

Describe your relationship with your mother: _____

_____

_____

What do you like about your mother? _____

_____

_____

What do you dislike about your mother? _____

_____

_____

Describe your relationship with your father: _____

_____

_____

What do you like about your father? _____

_____

_____

What do you dislike about your father? _____

_____

_____

How would you describe your parent's relationship with each other? _____

_____

_____

If one or both of your biological parents were missing who was your primary care taker? _____

_____

Please describe your relationship with them: _____

_____

List all siblings, their ages and occupation:

Name Age Occupation

_____

_____

_____

_____

_____

_____

Describe your relationship with your siblings: _____

_____

_____

_____

_____

_____

Is there any particular sibling that you had or are having difficulty with? Yes No

If so, please explain _____

_____

_____

List anyone else who lived in your childhood home and describe your relationship with them: _____

_____

_____

What is your worst childhood memory? _____

_____

_____

What is your best childhood memory? _____

_____

_____

List relatives that have experienced dependencies:

Name Relationship Are they in recovery

_____

_____

_____

_____

Has any family member had any type of treatment for a psychiatric, emotional or substance use disorder?

Yes No

If so, please list your family members and what they were treated for: _____

_____

_____

Describe similarities you notice in your relationship with others that remind of your parent or others in your family:

_____

_____

_____

Are there any current family problems that will distract you from treatment? Yes No

If yes please describe: _____

_____

_____

_____

_____

What family traditions or cultural influences have made an impact on your adult life? _____

_____

_____

What are your future goals for you and your family? _____

_____

_____

_____

_____

11. EDUCATION

Describe your school experience:

Highest Grade Completed Degree Name of School Location

Please list other certificates, licenses or relevant training: _____

How would you describe your school and educational experience? _____

What did you like about school? _____

What did you dislike about school? _____

What are your future educational goals? _____

12. VOCATIONAL AND EMPLOYMENT HISTORY

Describe your current employment position and duration: _____

Are you currently satisfied with your employment? _____

_____

Have you had past positions which were more desirable? _____

_____

Does your seeking treatment have anything to do with employment status? Yes No

Please explain: _____

_____

How would you identify or describe your ideal job or career? _____

_____

_____

What do you like about your work? _____

_____

What do you dislike about your work? _____

_____

What are your future vocational goals? _____

_____

_____

13. FINANCIAL

What are your current sources of income? _____

_____

Do any other household members contribute? _____

_____

Are your sources of income or other resources stable? _____

_____

Have drugs and/or alcohol caused you any financial stress through cost, resulting legal or medical repercussions, or other mismanagement of money issues? _____

_____

_____

Describe any financial setbacks you have experienced due to drugs and/or alcohol? _____

_____

_____

14. LEGAL

List any arrests Alcohol/Drug related Yes No _____

_____

_____

Penalties for the above: _____

_____

_____

Current legal status:

Probation/Parole: _____

Community Services: _____

Court order/Recommendation: _____

15. SEXUAL HISTORY

Age and brief description of your first sexual experience: _____

_____

_____

How do you believe this experience affected your later sexual identity? _____

_____

_____

Are you comfortable with your current sexual identity? _____

_____

_____

How would you define your sexual preference? _____

_____

_____

16. LEISURE AND RECREATION

Activity/Interest Checklist: Please check those activities you enjoy. In addition, circle those activities you did while using your drug of choice.

PARTICIPATIVE SPORTS:

☐ Baseball
☐ Basketball
☐ Football
☐ Boating
☐ Fishing
☐ Golf
☐ Hunting
☐ Ping Pong
☐ Pool
☐ Racquetball
☐ Skiing
☐ Soccer
☐ Tennis
☐ Volleyball
☐ Weight Lifting
☐ Other: _____

ENTERTAINMENT/CULTURAL

☐ Television
☐ Movies
☐ Video Games
☐ Art Shows
☐ Concerts
☐ Plays
☐ Museums
☐ Singing
☐ Listening to Music
☐ Playing Musical Instruments
☐ Visiting
☐ Volunteering
☐ Clubs/Organizations
☐ Other: _____

SOCIAL

☐ Barbeques
☐ Camping
☐ Conversation (face to face)
☐ Conversation (telephone)
☐ Dating
☐ Dining Out
☐ Family Activities
☐ Shopping/Going to Mall
☐ Parks
☐ Parties
☐ Reminiscing
☐ Spending Time With a Special Person
☐ Other: _____

HOBBIES

☐ Auto Mechanics
☐ Shopping/Bargain Hunting
☐ Cooking/Baking
☐ Electronics/Computers
☐ Drama/Acting
☐ Gardening/Yard Work
☐ Pets
☐ Arts & Crafts
  ☐ Model Building
  ☐ Crafts/Craft Shows
  ☐ Ceramics/Pottery
  ☐ Sewing/Knitting/Crochet
  ☐ Drawing
  ☐ Painting
  ☐ Wood Working
☐ Other: _____

COGNITIVE

☐ Board Games
☐ Card Games
☐ Computer Programs/Games
☐ Crossword Puzzles/Word Games
☐ Puzzles
☐ Reading
☐ Table Games
☐ Writing
☐ Collecting
☐ Other: _____

Please check those problems that affect your leisure time activities:

☐ Physical Abilities
☐ Lack of Interest/Motivation
☐ No One to Do Things with
☐ Using/Obtaining the Drug of Choice
☐ Fear of Failure
☐ Lack of Transportation
☐ Job
☐ Lack of Money
☐ Lack of Time
☐ Lack of Support
☐ Caring for Someone Else
☐ Other: _____

Do you have any physical problems which prohibit your participation in recreational activities? Yes No

If so, please explain _____

_____

Please answer the following questions by circling Yes No

- You feel awkward and uncoordinated in physical activities Yes No
- You shy away from group activities Yes No
- When you play games, you feel you have to win Yes No
- You tend to turn on TV when you don't really know what to do Yes No
- You feel nervous or uncomfortable when you meet new people Yes No
- You are often bored in your free time Yes No
- You don't know what leisure is Yes No
- You have to finish your work before you can play Yes No
- You would like to learn new recreational activities Yes No
- You have used your drug of choice before a special function Yes No
- You feel uncomfortable in situations where there is getting drunk or high Yes No
- Your main leisure activity is getting drunk or high Yes No
- Your weight affects what you do or don't do Yes No
- You are gambling more than usual Yes No
- Once you start gambling, you can't stop Yes No
- You need sex to feel good about yourself Yes No
- At times you use alcohol, drugs, food or gambling as a means to relax and just get away from it all Yes No

17. NUTRITION AND EATING HABITS

How many days a week do you eat breakfast? (Please check one)

☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

What kind of foods do you usually eat for breakfast including amount? _____

_____

How many days a week do you eat lunch? (Please check one)

☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

What kind of foods do you usually eat for lunch including amount? _____

_____

How many days a week do you eat dinner? (Please check one)

☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

What kind of foods you usually eat for dinner, including amount? _____

_____

On the average, do you usually eat snacks between meals through your day? Yes No

If yes, please explain, including what type of snack and amount:_____

_____

Do you usually eat something after dinner? Yes No

If yes, please explain, including what type of food and amount:_____

_____

How much do you drink during the day?_____

What type of food do you usually like to eat during the day? _____

Describe what kind of foods you usually eat for dinner, including amount: _____

What is your favorite food? _____

What is your least favorite food? _____

Circle any of the foods listed below that you DO NOT eat:

• Chicken • Fish • Vegetables • Meat Milk • Eggs •Cheese • Other: _____

Have you ever had and eating problem that required you to seek professional help? Yes No

If yes, please explain, including what type of snack and amount:_____

_____

_____

18. Religious and Spiritual Orientation

In which faith did you grow up? _____

How often to you attend Religious Services? (Please check one)

☐ Regularly ☐ Occasionally ☐ Rarely ☐ Do not Attend Service

Which of the choices below are you interest in or involve with? (Check as many that apply)

☐ Meditation ☐ Prayer ☐ Study Groups ☐ Spiritual Reading

☐ Nature ☐ Other: _____ ☐ No Interest

Do you believe in Higher Power? Yes No

Please explain: _____

_____

What does higher power mean to you? _____

_____

Has a belief in Higher Power made a difference in your life? Yes No

Please explain: _____

_____

_____

_____

_____

How do you practice your faith in a Higher Power? _____

_____

_____

_____

_____

Do you believe a Higher Power can help you in your recovery? Yes No

Please explain: _____

_____

_____

_____

19. MILITARY SERVICE

Branch of Military: _____

Type of discharge: _____

20. EMOTIONAL

Please check all of the symptoms that you are now experiencing:

☐ Depressed Mood	☐ Appetite Disturbance
☐ Sleep Disturbance	☐ Elimination Disturbance
☐ Fatigue/Low Energy	☐ Psychomotor Retardation
☐ Poor Concentration	☐ Poor grooming
☐ Mood swings	☐ Agitation
☐ Irritability	☐ Emotionality
☐ Generalized Anxiety	☐ Panic Attacks
☐ Phobias	☐ Obsession/compulsion
☐ Bingeing/Purging	☐ Laxative/Diuretic Abuse
☐ Anorexia	☐ Paranoid Ideation
☐ Delusions	☐ Hallucinations
☐ Aggressive Behaviors	☐ Conduct Problems
☐ Oppositional Behavior	☐ Sexual Dysfunction
☐ Grief	☐ Hopelessness
☐ Social Isolation	☐ Worthlessness
☐ Guilt	☐ Elevated Mood
☐ Hyperactivity	☐ Self-mutation
☐ Significant Weight Gain/Loss	☐ Emotional trauma victim
☐ Sexual Trauma victim	☐ Other: _____

Describe your strengths and abilities: _____

_____

Describe your strengths and abilities as they are related to your potential for recovery: _____

_____

Describe your weaknesses: _____

_____

Describe your weaknesses as they are related to your potential for recovery: _____

_____

Describe the effects drugs and/or alcohol had on either of the above: _____

_____

What do you like about yourself: _____

_____

What do you dislike about yourself: _____

_____

Have you ever thought about suicide? Yes No

If yes, please explain: _____

_____

Have you ever attempt suicide? Yes No

If yes, please explain: _____

_____

Do you believe that you are currently suicidal? Yes No

If yes, please explain: _____

_____

Have you ever been homicidal? Yes No

If yes, please explain: _____

_____

Are you currently homicidal? Yes No

If yes, please explain: _____

_____

Were drugs and/or alcohol involved in the above thinking? Yes No

If yes, please explain: _____

_____

Have you ever experienced any past or current sexual, psychological or physical abuse or trauma? Yes No

If yes, please explain: _____

_____

Please explain your current emotional state: _____

_____

_____

What are your future personal goals? _____

_____

_____

21. Goals and Objectives

What goals would you choose for yourself in treatment? Please check those that apply to you.

☐ Become more independent
☐ Learn to handle problems
☐ Get along better with others
☐ Feel better about myself
☐ Develop New Skills
☐ Be more comfortable with and trusting of others
☐ Make decisions for myself
☐ Follow through with decisions I have made
☐ Participate in drug free activities
☐ Be able to stand up for myself
☐ Finish the things that I start
☐ Be able to express my emotions appropriately and productively
☐ Other: _____

What goals do you have for yourself in this treatment program?

1. _____
2. _____
3. _____
4. _____
5. _____

22. Are there any other comments about yourself and your life you believe is important:

_____

_____

_____

_____

23. CLINICAL SUMMARY

_____

_____

_____

_____

_____

_____

_____

24. DIAGNOSIS

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

25. **RECOMENDATIONS**

_____

_____

_____

_____

_____

_____