Gwee's Integrated Health
Integrated Health Solutions

FACE SHEET

Date of Intake:

Services:

AHCCCS ID#:

☐ Mentoring

☐ IOP

CMDP #

Circle any applicable below:

Title 19 Title 21 SMI SA Child/Adolescent

Current Diagnosis Codes:

Client Full Name:

Male: ☐ Female: ☐

Preferred Name:

Date of Birth:

S.S.#:

Client Address:

City:

Zip code:

Client Mobile Telephone:

Home:

Work:

Referral Source:

Reason for referral:

Referring Probation Office:

Office Telephone:

Mobile:

E-Mail:

Gender Identity: _____ Sexual Orientation: _____

Race: _____ Language: _____

Marital Status: ☐ Married ☐ Single ☐ Other

Height: _____ Weight: _____Ethnicity: _____

Medical Conditions / Needs:

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Client Information Sheet

M ☐

C=

M=

Intake Date:

Client Name: DOB:

Address: Client: Adult ☒

Directions:

Telephone:_____ Other: _____

Emergency Contact:_____ Phone: _____

Probation Officer:_____ Phone:_____

Parole Officer:_____ Phone:_____

Visit Frequency:

Mentor:_____

IOP:_____

Allergies: ☐ (If checked, please write in detail below)

_____

No known-Allergies: ☐

_____

Nutrition Limitations: ☐ N/A: ☐

_____

_____

Current Behavioral Health needs:

_____

_____

Education: ☐ N/A: ☐

Grade: _____ Grade Status: _____

School Attending (IF MINOR):

Educational Needs: _____

_____

Last Place of Employment: ☐ N/A: ☐

_____

Resources Requested:

_____

_____

Assigned Mentor: Phone #:

Any Notes Upon

Intake:_____

_____

Intake Specialist Signature: _____ Date: _____

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Emergency Contact Information Form

This information will be used in the event of an accident or medical emergency.

Please be sure to sign and date this form

Name:

Phone: Home: Cell:

Email Address:

Address:

Primary Emergency Contact Name:

Last First

Relationship:

Phone:

Home: Cell: Work:

Secondary Emergency Contact Name

Last:_____ First:_____

Relationship:

Phone: _____

Home: _____ Cell: _____ Work: _____

Preferred Local Hospital: _____

Insurance Information Company: _____

Policy #: _____ Comments (include any special medical or personal information you would want an emergency care provider to know – or special contact information:

Signature: _____ Date: _____

Staff / Title

Date

CONSENT FOR TELEHEALTH TREATMENT

Client Name:

As a client receiving behavioral services through telehealth methods, I understand:

Telehealth is the delivery of behavioral health services using interactive technologies (audio, video or other electronic communications) between a provider and a client that are not in the same physical location. The interactive technologies used in Telehealth incorporate network and software security protocols to protect the confidentiality of patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

1. This service is provided by technology (included but not limited to video, phone, text, and email) and may involve direct face to face communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery. During your televised, details of your medical history and personal health information may be discussed with you or your behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

2. I may decline any telehealth services at any time without jeopardizing my access to future care, services, or benefits.

3. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My team and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today and modify our plan as needed.

4. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Client Signature

Date

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Client Rights

All Clients agreed to services are provided with the following rights:

- To be treated with dignity, respect and consideration
  - A client as not subjected to:
    - A.) Abuse
    - B.) Exploitation
    - C.) Coercion
    - D.) Manipulation
    - E.) Neglect
    - F.) Sexual abuse
    - G.) Sexual Assault
    - H.) Seclusion
    - I.) Restraint, if not necessary to prevent imminent harm to self or others;
    - J.) Retaliation for submitting a complaint to the Department or another entity; or
    - K.) Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student.
- To not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment
- To receive treatment that supports and respects the patient's individuality, choices, strengths and abilities; that supports the patient's personal liberty, except for a court order, by the patient's consent; and is provided in the least restrictive environment that meets the patient's treatment needs.
- To not be prevented or impeded from exercising the patient's civil rights unless the patient has been adjudicated incompetent or a court of competent jurisdiction has found that the patient is unable to exercise a specific right or category of rights.
- To submit grievances to Gwee's Integrated Health and/or complaints to outside entities without constraint or retaliation.
- To have grievances considered by Gwee's Integrated Health in a fair, timely and impartial manner.
- To seek, speak to, and be assisted by legal counsel of the patient's choice at the patient's expense.
- To receive assistance from a family member, designated representative, or other individual in understanding, protecting or exercising the patient's rights.
- To have patient's information and records be confidential and released only as permitted by state and federal law (under R-9-20211(A)(3) and (B), court order, or as authorized in writing by the patient's legal guardian.

• To privacy in treatment, including the right to not be fingerprinted, photographed, or recorded without consent (except for photographing for identification and administrative purposes as provided by A.R.S. Title 36-507(2); for video recordings used for security purposes that are maintained only on a temporary basis) as provided in R9-20-602(A)(5).

• To review, upon written request by the patient's legal guardian, the patient's record during normal agency business hours or at a time agreed upon between the patient's legal guardian and the contractor

except as described in R9-20-211(A)(6); to review the following at the agency of at the OBHL: this chapter, the report of the most recent inspection of the premises conducted by OBHL, a plan of correction in effect as required by OBHL.

• To be informed of all fees that the patient is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavior health service provided to a patient experiencing a crisis situation.

• To consent to treatment, unless treatment is ordered by a court of competent jurisdiction after receiving a verbal explanation of the patient's condition and the proposed treatment, including the intended outcome, the nature of the proposed treatment, any procedures involved in the proposed treatment, risks or side effects of the proposed treatment and any alternatives to the proposed treatment.

• To be free from abuse, neglect, exploitation, coercion, and manipulation.

• To be offered or referred for the treatment specified in the patient's treatment plan or to receive a referral to another agency if this agency is unable to provide a behavioral health service that the patient requests or that is indicated in the patient's treatment plan.

• To have the patient's parent, guardian, custodian, or agent participate in treatment decisions and in the development and periodic review and revision of the patient's written treatment plan.

• To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to ARS Title 36, Chapter 5, is necessary to save the patient's life or physical health, or is provided according to ARS 36-512

• To be free from abuse, neglect, exploitation, coercion, manipulation, retaliation for submitting a complaint, discharge/transfer/threat of discharge for reasons unrelated to the patient's treatment needs, except as established in the signed fee agreement, treatment that involves the denial of food/sleep/opportunity to use the toilet, restraint or seclusion of any form.

• To participate or refuse to participate in religious activities. • To control the patient's own finances except as provided by ARS 36-507(5).

• To participate or refuse to participate in research or experimental treatment; to give informed consent in writing/refuse to give informed consent/withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment.

• To be free from performing any labor for the agency.

• To refuse to acknowledge gratitude to Gwee's integrated Health through written statements, other media, or speaking engagements at public gatherings.

• To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside of the facility.

• If enrolled in a regional behavioral health authority as an individual, to receive assistance from that agency in understanding, protecting or exercising patient rights.

Your Rights Regarding Your Health Information and Privacy Practices

How We Collect Information About You: Gwee's Integrated Health and its employees' collect data through a variety of means including but not necessarily limited to intake forms, psychotherapy case notes, letters, phone calls, emails, voice mails, staffing and from intake information received by a referring agency that is necessary in the development and implementation of your

treatment plan. **What We Do Not Do with Your Information:** Information about your history that you provide to us in writing, via email, on the phone (including information left on voice mails), directly or indirectly given to us, is held in strictest confidence. We do not give out or disseminate any information about patients who receive our services that is considered patient confidential or is restricted by law.

How We Do Use Your Information: Information is only used as is reasonably necessary to provide you with counseling services which may require communication between Gwee's Integrated Health and other agencies involved in your care and treatment to determine the type of counseling services are necessary. We will first obtain a written authorization release form from you prior to the release or verbal sharing of any information about you or your treatment with our agency. Gwee's Integrated Health may only release information that has been generated by the employees of Gwee's Integrated Health in their treatment work with you. Any information received from other agencies will not be released by Gwee's Integrated Health .

Limited Right to Use Non-Identifying Personal Information from Other Sources: Any written therapy work becomes the property of Gwee's Integrated Health and is placed in your confidential and privacy protected patient file. We respect your right to privacy and assure you no identifying information will ever be publicly used without your prior direct consent. To review, upon written request, the client's own medical record according to A.R.S. 12-2293, 12-2294, and 12-2294,01

Consent to Treatment and Limited Confidentiality I have been referred for counseling, IOP, and/or mentoring and I understand that counseling should provide significant benefits but may also pose some risks in that it may cause uncomfortable thoughts and feelings or may lead to the recall of troubling memories. I understand that the type of treatment, the treatment modality and treatment plan will be established with me during the first 30 days of sessions with therapist. I further understand that these Treatment Plan goals will be revised as necessary and that I will have input into both my Individual initial Individual Service Plan at intake as well as any subsequent revisions of my Treatment Plan goals. My Treatment Plan goals will be reviewed every 90 days (or earlier as needed). I understand that if I am referred for treatment by an agency and my treatment is funded by that agency that my therapist must

speak openly and freely with the agency about my treatment and any related issues. This includes but is not limited to verbal phone contact and messages, email messaging that is secure and providing a written monthly report with session case notes of my counseling progress. Any other sharing of information will require a specific signed release of information form that indicates who the information can be released to, what information can be released and the purpose for the release of information as

well as an expiration date (maximum one year) for the signed release. I further understand that I can revoke a release that I have signed, but that will not affect any information that was released prior to the signing of the release. There are certain exceptions to confidentiality: 1. When there is a risk of imminent danger to myself or by me to another person; the therapist is legally bound to take necessary steps to prevent such danger .2. When there is information or suspicion of sexual or physical abuse of a child, the therapist is legally bound to report this to the proper authorities. 3. When there is a valid court order for the release of information, the therapist will comply with the law and for probation funded

patients will direct any order to the probation department. Except in an emergency, either consents or refuses treatment; may refuse or withdraw consent to treatment before treatment is initiated. Except in an emergency, is informed of alternatives to a proposed psychotropic medication pr surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure. Consents to photographs of the client before a client is photographed except that a client may be photographed when admitted to an outpatient and/or inpatient treatment center for identification and administrative purposes. I understand that if I am in treatment with a master's level therapist who is working on relicense, a session co-facilitated with an internship student from an accredited master's in counseling program, or a behavioral health technician, they will be under the clinical oversight of the Clinical Supervisor of Gwee's Integrated Health and will discuss my case openly in sessions. My consent to treatment is with the agency of Anew Recovery and its therapists. For any clinical concerns please directly contact Administrator Sarah Gwee 508-271-5150.

Patient Complaint Procedure If you have a complaint about the service you are receiving at Gwee's Integrated Health or feel you have been denied admission or have been discharged from at treatment without cause or feel you have been discriminated against in any manner, you are encouraged to access the agency complaint process. You may directly contact the Administrator Sarah Gwee (520) 271-5150 regarding your complaint and if the result of the phone contact does not resolve the situation, we encourage you to submit your complaint in writing so that a meeting can be held to address your complaint and provide a written record. You may call Administrator Sarah Gwee (508) 271-5150 for the appropriate form and may also request assistance in completing the form. The complaint should be sent to CEO /Administrator the who will set up a meeting with the therapist and arrange to meet with you within five (5) working days to attempt resolution of the complaint. Additional meetings may be scheduled to include other treatment team members with your

approval (such as case manager, probation officer). If you are unable to reach a resolution with our agency you are entitled to file a complaint with our agency funding sources for which we are contracting with for your treatment services: Maricopa/Pinal/Gila County Juvenile Probation, Arizona State Department of Corrections, or any other agency that Gwee's Integrated Health is contracting with for your treatment services. Your utilization of the complaint process will not affect the services you are receiving or the way in which you are treated. **Patient Fee/Refund Policy**

This policy outlines the funding sources for the fee for services of the agency:

- Patient fees will be based upon the contractual fee for service agreement in which they fall under.
- For probation referred patients, the probation department may assess the family for costs related to treatment but the determination for these costs is made by the probation financial department and not by Gwee's Integrated Health and these fees are paid directly to the department.
- Self-Pay patients will receive and sign a financial agreement. Services will be provided, and payment will only be collected if those services are provided. Should there be any refunds due, a check shall be issued and mailed within thirty (30) days. A charge of $25.00 will be assessed for any returned personal/business check. We require a minimum of one full business day (24 hours) prior to your appointment, or you may be charged the full hourly fee for the time you reserved for the appointment.
- If a patient is funded by private insurance carrier who accepts invoices from this agency, the insurance carrier will notify this agency of the co-pay amounts the patient is to be charged based on the current coverage. This agency will be responsible for collecting these fees if they apply
- Patients who are 30 days or more delinquent in payment for treatment services that they have received, may be suspended from further treatment until their financial account is brought current.

Gwee's Integrated Health has a right to change fees and will ensure a patient, or, if applicable, a family member, guardian custodian, designated representative, or agent receives written notice thirty (30) days prior to any changes in our fee policy. Notification of fee changes will also be posted in waiting area thirty (30) days prior to any changes.

Important Phone Numbers and Address

OBHL (Office of Behavioral Health Licensure) 150 N 18th Ave, #410 Phoenix, AZ 85007
ADHS (Arizona Department Health Services) Office Bureau of Medical Facilities Licensing 150 North 18th Avenue, # 410, Phoenix AZ 85007 Phone 602-364-3031
Maricopa Crisis 602-222-9444
Department of Child Safety (DCS Hotline 1-888-767-2445
Suicide Hotline: Maricopa: 1-800-631-1314 or 602-222-9444 Pinal: 1-800-796-6762 or 520-622-6000
Tribal RHBA: 1-800-654-8713
AHCCCS (Arizona Health Care Costs Containment System): 1-800-654-8713

Gwee's Integrated Health
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Insurance Consent Form

I,_____give signed authorization for release of information of information for transaction and assignment of benefits for claims to Gwee's Integrated Health .

Client Signature_____ Date_____

Staff Signature_____ Date_____

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Grievance Procedures

1. First, process the grievance or concerns with personnel. If the Client is not satisfied, obtain a grievance form.
2. Complete the form in detail when applicable.
3. Submit form to personnel or administrator. Grievance form will be initially responded to within two working days of its receipt.
4. The agency administrator will review, meet with resident and relevant parties (if applicable) to address the issues raised in the grievance.
5. Filled grievances will receive a formal written response within five working days.
6. If personal(s) filing grievance is not satisfied with the decision, a written complaint may be filled with the licensing agency for further intervention.
7. A person or persons shall not be discriminated against, prohibited reprisal or retaliated against, because he or she has filed a grievance with or outside of the agency.
8. No residents will be subjected to threats of early termination or rejection by personnel.
9. Policies and procedures will explain to the resident, parent, and guardian or designated representative at the time of admission.
10. A resident or the representative may file a complaint directly with the Bureau of Residential Facilities Licensing or the Arizona Office of Human Rights.

Department of Health Services

150 N 18th ave Phoenix AZ 75007
602-364-2639

Client Signature _____ Date _____

Clinic Agent Signature _____ Date _____

Personnel Signature _____ Date _____

Grievance Form

Client Name : _____

Category of Grievance :

- ☐ **Food**
- ☐ **Room/ Building**
- ☐ **Problem with Resident**
- ☐ **Rules**
- ☐ **Clothing**
- ☐ **Mistreated by Personnel**
- ☐ **Property**
- ☐ **Other**

Explain of Grievance :

_____

_____

_____

_____

_____

Client Signature : _____ Date : _____

House Manager / Director Response :

_____

_____

_____

_____

_____

Director / Manager Name	Signature	Date

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CONSENT FOR TREATMENT

I, the undersigned, _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me as the client. I have legal power to consent to medical, psychological, counseling, and mental health assessment and treatment for services. It is clearly understood that I hereby fully released from any claims and demands that might arise or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

Signed this:_____ day of_____ 20_____

_____ _____

Client Signature Date

_____ _____

Staff/Title Date

_____ _____

Staff/Title Date

Acknowledgement of Receipt of Consent to Treat Forms

Client Name: DOB:

By signing this form I, _____consent to treatment and recognize the limits of confidentiality. I, _____ acknowledge receipt of the Client Information Handout which contains the following information with a verbal explanation of the following items:

- Client Rights/Privacy Practices
- Consent to Treatment and Limited Confidentiality
- Patient Complaint Procedure
- Client Fee/Refund Policy
- Important Crisis/Resource Phone numbers

_____ _____

Client Signature Date

_____ _____

Staff / Title Date

Gwee's Integrated Health
Integrated Health Solutions

Intake Date:_____

Mental Health Intake Form

Name :		**DOB :**	
AHCCCS ID :		**Address :**	
Phone #		**Race/Tribal Affiliation :**	
Emergency Contact :		**Emergency Contact Ph#**	

What are the problems you are seeking help with?

1. _____
2. _____
3. _____

What are your treatment goals?

1. _____
2. _____

Current Symptoms Checklist : Please place a Check mark for current symptoms :

☐ Depressed Mood	☐ Inability to enjoy activities	☐ Sleep pattern disturbance
☐ Loss of Interest in Activities	☐ Difficulty Concentrating	☐ Forgetfulness
☐ Excessive Guilt	☐ Fatigue	☐ Racing Thoughts
☐ Increased Risky Behavior	☐ Decreased need for sleep	☐ Impulsivity
☐ Increased Irritability	☐ Crying Spells	☐ Excessive Energy
☐ Anxiety Attacks	☐ Avoidance	☐ Excessive Worry
☐ Audio Hallucinations	☐ Suspiciousness/Paranoia	☐ Visual Hallucinations

Any additional symptoms you are experiencing :

Suicide Screening :

Please check the boxes and write detailed answers below:

Do you Currently feel like you don't want to live?	☐ **NO** ☐ **YES**
Have you ever tried to kill or harm yourself before? If Yes, Please explain	☐ **NO** ☐ **YES**
How often do you have these thoughts?	☐ All day ☐ Multiple times/day ☐ Daily ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5-6 times/week ☐ **Other :** _____
When is the last time you had Thoughts of dying?	
Has anything happened to you recently to make you feel this way?	
On a scale of 1 – 10 (10 Being the strongest), how strong is your desire to kill yourself currently?	
Would anything make it better? If Yes, Please explain	☐ **NO** ☐ **YES**
Have you ever thought about how you would kill yourself? If Yes, please explain	☐ **NO** ☐ **YES**
Is the method you would use readily available? If Yes, please explain	☐ **NO** ☐ **YES**

Is there anything that would stop you from killing yourself? If Yes, please explain	☐ NO ☐ YES
Do you have access to guns or other means to hurt/kill yourself? If Yes, please explain	☐ NO ☐ YES

Safety Contract Completed? ☐ YES ☐ NO

Psychiatric History :

Please check the box if you are a family member has been diagnosed and/or treated for the below psychiatric disorders :

	YOU	FAMILY (If Yes, specify which family member/members)
Bipolar Disorder	☐ NO ☐ YES Age :	☐ NO ☐ YES Family member :
Depression	☐ NO ☐ YES Age :	☐ NO ☐ YES Family Member :
Anxiety	☐ NO ☐ YES Age :	☐ NO ☐ YES Family Member :
Aggression / Anger Outbursts	☐ NO ☐ YES Age :	☐ NO ☐ YES Family Member :
Schizophrenia	☐ NO ☐ YES Age :	☐ NO ☐ YES Family Member :
Post-traumatic stress disorder (PTSD)	☐ NO ☐ YES Age :	☐ NO ☐ YES Family Member :
Alcohol Abuse	☐ NO ☐ YES Age :	☐ NO ☐ YES Family Member :
Substance Abuse	☐ NO ☐ YES Age :	☐ NO ☐ YES Family Member :
History of Violence	☐ NO ☐ YES Age :	☐ NO ☐ YES Family Member :

Suicide	☐ **NO** ☐ **YES** Age :	☐ **NO** ☐ **YES** Family Member :

Treatment History :

Have you ever received **outpatient** treatment? ☐ NO ☐ YES **If Yes, Please complete the table below :**

Reason Treated	Dates Treated	Where Treated

Have you ever received **Inpatient** treatment? ☐ NO ☐ YES **If Yes, Please complete the table below :**

Reason Treated	Dates Treated	Where Treated

Medication History :

☐ I **Don't currently** and **have never taken** medications. If you checked this box, please skip to the Substance Use History section.

☐ I **Currently** take medications or **have taken medications in the past**. If you checked this box, please review the entire list of medications and check the appropriate boxes regarding past / current medications and complete the information. Please be as detailed as possible.

Medication Name	**Current / Past** (If taken in past, list the dates)	**Dosage / Frequency** (ie: 5omg. 2x/day)	**Response/Side Effects** (ie: Helpful, Not Helpful, Negative Side Effects)
	☐ Current ☐ Past _____		
	☐ Current ☐ Past _____		
	☐ Current ☐ Past _____		
	☐ Current ☐ Past _____		
	☐ Current ☐ Past _____		

Do you currently take any Over – the – Counter Medications? ☐ NO ☐ YES
If Yes, complete the information below :

Medication Name	Treating Illness	Total Daily Dosage	Estimated Start Date

Substance Use :

Have you ever been treated for alcohol or drug use / abuse?	☐ NO ☐ YES
If Yes, which substance?	
Where were you treated and when?	
How many days per week do you drink alcohol / use drugs?	
Have you ever felt you need to cut down on your drinking or drug use?	☐ NO ☐ YES
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?	☐ NO ☐ YES

Check if you have ever tried the following? If Yes, Please indicate how long (time frame) and last use.

Substance		Last use (approx)	Length of Use (approx. age, # of years, etc.)
Methamphetamine	☐ NO ☐ YES		
Cocaine	☐ NO ☐ YES		
Stimulants (pills)	☐ NO ☐ YES		
Heroin	☐ NO ☐ YES		
LSD / Hallucinogens	☐ NO ☐ YES		
Marijuana	☐ NO ☐ YES		
Pain Killers	☐ NO ☐ YES		
Methadone	☐ NO ☐ YES		
Tranquilizer/Sleeping pills	☐ NO ☐ YES		
Alcohol	☐ NO ☐ YES		
Ecstasy	☐ NO ☐ YES		
Other	☐ NO ☐ YES		

Caffeine Use :

		How Many drinks per day?
Coffee	☐ NO ☐ YES	
Soda	☐ NO ☐ YES	
Tea	☐ NO ☐ YES	

Education History :

Highest grade completed : _____ Where? _____

Did you attend College ? ☐ **NO** ☐ **YES** Where? _____ Major: _____

Highest Education level or Degree attained : _____

Legal History :

Have you been Arrested? ☐ **NO** ☐ **YES**

If YES, please complete the table below :

Charge	Approximate Date	Outcome

Have you served time in prison? ☐ **NO** ☐ **YES**

If YES, please complete the table below :

Charged	Date Admitted	Date Released

Are you currently on Probation / Parole? _____
Officer's Name : _____ Phone # : _____ County : _____

***Trauma History* :**

Have you been Emotionally abused?	☐ NO ☐ YES
Have you been Physically abused?	☐ NO ☐ YES
Have you been Sexually abused?	☐ NO ☐ YES

Occupational History :

Are you currently: ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

What is your current occupation?	
How long have you been at your current Position?	
Have you served in the military?	☐ NO ☐ YES Which branch?
How were you discharged?	☐ Honorable Date: ☐ Other Date: Type:

Family Background History :

Please write detailed answers in boxes below:

Where did you grow up?	
Who was in your household growing up?	

How many siblings do you have?	
What was your mother's occupation growing up?	
What was your father's occupation growing up?	
Did your parents divorce?	
What was your relationship like with your father growing up?	
What was your relationship like with your mother growing up?	
How old are you when you left home?	
Has anyone in your immediate family died?	

Personal/ Family Medical History **:**

Date and location of last physical exam : _____

Please complete the below table. If YES, please write an approximate date of diagnosis. If you are unaware of your family history, please write " **UNKNOWN** ".

CONDITION	PERSONAL	CONDITION	PERSONAL
Thyroid disease	☐ NO ☐ YES	Fibromyalgia	☐ NO ☐ YES
	Date :		Date :
Anemia	☐ NO ☐ YES	Heart Disease	☐ NO ☐ YES
	Date :		Date :
Liver Disease	☐ NO ☐ YES	Epilepsy / Seizures	☐ NO ☐ YES
	Date :		Date :
Chronic Fatigue	☐ NO ☐ YES	Chronic Pain	☐ NO ☐ YES
	Date :		Date :
Kidney Disease	☐ NO ☐ YES	High Blood Pressure	☐ NO ☐ YES
	Date :		Date :
Diabetes	☐ NO ☐ YES	High Cholesterol	☐ NO ☐ YES
	Date :		Date :
Asthma / Respiratory issues	☐ NO ☐ YES	Head Trauma	☐ NO ☐ YES
	Date :		Date :
Stomach / Intestinal problems	☐ NO ☐ YES	Hepatitis	☐ NO ☐ YES
	Date :		Date :
Cancer	☐ NO ☐ YES	Other	☐ NO ☐ YES
	Date :		Date :

Medical Background :

Current Weight :	
Current Height :	
Allergies :	

Personal Background :

Marital Status	☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed
How many marriages have you had?	
How long did each marriage last?	
How many divorces have you had?	
If widowed, how long?	
Are you currently in a relationship?	☐ NO ☐ YES
What is your spouse/significant other's occupation?	
Describe your relationship with your spouse/significant other	
Are you sexually active?	☐ NO ☐ YES If Yes, are you using Birth control methods? ☐ NO ☐ YES Are you interested in help getting Birth control? ☐ NO ☐ YES
What is your sexual orientation?	☐ Straight/Heterosexual ☐ Bisexual ☐ Transsexual ☐ Asexual ☐ Gay/Lesbian/Homosexual ☐ Unsure/Questioning ☐ Prefer Not to answer ☐ Other
Do you have children?	☐ NO ☐ YES Ages :
Describe your relationship with your children?	

List everyone that currently lives with you	

For Women Only :

Date of last menstrual period :	
Are you currently pregnant?	☐ NO ☐ YES
Do you think you might be pregnant?	☐ NO ☐ YES
Are you planning to get pregnant in the near future?	☐ NO ☐ YES
Are you using Birth control?	☐ NO ☐ YES Method :
How many times have you been pregnant?	
How many live births?	

Do you have any concerns about your Physical / Mental Health you would like to discuss with us or anything we may have missed above? ☐ NO ☐ YES

If YES, please explain : _____

_____

_____

Client Name Signature Date

BHP Print Name Signature Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. 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 _____

A2663B 10-04-2005

BHT Print Name Signature Date

Adverse Childhood Experience (ACE) Questionnaire

All questions pertain to while you were growing up, during your first 18 years of life :
Check the box for " **YES** "

1. Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you or act in a way that made you afraid you might be physically hurt?	☐
2. Did a parent of adult in the household often push, slap, or throw something at you or ever hit you so hard that you had marks or were injured?	☐
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way or try to or actually have oral, anal, or vaginal sex with you?	☐
4. Did you often feel that no one in your family loved you or thought you were important or special or that your family didn't look out for each other, feel close to each other or support each other?	☐
5. Did 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?	☐
6. Were your parents ever separated or divorced?	☐
7. Was your mother or stepmother often pushed, grabbed, slapped, or had something thrown at her? Was she sometimes or often kicked, bitten, hit with a fist, or hit with something hard? Was she repeatedly hit over at least a few minutes or threatened with a gun or knife?	☐
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	☐
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	☐

10. Did a household member go to prison?	☐
Add up the total number of checkboxes and this is your ACE score :	

**** ACE scores of 4 or more, please for trauma counseling**

GAD – 7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being to stop or control worrying	0	1	2	3
3. Worrying to 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 total : _____ + _____ + _____ + _____ =

Total score : _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Source: 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 ris8@columbia.edu PRIME-MD® is a trademark of Pfizer Inc.

Scoring GAD – 7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to response categories, respectively, of " Not at all, " " several days, " " more than the days, " and " nearly everyday. "
GAD – 7 total score for the seven items ranges from 0 to 21.

0 – 4 : Minimal Anxiety
5 – 9 : Mild Anxiety
10 – 14 : Moderate Anxiety
15 – 21 : Severe Anxiety

DASS 21

Name : _____ Date : _____

Please read each statement and circle a number 0, 1, 2, or 3 which indicate how much the statement applied to you over the past week. There No right or Wrong answers. Do not spend too much time on any statement.
The rating scale is as follows:

0 Did not apply to me at all – NEVER
1 Applied to me to some degree, or some of the time - SOMETIMES
2 Applied to me to a considerable degree, or a good part of time – OFTEN
3 Applied to me very much, or most of the time – ALMOST ALWAYS

FOR OFFICE USE

	N	S	O	AA		D	A	S
1. I found it hard to wind down	0	1	2	3				
2. I was aware of dryness of my mouth	0	1	2	3				

3. I couldn't seem to experience any positive feeling at all	0	1	2	3				
4. I experience breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3				
5. I found it difficult to work up the initiative to do things	0	1	2	3				
6. I tended to over – react to situations	0	1	2	3				
7. I experienced trembling (eg, in the hands)	0	1	2	3				
8. I felt that I was using a lot of nervous energy	0	1	2	3				
9. I was worried about situations in which I might panic and make a fool of myself	0	1	2	3				
10. I felt that I had nothing to look forward to	0	1	2	3				
11. I found myself getting agitated	0	1	2	3				
12. I found it difficult to relax	0	1	2	3				
13. I felt down-hearted and blue	0	1	2	3				
14. I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3				
15. I felt I was close to panic	0	1	2	3				
16. I was unable to become enthusiastic about anything	0	1	2	3				
17. I felt I wasn't worth much as a person	0	1	2	3				
18. I felt that I was rather touchy	0	1	2	3				
19. I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3				
20. I felt scared without any good reason	0	1	2	3				
21. I felt that life was meaningless	0	1	2	3				
	TOTALS :							

DASS Severity Ratings

The DASS is a **quantitative** measure of distress along the 3 axes of depression, anxiety[1], and stress[2]. It is not a categorical measure of clinical diagnoses.

Emotional syndromes like depression and anxiety are intrinsically dimensional – they vary along a continuum of severity (Independent of the specific diagnosis). Hence the selection or a single cut-off score to represent clinical severity in necessarily arbitrary. A scale such as the DASS can lead to a useful assessment of disturbance, for example individuals who may fall short of a clinical cut-off for a specific diagnosis can be correctly recognized as experiencing considerable symptoms and as being at high risk of further problems.

However for clinical purposes it can be helpful to have " labels " to characterize degree of severity relative to the population. Thus the following cut-off scores have been developed for defining mild / moderate / severe / extremely severe scores for each DASS scale.

Note : the severity labels are used to describe the full range of scores in the population, so " mild " for example means that the person is above the population means that the person is above the population mean but probably still way below the typical severity of someone seeking help (ie it does not mean a mild level of disorder).

The individual DASS scores do not define appropriate interventions. They should be used in conjunction with all clinical information available to you in determining appropriate treatment for any individual.

[1]Symptoms of psychological arousal
[2]The more cognitive, subjective symptoms of anxiety

DASS 21 SCORE

DEPRESSION SCORE	ANXIETY SCORE	STRESS SCORE

	Depression	Anxiety	Stress
Normal	0 – 4	0 – 3	0 – 7
Mild	5 – 6	4 – 5	8 – 9
Moderate	7 - 10	6 – 7	10 – 12
Severe	11 – 13	8 – 9	13 – 16
Extremely Severe	14 +	10 +	17 +

PCL – 5

Instructions : Below is the list of problems that people sometimes have 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 <u>in the past month.</u>

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 (eg, 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 (eg, 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(eg, 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 (eg, 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 " superalert " 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

Consent for Service

Mental health treatment is a confidential process designed to help you address your concerns and teaches ones to better understand one's self. As a client at **Gwee's Integrated Health** , you will learn the skills necessary for your healing through individual counseling, group counseling, life skills training, and case management. There may be periods of stress and anxiety while learning to implement strategies taught by providers into your current lifestyles. Staff members are available 24/7 to assist and support you throughout the counseling services.

I agree _____ (initial)and give permission to participate in **Gwee's Integrated Health** services and assistance.

I understand that others may be involved in my treatment and release of information must be obtained. I agree to participate with the activities to be carried out to resolve and improve functioning.

I have read and discussed the above information with my providers. I understand the risks and benefits of counseling, the nature of limits and confidentiality and what is expected of me as a client of **Gwee's Integrated Health** .

I understand that I may withdraw my consent to release and to participate with **Gwee's Integrated Health** at any time.

Client Print Name Signature Date

Consent to Search

In attempt to keep all the Clients and Staff safe at all time, your personal property may be searched at any time. All belongings will be searched upon intake and randomly thereafter. Any dangerous items, medication, Drugs, alcohol, or paraphernalia will be confiscated.

Client Print Name Signature Date

Consent to Transport

I _____ (Client name) give permission to be transported by **Gwee's Integrated Health** as necessary during the provision of my therapeutic services. I understand that there are inherent risks involved such as traffic delays, accidents, etc. and I acknowledge and accept that risk with regard to being transported by the aforementioned.

Client Print Name | Signature | Date

Media Release

☐ YES ☐ NO I give **Gwee's Integrated Health** Media personnel permission to Photograph myself / my youth.

☐ YES ☐ NO I give **Gwee's Integrated Health** media personnel permission to share photographs / videos of myself on community outreach pages such as Facebook, Twitter, and Instagrams.

☐ YES ☐ NO I understand there are no monetary gains associated with my photographs / videos of myself.

Client Print Name | Signature | Date

Notice of Security Cameras

I understand **Gwee's Integrated Health** facility has security cameras throughout the facility in the common areas for safety purposes. I understand these cameras can be reviewed by management personnel at any time. By signing below, I affirm that I have been notified of the security cameras and their purpose as it pertains to this facility.

Client Print Name | Signature | Date

Signature Page

By Initialing and Signing below, you are confirming you have read and agree to the below consents. You may request a print copy of each of the consents from the program manager. Please initial next to each consent and sign your name at the bottom.

_____ **Financial Responsibility and Agreement**
(Initials)

_____ **HIPAA Policy Agreement and Consent**
(Initials)

_____ **Grievance Policy and Procedure**
(Initials)

_____ **Client Rights and Responsibilities**
(Initials)

_____ **Confidentiality / Privacy Agreement**
(Initials)

Client Print Name Signature Date

Client Print Name Signature Date