



MAIN OFFICE:
LE MARS

P.O. Box 70 • Le Mars, Iowa 51031-0070
712-546-4624 • 1-800-325-1192
FAX 712-546-9395
www.plainsareamentalhealth.org

Welcome to Plains Area Mental Health Center

Date:

Dear _____

Congratulations on taking this first step toward better mental health. We thank you for choosing Plains Area Mental Health Center as your mental health provider.

Attached are intake papers for your first appointment on _____ with _____. Please sign or initial where highlighted and **bring with you to your appointment.**

Informed Consent for Services: Please review, initial on bottom of each page and sign where indicated. This contains information on our services, consent to treat, your rights and responsibilities, treatment of children, payment information, confidentiality and the appeals process.

Letter to Physician: Sometimes in therapy there may be a need for communication with your primary care physician. If you wish to allow communication with your physician, please complete the authorization where highlighted. If you choose no communication with your physician, please write “decline” and initial on the letter.

The “Notice of Privacy Practices” outlines our privacy practices as required by HIPAA and is yours to keep. Just sign and return the **“Acknowledgement of receipt of Notice of Privacy Practices”** form.

Personal Intake History – Please complete for your initial appointment and give to your therapist. This will assist the therapist at your first appointment.

If you have any questions in completing these forms, please feel free to call or ask for assistance. **Remember, the most important factor in achieving success with your mental health is persisting until you have met your goals.**

CHEROKEE - STORM LAKE
P.O. Box 972 • Cherokee, IA 51012-0972
712-225-2575

SATTELITE OFFICES:
IDA GROVE:
P.O. Box 168 • Ida Grove, IA 51445-0168
712-364-3500

ORANGE CITY
P.O. Box 70 • Le Mars, IA 51031-0070
800-325-1192

PLAINS AREA MENTAL HEALTH, INC.

INFORMED CONSENT FOR SERVICES

I request Plains Area Mental Health, Inc. (herein referred to as Plains Area) provide diagnostic, treatment, or other services for: [redacted]

Consumer's Name

DESCRIPTION OF SERVICES

The following is a brief explanation of each service that is provided by Plains Area:

- Psychotherapy is a service that assists individuals of all ages who are experiencing problems such as depression, anxiety/fear, difficulty in work/school, marital or family conflict, mood swings, irritability, anger/aggressiveness, difficulty in social/peer relationships, stress, or children at risk. Following an initial assessment a plan of treatment is developed jointly by the provider and you (and parent/guardian in the case of a minor). The frequency and duration of treatment varies and will depend on your individual needs. Psychotherapy is provided by master's level mental health professionals. Intake sessions will last 45-60 minutes while ongoing therapy sessions will run 20-25 minutes or 45-50 minutes, depending on need.
• Psychiatric Evaluation is a service provided by psychiatrists (MD or DO), Psychiatric Physician Assistants, or Nurse Practitioners to determine diagnosis and /or to determine the benefit(s) of medication therapy. Appointments will last 30-50 minutes, depending on need.
• Medication Management is provided by psychiatrists (MD or DO), Psychiatric Physician Assistants, or Nurse Practitioners, and Nurses to prescribe and monitor psychotropic(mental health) medication therapy including side effects or adverse reactions, benefits, and interactions that may occur from use of other medications, substances and medical conditions. Appointments will last 10-25 minutes, depending on need.
• Emergency Services are provided 24-hours-a-day, seven-days-a-week. Walk-in emergencies are handled during open business hours. After hour emergencies are handled by the Plains Area on-call system. The following procedures should be followed to access the Emergency Services: Call any Plains Area office during office hours or the after-hours number (1-888-546-0730) when the offices are closed. The on-call line is staffed by mental health professionals. In the event they are unable to answer your call immediately, please leave a message and they will return your call. If you do not receive a call back and this is a life threatening emergency, you should call 911.
• The Senior Care Program offers comprehensive care for elderly who are experiencing emotional, behavioral, or psychiatric problems of acute or chronic durations, including those that are complicated by medical or neurological problems. Our psychiatric staff works with family members, nursing home staff, and medical personnel to develop comprehensive treatment planning and routine follow-up at nursing home facilities.
• The Remedial Services Program provides skill development and crisis intervention to children and their families to minimize or eliminate behavioral symptoms associated with a psychological disorder. Skill development targets problem solving, conflict resolution, social skills, effective communication, and interpersonal relationship skills. Remedial services are provided in the home or community.
• The Community Support Program provides assistance to adults who have a mental illness in maximizing their potential and live as independently as possible. This program provides assistance and support for community integration, crisis prevention and planning, social skill development, linkage to other supports and resources, symptom management, family education and support, building natural supports, evening and weekend recreational opportunities.
• Consultation and Education is provided to individuals and professionals throughout the region in regard to the mental health needs of their families, employees, patients, students, and clients. Educational presentations are available to community organizations, schools, businesses, and the general public upon request.
• Elderly Peer Program is a service that provides elderly individuals who may be physically limited and socially isolated or who are at risk for emotional and physical problems because of stress, such as stress due to the loss of a spouse. Visitation is provided in the home by trained volunteers who are over the age of 60. The support provided by peers is designed to alleviate depression, fear and loneliness that are associated with causing physical and emotional problems. The peers are trained by Plains Area staff and meet regularly for ongoing consultation and education.

INFORMED CONSENT

I understand, as in the case of medical services, no guarantee can be provided that the concerns or issues for which I am seeking services will be resolved. Because mental health treatment is a cooperative effort between me and my provider, I will work with my provider in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my concerns.

I understand that confidentiality of records of information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information, as is outlined in the Privacy Notice provided to me.

I understand that my provider may disclose any and all records pertaining to my treatment if necessary for claims processing, care management, coordination of treatment, quality assurance or utilization of this facility and to the extent necessary to facilitate the provision of administrative and professional services.

I understand that I have the right to inspect the mental health records pertaining to my treatment under the supervision of my provider or administration at Plains Area.

I understand that state and local laws require that my provider report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my provider to disclose confidential information and this is outlined in the Privacy Notice provided to me.

I understand my records will be kept for a period of seven years after the last date of service with Plains Area (a Brief Service or Intake and Discharge Summary and this Consent Form will be kept perpetually). In the case of minors, records will be kept until the age of 25 or seven years after the last date of service which ever is longer.

CONSUMER RIGHTS

I have read and had explained to me the basic rights of individuals who undergo treatment at Plains Area. These rights include:

1. All consumers shall receive the same quality of care without regard to race, color, creed, sex, age, sexual orientation, social or economic status, political belief or type of problem. Language barriers, cultural differences, and cognitive deficits are taken into consideration and provisions are made to facilitate meaningful consumer participation in services.
2. Persons with mental illness, mental retardation, and other developmental disabilities have the same fundamental rights as all persons. Rights can be limited only with the informed consent of the consumer, the consumer's guardian or legal authorities within the following guidelines: the limit is based on an identified individual need; skill training is in place to meet the identified need; periodic evaluation of the limit is conducted to determine the continuing need for the limitation.
3. Individuals in need of any service provided by Plains Area have the right to be provided that service with as little delay as possible.
4. Only information essential to an orderly and productive delivery of service shall be required from an individual or family as a condition for service.
5. Consumers will be required to participate only in procedures that are essential to the delivery of care commensurate with their need(s). Consumers shall be informed of the costs of services offered to them.
6. Consumers shall be provided descriptions of the predominant hazards, which may exist in any unusual treatment procedure. Plains Area will not perform any research without a consumer's written, informed consent.
7. Consumers' identities will be protected unless information must be communicated appropriately as outlined in the Privacy Notice provided to me.
8. Individuals admitted into voluntary outpatient, evaluation or emergency care would not, by any routine or administrative action, be enrolled in any greater level of care without a full explanation or opportunity to participate in such decisions.
9. Consumers shall have the right to refuse any service or method of treatment.
10. Consumers shall have the right to be treated without loss of dignity, individuality, privacy or respect. Consumers shall be addressed in a manner that is appropriate to their chronological age.
11. Consumers will be provided opportunity to participate in the formulation of the plan of treatment and services provided to them by Plains Area.
12. Consumers shall have the right to receive an understandable explanation of their diagnosis and the services provided, including the procedures involved and the expected results and duration of those procedures and services.
13. Consumers have the right to appeal Plains Area actions or decisions pertaining to decisions made regarding their care and services. The Appeal / Grievance Procedure must be adhered to, as outlined in the Appeal/Grievance section below.

CONSUMER RESPONSIBILITIES

I understand that it is my responsibility to inform my primary medical doctor of any medications prescribed in the course of my treatment at Plains Area.

I understand that it is my responsibility to inform Plains Area of any medications I am currently taking, past and present medical/health problems or illness, and any unusual changes in my health condition.

I understand that it is my responsibility to keep my appointments and give at least 8 hours notice if I am not able to keep my appointment. I further understand that if I have two no-shows I may be subject to same day scheduling and will not be allowed to make appointments ahead of time.

I understand that it is my responsibility to be honest and provide accurate and complete information about myself.

I understand that it is my responsibility to understand my problems and the services being provided. If I do not understand my problems and the services being provided, I will discuss this with my provider. I understand the success of the service requires my full cooperation.

I understand that it is my responsibility to follow my plan of treatment, as established by me and my service provider, and inform my provider of any changes in my condition or circumstances that may affect my plan of treatment.

I understand that I am responsible for the results of my decisions including those that may result when I refuse to follow the plan of treatment and /or the instructions to achieve it.

I understand that it is my responsibility to respect the rights, privacy, and property of staff and other consumers I may come into contact with while receiving services at Plains Area.

I understand that it is my responsibility to refrain from making unreasonable demands on the time and services of Plains Area personnel.

It is my responsibility to understand my insurance benefits and agree that financial obligations to Plains Area for services provided will be taken care of quickly. I further understand that payment is due at the time of the service. If I am unable to meet my financial obligations to Plains Area, I can ask for a fee consultation.

TREATMENT OF MINOR CHILDREN

I understand that both parents retain a legal right to receive information about their child unless Plains Area is presented with legal proof that there is a no-contact order or termination of parental rights. The non-custodial parent has the right to know that their child is being seen.

I understand that Plains Area will bill any amount due after third party payment to the person who is signing this agreement. I understand it is my responsibility to secure payment for any amount owed by the other parent.

I understand that Plains Area clinical staff are Mandatory Child Abuse Reporters and must report to the Department of Human Services if they suspect physical, sexual, or emotional abuse, denial of critical care, or neglect.

I understand I have the responsibility to be involved with my child's treatment as recommended by my service provider.

INFORMATION ABOUT MEDICARE AND MEDICAID

I understand Medicare or Medicaid Insurance will not reimburse both a therapy and a psychiatric service provided on the same day.

I understand if I carry Medicaid insurance I cannot not be charged any out of pocket expenses for any service at Plains Area.

INFORMATION AND AGREEMENTS REGARDING PAYMENT & INSURANCE

I understand and agree to the following conditions of payment for professional services at Plains Area:

1. It is my responsibility to contact or respond to my insurance carrier for any restrictions or requirements. If I fail to do so, I will be responsible for the full fee. The full fee will be charged to those who have insurance coverage, but choose not to file.
2. To release information necessary to process claims to a third party payer. This may include name, age, sex, address, insurance number, consumer number, diagnosis, dates of service, length of service, provider name, type of treatment rendered, and my treatment plan and progress notes.
3. That if I carry group insurance through my employer, my employer's benefit department may be provided this information.
4. That a psychiatric diagnosis is often required to secure third party reimbursement.
5. That my third party payer(s) will reimburse Plains Area directly for services rendered and billed.
6. It is my responsibility to complete the CPC process if I request a sliding fee. I agree to pay the established percentage determined by the CPC of my county of legal settlement.
7. That payment and co-payment is due at time service is provided, unless payment plan has been established.
8. That there will be a minimum charge (\$12.00 psychotherapy or \$25.00 psychiatric) or equal to my sliding fee, if the above named consumer for whom I am financially responsible, fails to keep an appointment (without 8 hours notice given to the applicable PAMHC office).
9. If, in the judgment of the staff of Plains Area, my income information has been reported fraudulently, or if my account becomes delinquent, I understand that the staff of Plains Area has the right to release my name and account information to a private collection agency.

- 10. That if I fail to make payments under the terms of this agreement, a fee conference with Plains Area staff may be required before further professional services will be provided to the above named consumer.
- 11. **I will submit a current insurance card and notify staff at Plains Area of any changes in my insurance. I realize I will be charged full fee until current information is provided.**
- 12. **It is my responsibility to notify insurance card holder, if other than myself, that their insurance or the insurance card holder will be billed for payment of these services.**
- 13. That if services are supported by third-party payers, those services may be subject to audit by authorized representatives of those payers for purposes of verifying the fact of service and I consent to reviews of services rendered for such purposes. I further understand that such audits will not involve sharing information other than that authorized by state and federal laws as outlined in the Privacy Notice provided to me relating to disclosure of mental health information.
- 14. That if a Plains Area service provider is subpoenaed to court by my attorney, the fee charged is the current per hour rate for all time away from the office. Providers are not paid for their testimony but are compensated for their time away from their practice at Plains Area. Sliding scale fees do not apply to these charges.

Financial Arrangements:

For your convenience, we offer the following methods of payment. Please check which you prefer.

- Cash
- Personal Check
- Credit Card

Any outstanding balance may be charged to my credit card Visa MasterCard Discover American Express

Name on Card: _____ Card # _____ Expiration Date: _____

Signature: _____	Date: _____
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INFORMATION ABOUT CONFIDENTIALITY

According to state and federal laws, any information you provide to any staff member at Plains Area is confidential and privileged information and cannot be revealed to others without your written consent. This includes spouse, family, friends, courts, attorneys, employers and law enforcement. However, there are exceptions to full confidentiality. The following are general exceptions to full confidentiality. You have been given a Privacy Notice that notifies you of specific confidentiality rules and how information about you may be disclosed.

- 1. All Plains Area service providers are mandatory reporters of child abuse and dependent adult abuse, and a report to the Department of Human Services (DHS) will be made if such abuse is suspected.
- 2. If a Plains Area service provider believes that a consumer is in danger of harming self or others, the Plains Area service provider will act to prevent harm from occurring. Those actions may include providing information about the consumer to others.
- 3. The parent or legal guardian of a minor has the right to information about services that are provided to the minor, with the exception of substance abuse / use information.
- 4. Limited information about a consumer who is diagnosed as having a chronic mental illness may be released to a spouse, parent, adult child or adult sibling if the disclosure is necessary to assist in the consumer's care or treatment.
- 5. Periodic reports will be made to the court about the status of consumers who are court-ordered to receive services at Plains Area.
- 6. Plains Area staff members must provide information that is required by a court order.
- 7. On occasion, Plains Area providers consult with other mental health professionals. During those consultations, the consumer's identity is not revealed, and those consultants are legally bound to maintain confidentiality with respect to those consultations.
- 8. During accreditation surveys or reviews, representatives of the Iowa State DHS may check consumer records for compliance with state standards. Those reviewers are required to keep all consumer information confidential.

APPEAL/GRIEVANCE PROCEDURE

All consumers who receive services from Plains Area have the right to express their concerns without fear of restraint, interference, coercion, discrimination, reprisal, or retaliatory action. This principle also applies to any person taking part in an appeal representation, either as a witness or employee representative. Any consumer who feels that he/she has been subject to unfair treatment will have the right to an appeal.

It shall be the responsibility of Plains Area authorities to hear promptly and courteously all appeals registered in good faith by consumers of services provided by Plains Area, and to clarify misunderstandings and make reasonable adjustments of complaints. All problems will be settled whenever possible at the lowest level. If you feel the issue is not resolved you may follow the appeal process below.

The **appeal process** is as follows:

1. In the event of a disagreement between a consumer and Plains Area, the consumer should first attempt to discuss the issue directly with his or her service provider.
2. In the event the dispute is unable to be resolved, the consumer or service provider may present the nature of the dispute either verbally or in writing to the Executive Director of Plains Area within **five (5)** working days after the consumer's discussion with his or her service provider.
3. The Executive Director, within **five (5)** working days, shall then notify the service provider and consumer that the Executive Director is aware of the dispute.
4. Documentation shall be entered into the consumer record. Any correspondence generated from the dispute shall be filed in the consumer record and be a permanent part of the record. The Director shall issue a decision within **five (5)** working days from the initial receipt of the dispute.
5. In the event the Director is unable to resolve the dispute, the Director shall so state in memo form to both parties within the five-day period as stated above.
6. In the event the Director is off duty, the grievance shall be held until the Director's return.
7. The grieving party may then elect to present the dispute to the President of the Board of Directors.
8. If the consumer is presenting the complaint, the consumer must sign a release of information allowing Plains Area's clinical staff to discuss the case so that confidentiality is not breached and the Board Member can understand the issue. If the consumer refuses to sign, the Executive Director's decision will be considered final. The President has **fifteen (15)** working days to respond to the complainant with a decision that shall be in writing.
9. In the event the release is signed, and the President of the Board is in receipt of the dispute, he or she may elect to resolve the decision (as above) or appoint a subcommittee of Board Members to review the dispute. A meeting must take place in **fifteen (15)** working days and decisions must be issued in **five (5)** working days from the date of the hearing in writing with a copy to the consumer and to Plains Area.
10. If the dispute is decided upon by either the President of the Board or a subcommittee of the Board, but is unsatisfactory to either party, the Full Board shall make a ruling on the matter at a regularly scheduled meeting in the form of a majority vote and the decision shall be considered final at that juncture.
11. Board members should inform any consumer of the grievance procedure in the event that a consumer accesses the Board directly, prior to following the grievance procedure. Plains Area staff will educate the consumer about his or her rights as it pertains to the grievance.
12. If the Board member wishes to discuss the case with staff of Plains Area, then, the Board Member (and Plains Area staff, as appropriate) shall have the consumer sign a release before any discussion takes place between a Plains Area staff and a member of the Board. The latter is included to protect the consumer's right to confidentiality. The purpose of including this provision is to avoid a full grievance if possible and attempt informal resolution of any complaint or problem brought forth by a consumer of Plains Area.

I have read, reviewed and received a copy of the above information. I understand and agree to abide by the above information for all the services that I receive at Plains Area. My signature below and my initials on each page attest to my review, understanding, and acceptance of the information outlined in this Consent to Services.

Signature of Consumer, Custodial: Parent or Legal Representative		Date: _____	_____ Signature of Witness
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Annual Review of Consent (date and initial):

- Date _____ Consumer ____/____/____ Witness _____
- Date _____ Consumer ____/____/____ Witness _____
- Date _____ Consumer ____/____/____ Witness _____
- Date _____ Consumer ____/____/____ Witness _____



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YOU KEEP

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Privacy Notice or want more information, please contact our Privacy Officer at Plains Area Mental Health Inc., 712-225-2575, or in writing at PO Box 972, Cherokee, IA 51012.

Protected Information. While receiving care from Plains Area Mental Health Inc., information regarding your medical history, treatment, and payment for your health care may be originated and/or received by us. Information which can be used to identify you and which relates to your past, present, or future health condition, receipt of health care or payment for health care. This information is Protected Information.

Our Responsibilities. Federal and State laws impose certain obligations and duties upon us as a covered health care provider with respect to your Protected Information. Specifically, we are required to:

- Provide you with a notice of our legal duties and Plains Area's policies regarding the use and disclosure of your Protected Information;
- Maintain the confidentiality of your Protected Information in accordance with state and federal law;
- Abide by the terms of this notice.
- Respect your rights regarding requests for restrictions of uses and disclosures, requests for access to your information, requests for amendment, requests for accountings of disclosures, requests for revoking authorizations, and requests for alternative communications.

How your Protected Information may be used and disclosed. Generally your Protected Information will not be disclosed without prior written authorization. However we may disclose your Protected Information without your consent in the following situations:

You waive your right to confidentiality of mental health records when you assert your mental or emotional condition as a claim or defense. Iowa Code 228.6(4) and Iowa Code 622.10(3)(c) and 164.512 HIPAA

Treatment Purposes: Mental Health Information may be disclosed for the purpose of providing additional treatment if you have made a written request. Iowa Code 228.2(3). Additionally we may disclose mental health information to other providers of professional services who may be involved in your care. Iowa Code

your care. Iowa Code 228.5(1) and 164.506 HIPAA; Examples: We may provide your primary physician a list of medications that have been prescribed to you by Plains Area Mental Health Inc.'s psychiatrist so that your doctor can best treat your medical problems. We may also have contact with your pharmacist in order to get your prescriptions filled correctly. This may also include sharing information with other professionals that are on your treatment team such as a case manager. We may also contact you to provide appointment reminders which may be by telephone including leaving a message on an answering machine or by mailing you a reminder. We may also contact you to provide information about treatment alternatives or related services that may be of benefit to you.

Custody of Children: Unless otherwise ordered by the court in the custody decree, both parents shall have legal access to information concerning the child including but not limited to medical, educational, and law enforcement records. Iowa Code 598.41(1e) and 164.502 HIPAA

Emergencies: Mental health information may be disclosed at any time to another facility, physician, or mental health professional in cases of a medical emergency. Iowa Code 228.2(3) and 164.512 HIPAA

Payment and Operations: Plains Area Mental Health contracts with a Clearinghouse for billing and payment operations. Pursuant to an authorization from you to provide a third party payer information for payment purposes we may release the minimum necessary information that is required for billing through the Clearinghouse without a specific authorization from you. The Clearinghouse must abide by confidentiality and use and disclosure laws as set out in this Notice and any other applicable law and as specified in the Business Associate Agreement. We may disclose information to other Business Associates for Healthcare Operation purposes including our Auditor, Legal Counsel, Medical Director, or any Business Associate that performs services on our behalf. Where possible the information will be de-identified or minimum necessary information will be disclosed. All Business Associates must abide by confidentiality and use and disclosure laws as set out in this Notice and any other applicable law as specified by the Business Associate Agreement. 164.504 HIPAA

Collections: Information necessary to collect payment on an unsettled account. You will receive special notice prior to us disclosing information to collection agencies. Iowa Code 228.5(2) and 164.506 HIPAA

Research and Health Oversight: While Plains Area Mental Health, Inc. does not engage in research on a regular basis, research projects may be allowed. The policies and procedures concerning research must be adhered to. Please see 11.2 of our Policy and Procedures. Mental health information may be disclosed for conducting scientific research and data research, management audits, or program evaluations of Plains Area Mental Health Center. In most cases we will remove any information that can identify you and, persons conducting audits and evaluations are also held to keeping your Protected Information confidential. Iowa Code 228.5(3). Audits, investigations, inspections relating to service provision and compliance with applicable laws and regulations. 164.512 HIPAA

Specific authorization by law:

- When otherwise specifically required by other states or the federal government by laws that specifically relate to the protection of human health and safety. Iowa Code 228.6(1) and 164.512 HIPAA
- When specifically authorized by provisions relating to hospitalization of persons with mental illness. Iowa Code 229.25 and 164.512 HIPAA
- When specifically authorized by provisions relating to government support of individuals with mental illness. Iowa Code 230.20 and 230A.13 and 164.512 HIPAA

Child or Dependent Adult Abuse: Plains Area Mental Health employees are mandatory reporters of child abuse and must disclose information necessary to report any known incident of child or dependent adult abuse under

under requirements by law. Iowa Code 232.74 and .147 and Iowa Code 235B and 164.512 HIPAA

Court Order: Court orders may authorize disclosures. Iowa Code 228.6(2) and 512 HIPAA

Commitment: Disclosure may be made to initiate or complete civil commitment proceedings. Iowa Code 229 and 228.6(3) and 164.512 HIPAA

Family members: We may disclose information to family members if you are diagnosed as having a chronic mental illness. The information is limited to a summary of your diagnosis and your prognosis, a list of your medications and your history of the last six months of compliance in taking these medications, and your treatment plan. The family member must be directly involved in your care or monitoring your treatment and this must be verified by the treating physician, mental health professional or someone other than the family member involved in your care. However, if you are not incapacitated you have the right to object to disclosures to family members. Iowa Code 228.8 and HIPAA 164.510

Workers Compensation: We are required to disclose Protected Information in Workers Compensation cases. Iowa Code 85.27 and 164.512 HIPAA

Victims of abuse and neglect: If we feel disclosure is necessary to prevent serious harm to you or others we may disclose information if you are incapacitated and unable to agree to the disclosure. Disclosure will be made only if failure to release the information would adversely affect a law enforcement activity and only if the information will not be used, in any way, against you. 164.512 HIPAA

Law enforcement: We may release your Protected information to law enforcement for the following purposes:

- Pursuant to a court order or warrant.
- Identifying or locating a suspect, fugitive, or material witness or missing person.
- If you are a crime victim, but only if you consent, or if you are unable to consent and the information is necessary to determine if a crime has occurred, non-disclosure would significantly hinder the investigation, and disclosure is in your best interest.
- To alert law enforcement if a person's death was caused by suspected criminal conduct.
- By emergency care personnel if the information is necessary to alert law enforcement of a crime, the location of a crime, or characteristics of the perpetrator. 164.512 HIPAA

Coroner, Medical Examiners, Funeral Homes: Protected Information may be released to a coroner or medical examiner in order to identify a deceased person, determine the cause of death, or other duties authorized by law. Protected Information may be released to funeral directors to carry out their duties. 164.502 and 164.512 HIPAA.

Specialized Government Functions:

- Military and veterans activities.
- National security and intelligence activities.
- Protective service of the President and others.
- Medical suitability determinations for the Department of State Officials.
- Correctional institutions and law enforcement custodial situations.
- Provisions of public benefits. 164.512 HIPAA

Public Health Activities:

- Preventing or controlling disease, injury, or disability.
- Reporting births or deaths.

- Reporting reactions to medications or problems with products.
- Notifying individuals exposed to disease who may be at risk for contracting or spreading the disease. 164.512 HIPAA

Your Rights. Federal and state laws grant you certain rights with respect to your Protected Information. Specifically you have the right to:

- Receive notice of our policies and procedures used to protect your Protected Information.
- Request that certain uses and disclosures of your Protected Information be restricted. However, we have the right to refuse your request in certain instances. The request needs to be in writing using a form provided by Plains Area Mental Health, Inc.
- Have access to your Protected Information. However, we have the right to deny this request in certain instances. Requests for review or copies of your information need to be done in writing using a form provided by Plains Area Mental Health, Inc.
- Request that your information be amended. We can only amend the information that has been produced by an employee of Plains Area Mental Health, Inc. and may be denied in certain instances. A request for amendment can be done by requesting a form provided by Plains Area Mental Health, Inc.
- Obtain an accounting of certain disclosures by us of your protected information for the past six years. An accounting can be requested by completing a form provided by Plains Area Mental Health, Inc.
- Revoke any prior authorizations for use or disclosure except to the extent the action has already been taken. Revocations can be done by requesting a form provided by Plains Area Mental Health, Inc.
- Request that any communications to you are done by an alternative means or at alternative locations such as a different mailing address or phone number.

Effective Date: This notice becomes effective on April 14, 2003. Please note we reserve the right to revise this notice at any time. A current notice of our privacy practices may be obtained from any of the Plains Area Mental Health, Inc. Offices in Cherokee, Ida, Plymouth, and Sioux counties in Iowa. The phone numbers and addresses are listed on the letterhead on the first page of this notice. You may also call 712-225-2575 and request one be sent to you. You may also request one by writing to the Privacy Officer at P.O. Box 972, Cherokee, Iowa 51012.

Any complaints can be reported to the Privacy Officer at Plains Area Mental Health, Inc. at 712-225-2575 or in writing at P.O. Box 972, Cherokee, Iowa 51012. You can also report any complaints to the U.S. Secretary of the Department of Health and Human Services. Plains Area Mental Health is obligated by law to refrain from any intimidating or retaliatory acts against any individual for filing a complaint or assisting in the investigation of a complaint.



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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of Plains Area Mental Health Center’s Notice of Privacy Practices which explains the ways in which my health information may be used and disclosed by Plains Area Mental Health Center and explains my rights with respect to my health information. I understand that Plains Area Mental Health Center has the right to revise any of these privacy practices and amend the Notice of Privacy Practices. I have been informed that in the event Plains Area Mental Health Center has revised these practices, a revised Notice will be posted at each Plains Area office as listed above on letterhead and I may request a copy from any of these locations. If I wish to discuss the Notice I may contact the Plains Area Mental Health Center’s Privacy Officer at P.O Box 972, Cherokee, IA 51012 or by phone at 712-225-2575.

Signature of Client/Legal Guardian or Representative

Date Signed

Relationship to client if Guardian or Representative

Signature of Witness

Date Signed

CHEROKEE - STORM LAKE
P.O. Box 972 • Cherokee, IA 51012-0972
712-225-2575

SATTELITE OFFICES:
IDA GROVE:
P.O. Box 168 • Ida Grove, IA 51445-0168
712-364-3500

ORANGE CITY
P.O. Box 70 • Le Mars, IA 51031-0070
800-325-1192



MAIN OFFICE:
LE MARS

P.O. Box 70 • Le Mars, Iowa 51031-0070
712-546-4624 • 1-800-325-1192
FAX 712-546-9395
www.plainsareamentalhealth.org

Medication Management Services Client Information Sheet

YOU KEEP

Thank you for choosing Plains Area Mental Health Center for your psychiatric medication management services. Listed below are PAMHC guidelines for these services.

1. **Please request refills at least 7 days in advance**, by phoning into our medication refill line. **Please plan accordingly.**

Speak slowly and leave the following information:

- Name of Client
- Phone number where you can be reached
- Name and dosage of medication
- Doctor prescribing medication
- Number of meds left
- Pharmacy name and phone number
- Indicate if you need samples, prescription, or call pharmacy
- Date of next appointment
- If you wish the nurse to return your call

2. If you need a written prescription mailed, please allow enough time for this to occur.
3. Sample medications will be given to those who are indigent or do not have prescription coverage on a limited basis.
4. Please make sure you keep scheduled appointments with the doctors. We are unable to authorize refills for clients who have not been seen as recommended by their doctor.
5. Please do not call the psychiatrist at other offices (ie. MHI, Sioux City, etc). Contact your Plains Area Mental Health office for questions about your medications.
6. Only “authorized” persons will be able to pick up prescriptions or sample medications. Authorized meaning:
 1. Yourself if the prescription or samples are for you and you are 18 years of age
 2. Anyone 18 or older and whom the client has completed a PAMHC Authorization form to allow an individual to pick up medications or prescriptions for you.
 3. Parents can pick up prescriptions or medications for their minor children without an Authorization.

CHEROKEE - STORM LAKE
P.O. Box 972 • Cherokee, IA 51012-0972
712-225-2575

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Date: _____

Dear Dr: _____

Your patient , _____, is being seen for services at Plains Area Mental Health Center. We are not requesting information at this time, but if we can be of service to you in the care of this patient, please feel free to contact us. A signed authorization is enclosed.

Sincerely,

PLAINS AREA MENTAL HEALTH CENTER

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P.O. Box 972 • Cherokee, IA 51012-0972
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AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MENTAL HEALTH INFORMATION

TO: _____
Agency/Individual

EXPIRATION DATE: I understand that this authorization is effective until the earlier of (i) the termination of all services to Patient, or (ii) if the following is completed: _____ (date on which this authorization expires).

PHONE NUMBER: _____

FAX NUMBER: _____

Street Address

City, State, Zip Code

REGARDING: CLIENT NAME: _____ CLIENT DOB: _____

PAMHC Service Provider(s): _____

The exchange of the following information has been authorized by the above named client:

FAXED information accepted as original.

- Check Yes No
Psychological Assessment
Pertinent History
Discharge or Closing Summary
Psychiatric Evaluation
Pertinent Medical Information
Prognosis or Response to Treatment

Information that is disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Privacy Rule.

I understand that PAMHC may not refuse treatment to me if I refuse to sign this authorization.

Other: _____

The purpose or need for the disclosure of the above information is: _____

Signature of Client or Authorized Representative: _____

I understand that I may revoke this Authorization at any time by giving written notice to Plains Area Mental Health Center.

Date Signed: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND FEDERAL LAW

I specifically authorize the release of information relating to: (Client must initial appropriate items)

- Mental Health Information
Substance Abuse (alcohol/drug abuse - client must initial & sign regardless of age)
HIV Information

Client Signature

Signature of Client or Authorized Representative - Date

Address City State

Initial I understand that I may review the disclosed information with professional staff. Yes No

Confidentiality of mental health information is protected by federal and state law, i.e. Chapter 228 of the Iowa Code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part.2, and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties. 1/07kk

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Plains Area Mental Health Center Personal Intake History

The goal of Plains Area Mental Health Center is to provide the most appropriate services that we can for your current concern(s).

With that in mind, we are asking that you complete this information form. Some of the information obtained is required by our accreditation under Iowa Chapter 24 Rules. We are aware that we ask some very personal questions and you may have concerns about answering them at this time. Please understand that we will need this information to determine how best to serve you, our customer. Please complete all sections and mark all areas that apply in each section. This information is confidential and will be maintained as such in accordance with our Privacy Notice provided to you. The staff person you work with at your first appointment will review this form with you and answer any questions you may have. Staff will complete the sections titled "Reviewer's Comments" while meeting with you.

Consumer Name: _____ Age: _____ Birth date: _____

Please list other names consumer may be known by: _____

Primary language of consumer: _____ Are interpreter services needed? [] No [] Yes

Person(s) completing form if other than consumer: _____

How did you hear about the Center or who referred you to us? _____

Presenting Concern/Reason for seeking treatment: _____

Current Symptoms, Concerns or Reasons for seeking services:

<input type="checkbox"/> Sleeping—not enough <input type="checkbox"/> Sleeping—too much <input type="checkbox"/> Appetite or eating problems <input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Sadness, tearfulness <input type="checkbox"/> Anxiety, nervousness <input type="checkbox"/> Panicky or panic attacks <input type="checkbox"/> Fearfulness or paranoia <input type="checkbox"/> Guilt or shame <input type="checkbox"/> Grief or loss <input type="checkbox"/> Nightmares <input type="checkbox"/> Not assertive enough <input type="checkbox"/> Loss of pleasure <input type="checkbox"/> Loss of interest <input type="checkbox"/> Poor self esteem/image <input type="checkbox"/> Stress or tension	<input type="checkbox"/> Concentration problems <input type="checkbox"/> Fidgety/hyperactive <input type="checkbox"/> Disobedient / discipline issues <input type="checkbox"/> Memory problems <input type="checkbox"/> Confusion <input type="checkbox"/> Anger, hurting others <input type="checkbox"/> Loneliness <input type="checkbox"/> Medical / physical issues <input type="checkbox"/> Sexual problems <input type="checkbox"/> Legal concerns <input type="checkbox"/> Financial concerns <input type="checkbox"/> Court or DHS requires <input type="checkbox"/> Work/school conflict or stress <input type="checkbox"/> Family conflicts <input type="checkbox"/> Marital conflict or stress <input type="checkbox"/> Other relationship problems	<input type="checkbox"/> Thoughts of suicide <input type="checkbox"/> Thoughts about harming self <input type="checkbox"/> Thoughts about harming others <input type="checkbox"/> Other odd or troubling thoughts <input type="checkbox"/> Hearing voices/seeing things <input type="checkbox"/> Alcohol or drug problems <input type="checkbox"/> Sexual abuse victim <input type="checkbox"/> Sexual abuse perpetrator <input type="checkbox"/> Physical abuse victim <input type="checkbox"/> Physical abuse perpetrator <input type="checkbox"/> Emotional abuse victim <input type="checkbox"/> Emotional abuse perpetrator <input type="checkbox"/> Physical health problems <input type="checkbox"/> Housing problems
Other:		

How long have you been experiencing the problem(s)? _____

What have you done to address the problem(s)? _____

What are your goals for treatment? _____

Now, please rank the above goals in order of importance to you (1 – most important, 2 – next most important, 3+ etc.)

SOCIO-ECONOMIC HISTORY

Consumer/Family financial situation:

- no financial problems
- moderate financial problems
- large indebtedness
- poverty/below poverty income
- impulsive spending
- relationship conflicts over finances
- current/previous bankruptcy

Employment history and current status:

Current Past

- | | | | |
|--------------------------|--------------------------|------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Employer: _____ | Dates: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Position: _____ | # of Hours/Week: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Employer: _____ | Dates: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Position: _____ | # of Hours/Week: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Employer: _____ | Dates: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Position: _____ | # of Hours/Week: _____ |

Not currently in the workforce due to:

- Unemployment Retirement Homemaker Workers Comp
 - Laid Off Disability Student Living in a facility
- Length of Time: _____

Living situation:

- housing adequate
- homeless
- housing overcrowded
- living in a facility - Name: _____
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional

Social support system:

- supportive network ___ family ___ friends ___ church ___ work
- few friends no friends distant from family of origin
- substance-use-based friends

Describe any past or current significant issues in Financial or Living situation, past or current Employment, or Social Support system:

Reviewer's Comments:

CULTURAL, SPIRITUAL AND RECREATIONAL INFORMATION

Cultural / Ethnic (mark all that apply)

- African American Other Hispanic _____
- Alaskan Native Puerto Rican
- Asian Pacific Islander
- Cuban White
- Mexican Other: _____
- Native American

Spiritual/Religion (Optional)

- No religious / spiritual connections/beliefs
- Protestant
- Catholic
- Jewish
- Other: _____

Have you experienced any problems related to your cultural/ethnic/spiritual/religious identity? No Yes Explain: _____

Community / Recreation / Hobbies

- | | | |
|--|--|---|
| Currently active in community/recreational activities? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Please explain answers: _____

_____ |
| Formerly active in community/recreational activities? | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Currently engaged in hobbies? | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Currently participate in spiritual activities? | <input type="checkbox"/> No <input type="checkbox"/> Yes | |

Reviewer's Comments:

EDUCATIONAL HISTORY AND INFORMATION

- High School Graduate – School Name/Year: _____
- GED – Year _____ Focus/Major _____
- Tech or Trade School – Name/Dates: _____
- Two year degree – School Name/Dates: _____
- Four year degree – School Name/Dates: _____
- Graduate courses/degree- School Name/Dates: _____
- If none of above, highest grade level achieved: _____

School Performance (What kind of student were you?):

- Excellent Above Average Average Below Average
- Explain: _____

Barriers to Learning:

- None Inattention/Focus Behavioral issues
- Difficulty w/ reading/writing Emotional issues
- Difficulty w/ mathematics Other _____

Type of classes attended:

- Regular Mix of Regular and Special Education
- Special Education
- Other: _____

Current student-School Name: _____
 Current Grade: _____ Teacher's Name: _____
 Average grades: _____ How long at current school? _____
 Extracurricular activities: _____
 Relationship w/ teacher(s): _____
 Relationships w/ peers: _____

Reviewer's Comments: _____

MILITARY BACKGROUND

- Never served in military
- Served in: Branch: _____ Dates: _____ Involved in combat: No Yes Where: _____
- Service related concern(s): No Yes Explain: _____

Discharge Status:

- Honorable Other – Explain: _____
- Rank at discharge: _____

Reviewer's Comments: _____

LEGAL HISTORY AND INFORMATION

- Legal Guardian:** Name: _____ Phone: _____
- Power of Attorney** for medical matters: Name: _____ Phone: _____
- Conservator/Payee** for financial matters: Name: _____ Phone: _____
- Advance Directives** for inpatient mental health treatment: No Yes If yes, explain: _____

- Outpatient Mental Health Commitment** **Court ordered to treatment**
- Alcohol/drug related legal problems** **Other:** _____

Involvement in **Civil Proceedings:** No Yes Explain: _____

Department of Human Services involvement with child/family: No Yes Reason: _____

List Name and County of DHS Caseworker assigned: _____

Foster care involvement: No Yes Names/dates of foster parent(s): _____

Was (or is) consumer **adopted** or involved in **adoption proceedings?** No Yes Explain: _____

If **minor** and parents were never married or are divorced, how is **custody** structured (e.g., sole, joint, etc.)? _____

Child Support Enforcement Orders Yes If yes, explain: _____

History of Legal Charges (mark all that apply):

None Current Detention Center/Jail Conditional Release Restraining / No Contact Orders
 Awaiting Charge On probation On parole

Juvenile: No Yes If yes, for what: _____
 Felony Misdemeanor

Adult No Yes If yes, for what: _____
 Felony Misdemeanor

List and date most recent **charges**: _____

List and date **convictions**: _____

List date(s) and reason(s) of **incarceration(s)**: _____

Juvenile Court involvement (including any related to child abuse, neglect, or dependency)

Current: No Yes Explain: _____

Past: No Yes Explain: _____

No legal issues / involvement / orders

Reviewer's Comments: _____

FAMILY / RELATIONSHIP HISTORY AND INFORMATION

Immediate/Current Family and Relationships:

(Staff only- Genogram Completed on page 10) No Yes

Marital / Intimate / Dating status (mark all that apply):

single, child / adolescent
 single adult, never married → → → → never been in a serious relationship
 engaged ___ months not currently in a relationship
 married for ___ years currently in casual relationship
 divorced for ___ years ___ months currently in a serious relationship
 separated for ___ years ___ months for ___ years ___ months
 divorce in process ___ months
 live-in for ___ years ___ months
 ___ # of prior marriages (self)
 ___ # of prior marriages (partner)
 widowed for ___ years ___ months

Present relationship satisfaction:

very satisfied with relationship
 satisfied with relationship
 somewhat satisfied with relationship
 dissatisfied with relationship
 very dissatisfied with relationship

List all persons currently living in consumer's household:

Name	Age	Sex	Relationship to consumer
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List children not living in same household as consumer:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Frequency of visitation of above: _____

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

Describe any past or current significant issues in other immediate family relationships: _____

Family of Origin:

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[]	[]	[]
father	[]	[]	[]
stepmother	[]	[]	[]
stepfather	[]	[]	[]
brother(s)	[]	[]	[]
sister(s)	[]	[]	[]
other (specify)	[]	[]	[]

Parents' current marital status:

- married to each other ___ years
- separated for ___ years
- divorced for ___ years
- mother remarried ___ times
- father remarried ___ times
- mother involved with someone
- father involved with someone
- mother deceased for ___ years
age of consumer at mother's death ___
- father deceased for ___ years
age of consumer at father's death ___

Describe parents of consumer:

	<u>Father</u>	<u>Mother</u>
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____
age of parent	_____	_____

Describe childhood family experience:

- outstanding home environment
- normal home environment
- chaotic home environment
- witnessed physical/verbal/sexual abuse toward others
- experienced physical/verbal/sexual abuse from others

Adults Please list names/ages of **step-parents**: _____

Adults – Please list first names/ages of **siblings**: _____

Age consumer left home (if applicable): _____

Circumstances: _____

Describe any past or current significant issues in family of origin relationships: _____

Special circumstances in childhood: _____

Reviewer's Comments: _____

MEDICAL HISTORY

Describe current physical health: Good Fair Poor

List name of consumer's primary care physician:
 Name _____ Phone _____
 Will you authorize communication with the primary care physician?
 No Yes
 Date and Reason for last visit: _____

List name of consumer's psychiatrist: (if any):
 Name _____ Phone _____
 Will you authorize communication with the psychiatrist?
 No Yes
 Date and Reason for last visit: _____

Allergies None Known; List all known: _____

Is there history of any of the following in Consumer or Family:

- | | | | |
|--|--------------------------|--------------------------------|--------------------------|
| <u>C</u> | <u>F</u> | <u>C</u> | <u>F</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| tuberculosis | | heart disease | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| birth defects | | high / low blood pressure | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| head / brain injury | | fibromyalgia / muscle pain | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| mental retardation | | stroke | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| headaches | | asthma / lung disease | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| thyroid problems | | diabetes | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| cancer | | Alzheimer's disease / dementia | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| other chronic or serious health problems | | | |

Describe any serious hospitalizations, accidents or surgeries. Please include dates, ages, and which of the above it was: _____

List any abnormal lab test results including date and result: _____

Current medication usage? No Yes If yes, please complete:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial – Y or N?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Please list any Herbal Remedies currently used: _____
 (e.g., Black Cohosh, Dong Quai, Ephedra, Garlic, Ginko, Ginseng, Goldenseal, Milk Thistle, Scotch Broom, St. John’s Wort)

Nutritional / Eating / Sleeping Habits:
 How many meals do you eat a day? _____ How many snacks in a normal day? _____
 Are you underweight overweight by how many pounds _____ Special diet? No Yes Explain: _____
 Has your weight changed in the last six months? No Yes Explain: _____
 Do you have problems with: chewing swallowing choking nausea binge eating purging (purposeful vomiting)
 Please describe the consumer’s **typical night’s sleep:** _____

Reviewer’s Comments: _____

DEVELOPMENTAL HISTORY- Required for Children/Adolescents – (ADULTS OPTIONAL)

<p>Mother’s problem(s) during pregnancy: <input type="checkbox"/> none <input type="checkbox"/> high blood pressure <input type="checkbox"/> kidney infection <input type="checkbox"/> German measles <input type="checkbox"/> emotional stress <input type="checkbox"/> bleeding <input type="checkbox"/> alcohol use <input type="checkbox"/> drug use <input type="checkbox"/> cigarette use <input type="checkbox"/> other _____</p>	<p>Birth: <input type="checkbox"/> normal delivery <input type="checkbox"/> difficult delivery <input type="checkbox"/> cesarean delivery <input type="checkbox"/> complications _____ <input type="checkbox"/> premature birth, by # of weeks _____ <input type="checkbox"/> birth weight ___lbs __oz Infancy: <input type="checkbox"/> feeding problems <input type="checkbox"/> sleep problems <input type="checkbox"/> toilet training problems</p>	<p>Childhood health: <input type="checkbox"/> chickenpox (age _____) <input type="checkbox"/> German measles (age _____) <input type="checkbox"/> red measles (age _____) <input type="checkbox"/> rheumatic fever (age _____) <input type="checkbox"/> whooping cough (age _____) <input type="checkbox"/> scarlet fever (age _____) <input type="checkbox"/> autism <input type="checkbox"/> ear infections <input type="checkbox"/> allergies to _____ <input type="checkbox"/> significant injuries _____ <input type="checkbox"/> chronic, serious health problems _____</p>	<p><input type="checkbox"/> lead poisoning (age _____) <input type="checkbox"/> mumps (age _____) <input type="checkbox"/> diphtheria (age _____) <input type="checkbox"/> poliomyelitis (age _____) <input type="checkbox"/> pneumonia (age _____) <input type="checkbox"/> tuberculosis (age _____) <input type="checkbox"/> mental retardation <input type="checkbox"/> asthma</p>
---	---	---	--

<p>Delayed developmental milestones (mark only those milestones that did not occur at expected age): <input type="checkbox"/> sitting <input type="checkbox"/> controlling bowels <input type="checkbox"/> rolling over <input type="checkbox"/> sleeping alone <input type="checkbox"/> standing <input type="checkbox"/> dressing self <input type="checkbox"/> walking <input type="checkbox"/> engaging peers <input type="checkbox"/> feeding self <input type="checkbox"/> tolerating separation <input type="checkbox"/> speaking words <input type="checkbox"/> playing cooperatively <input type="checkbox"/> speaking sentences <input type="checkbox"/> riding tricycle <input type="checkbox"/> controlling bladder <input type="checkbox"/> riding bicycle <input type="checkbox"/> other _____</p>	<p>Emotional / behavior problems (mark all that apply): <input type="checkbox"/> drug use <input type="checkbox"/> echoes words of others <input type="checkbox"/> distrustful <input type="checkbox"/> alcohol abuse <input type="checkbox"/> not trustworthy <input type="checkbox"/> extreme worrier <input type="checkbox"/> chronic lying <input type="checkbox"/> hostile/angry mood <input type="checkbox"/> self-harm acts <input type="checkbox"/> stealing <input type="checkbox"/> indecisive <input type="checkbox"/> impulsive <input type="checkbox"/> violent temper <input type="checkbox"/> immature <input type="checkbox"/> easily distracted <input type="checkbox"/> fire-setting <input type="checkbox"/> bizarre behavior <input type="checkbox"/> poor concentration <input type="checkbox"/> hyperactive <input type="checkbox"/> self-harm threats <input type="checkbox"/> often sad <input type="checkbox"/> animal cruelty <input type="checkbox"/> frequently tearful <input type="checkbox"/> breaks things <input type="checkbox"/> assaults others <input type="checkbox"/> frequently daydreams <input type="checkbox"/> disobedient <input type="checkbox"/> lack of attachment <input type="checkbox"/> other _____</p>
--	--

Social interaction (mark all that apply):

- normal social interaction
- isolates self
- very shy
- gang involvement
- alienates self
- inappropriate sex play
- dominates others
- associates with acting-out peers
- problems with authority
- other _____

Intellectual / academic functioning (mark all that apply):

- normal intelligence
- high intelligence
- learning problems
- authority conflicts
- attention problems
- underachieving
- mild retardation
- moderate retardation
- severe retardation

Describe any other developmental problems or issues: _____

Please describe how parents / caregivers **discipline and the consumer's response:** _____

Reviewer's Comments: _____

EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient psychotherapy?		<input type="checkbox"/> No <input type="checkbox"/> Yes, please list:				
Prior provider name	City	State	Dates	Diagnosis/Reason	Intervention/Modality	Beneficial – Y or N?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Has any family member had outpatient psychotherapy? No Yes If yes, who/why (list all): _____

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?		<input type="checkbox"/> No <input type="checkbox"/> Yes, please list:				
Inpatient facility name	City	State	Dates	Diagnosis/Reason	Intervention/Modality	Beneficial – Y or N?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? No Yes If yes, please list who/why (list all): _____

Prior psychiatric medication usage?		<input type="checkbox"/> No <input type="checkbox"/> Yes, please list:					
Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial – Y or N?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Has any family member used psychiatric medications? No Yes If yes, who/what/why (list all): _____

Reviewer's Comments: _____

SUBSTANCE USE HISTORY

Substances used: (check & complete all that apply)	Current Use (Yes/No)	Age of first use	Age of last use	Frequency	Amount	Method of Use
<input type="checkbox"/> caffeine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> tobacco / nicotine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> alcohol	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> amphetamines/speed	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> anabolic steroids	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> barbiturates/downers	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> cocaine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> crack cocaine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> ecstasy	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> hallucinogens (e.g., LSD)	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> hashish	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> heroin	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> inhalants (e.g., glue, gas)	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> marijuana	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> methamphetamine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> prescription med misuse	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> other _____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> other _____	_____	_____	_____	_____	_____	_____

Primary substance(s) of choice: 1st: _____ 2nd: _____ 3rd: _____

Benefits of substance use: What benefits and/or reasons do you have for using the above substances? _____

Consequences of substance use (mark all that apply):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> hangovers | <input type="checkbox"/> withdrawal symptoms | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> binges |
| <input type="checkbox"/> seizures | <input type="checkbox"/> medical conditions | <input type="checkbox"/> assaults | <input type="checkbox"/> school suspension/expulsion |
| <input type="checkbox"/> blackouts | <input type="checkbox"/> tolerance changes | <input type="checkbox"/> suicidal impulse | <input type="checkbox"/> arrests / legal involvement |
| <input type="checkbox"/> overdose | <input type="checkbox"/> loss of control amount used | <input type="checkbox"/> job loss / suspension | <input type="checkbox"/> relationship conflicts |
| <input type="checkbox"/> other(s) _____ | | | |

Consumer's Substance use status:

- no history of use or problems
- past use / no longer using
- occasional use / social
- active use – problematic
- early in recovery

Consumer's Treatment history:

- outpatient (age[s] _____)
- inpatient (age[s] _____)
- 12-step program (age[s] _____)
- stopped on own (age[s] _____)
- other (age[s] _____)
describe: _____

Family history of Alcohol/Drug problems:

- | | | | |
|---|---|---|---|
| <u>A</u> <input type="checkbox"/> <u>D</u> <input type="checkbox"/> | <input type="checkbox"/> father | <u>A</u> <input type="checkbox"/> <u>D</u> <input type="checkbox"/> | <input type="checkbox"/> stepparent/live-in |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> mother | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> uncle(s)/aunt(s) |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> grandparent(s) | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> spouse/significant other |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> sibling(s) | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> children |
| <input type="checkbox"/> | | | |

Reviewer's Comments: _____

VIOLENCE / ABUSE HISTORY

- No history of violence / abuse Emotional Abuse victim perpetrator
- Physical Abuse victim perpetrator Domestic Violence victim perpetrator
- Physical Neglect victim perpetrator Sexual Abuse/Molestation victim perpetrator
- Community Violence victim perpetrator Elder Abuse victim perpetrator

Please explain: _____

Reviewer's Comments: _____

SEXUAL ORIENTATION, HISTORY AND INFORMATION (optional)

- child or unknown heterosexual orientation homosexual orientation bisexual orientation
- currently sexually active currently sexually satisfied currently sexually dissatisfied age first sexual experience _____
- age first pregnancy / fatherhood _____ history of multiple partners: age _____ to _____; number of partners: _____
- history of unprotected / unsafe sex, please list: age _____ to _____

Are sexual issues an area of concern for you at this time? No Yes If yes, please explain additional information you may wish: _____

Reviewer's Comments: _____

To the best of my knowledge, what I have said is true and I have not withheld any information.

Signature of person completing form:

Date:

Information for this Personal Intake History has been provided by (mark all that apply)

- Consumer Parent(s) Guardian(s) Family/Friend
- Physician Law Enforcement Records Other Service Provider Interview: _____
- School Personnel Other: _____

Signature/Credentials/ID# of person reviewing form: _____ **Date:** _____

Family Genogram

(Staff – If preferred, please complete genogram of consumer’s family in the space below using these symbols as a guide)

□	○	—	/	//	m.60	s.72	d.74	X	43-75	---	≡
Male (double lines around client)	Female	Relationship	Separated	Divorced	Married date	Separated date	Divorced date	Death	Birth – Death date	Living together	Distant relationship	Very close relationship
