
Client Name:

Therapist must initial that they have all required forms in file.

_____ Referral Page

_____ Client Information

_____ Consent Form

_____ Confidentiality (Must have for school clients)

_____ Professional Disclosure

_____Treatment Advocate (Adults Only)

_____ MSE

_____ Trauma Screening

_____ Suicide Screening

_____ DAST Screening

_____ Credit Card Authorization (Private Pay/ Private Insurance)

Client's will become active in Chart Caddy after every document is completed and turned in

Therapist Signature

Office Signature

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Client Name:

## Referral Form for Mental Health Services

### Client Information

| | | | |
|---|---|---|---|
| Name: | | Date of Birth: | Race/Ethnicity: |
| Gender: ☐ Male | ☐ Female | ☐ Couple | School & Grade: |
| ☐ Home based | ☐ Office-Based Outpatient | ☐ School Based (if therapist is available) | |
| **CONTACT NUMBERS:** | | Message ok? ☐ Yes | ☐ No |
| **ADDRESS:** | | | |

### Parent or Legal Guardian Information:

| | |
|---|---|
| Name of Parent or Legal Guardian: | Address: |
| Contact Numbers: | Type of setting: ☐ Home ☐ Group Hom ☐ Foster Home ☐ Psychiatric hospital ☐ Other |

### Payment Information:

Type of Insurance ☐ Medicaid/ Soonercare) ☐ Private Insurances ☐ Self Pay

Insurance Provider _____ ID Number _____ Deductible _____ Copay _____

### Referral Source Information: How did you hear about us?

_____

**Reason for referral for treatment:** In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

_____

**Required Screeners by ODMHSAS:**

**History of Trauma?** ☐ **Yes** ☐ **No If yes- please explain:** _____

During the past year (12 months) have you:

Experienced a traumatic event, natural disaster, accident/injury or loss of a family member or loved one ☐ Yes ☐ No

Upsetting thoughts or memories about the event? ☐ Yes ☐ No

Difficulty concentrating? ☐ Yes ☐ No

Acting or feeling as though the event were happening again? ☐ Yes ☐ No

**Self-Harm Brief Assessment:**

Have you ever done any of the following with the purpose of intentionally hurting yourself?

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MFT
Metro Family Therapy

Client Name:

Scratched or pinched with fingernails or other objects to cause bleeding or marks on the skin? ☐ Yes ☐ No

Cut wrists, arms, legs, torso or other areas of the body? ☐ Yes ☐ No

Ingested a dangerous substance? ☐ Yes ☐ No

Attempted or successfully broken own bones? ☐ Yes ☐ No

Banged or punched objects or self to cause bruising or bleeding? ☐ Yes ☐ No

**Present thoughts of suicide? ☐ Yes ☐ No If yes- please explain:** _____

Have you ever wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No

Have you ever had any thoughts of killing yourself? ☐ Yes ☐ No

Availability: _____

Counselor Preferences: _____

Additional Comments:

_____

_____

_____

_____

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MIFIT Client Name:

## Client Information

**Clinicians- This form must be completed. If it is not applicable, please write N/A where appropriate.**

Client's Name: _____ D.O.B. _____ Sex: _____ Race: _____

Client's Address: _____City:_____ State: _____ Zip:_____

County of Residence: _____ Client's Phone Number: _____

Client Cell Number: _____ Client Work Number: _____

Client email: _____ Social Security Number: _____

Referring Person/Agency Name: _____

Annual Family Income: _____ Number of Dependents: _____

☐**Insurance (if yes, which)** _____ ☐ **Medicaid #**_____ ☐ **Self Pay**

**Reason for Referral:**

_____

**Parents/Guardians**

Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Cell Number: _____

Work Number: _____ email: _____

**Emergency Contact**

Name: _____ Relationship: _____

Phone Number: _____

**OTHER CUSTODIAL PARTIES**

Is the client a ward of the court? ☐ Yes ☐ No If yes, County of jurisdiction: _____

Name of caseworker: _____

Is the patient on probation? ☐ Yes ☐ No

If yes, Name of Probation Officer & County of Court Jurisdiction:_____ _____

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Metro Family Therapy

Client Name:

# Consent Form

1. I request and authorize **Metro family therapy, LLC, Inc. (MFT),** its employees, staff, and **qualified mental health providers (QMHP)** to administer treatment to me (or my child/trustee) and to continue such treatment as deemed professionally necessary.

2. I hereby authorize psychological treatment including diagnosis by a QMHP, case management, rehabilitation, and psychotherapy. Treatment may be rendered in any confidential setting. It is understood that this consent is given in advance of any specific diagnosis or recommendation of treatment but is given to encourage and authorize MFT staff to exercise their judgment to identify needed services.

3. I understand that the telephone is not a secure and confidential means for services and shall only be used for scheduling purposes. If there is an emergency and I am unable to contact MFT, I will call 911 or go to my nearest emergency room, and I release MFT for any further responsibility.

4. I agree to be actively involved in the development of the treatment plan and its implementation as prescribed by the treatment team of **MFT** while in treatment. I agree to be involved in treatment by attending family, individual, or group therapy sessions. The type and schedule of services may be set by State, Federal and/or payer source guidelines. No guarantees or assurance have been given by anyone as to the results that may be obtained.

5. I understand that I am responsible for any outstanding balance that is not covered by my insurance, which is due at time of services, and I authorize non-payments to be referred to collection agencies.

6. I consent to be contacted following discharge so MFT can get information to improve the quality and types of services provided. This contact may include client satisfaction surveys or phone calls at certain intervals.

7. I agree to give 24-hour notice of cancellation for an appointment. I understand that by not showing up for planned services, I may be charged and after 3 no shows, my treatment plan may be reviewed by treatment staff to determine the appropriateness of continued treatment or recommendation for discharge.

8. I grant permission to MFT staff to refer me, or a minor child in my care who is receiving services from MFT, to a hospital for emergency medical treatment, if the situation should arise. I understand I will be financially responsible for any subsequent charges. My signature below indicates that I hereby release and discharge MFT from any and all liability for the performance of these services. I may be released from such consent upon written notice to MFT prior to my release from services.

9. Per Licensing Rules and Regulations, 310:405-3-2, LMFT/LPC's are not qualified or permitted to provide custody evaluations, reports, or expert testimony. A written treatment plan progress report can be requested for a 70-dollar fee.
10. I have read the Consent for Treatment form, understand all of its content, and agree to treatment freely, voluntarily, and without coercion. I have read, had read to me, or given a full copy of a client handbook and understand these rules and procedures.
11. Minors under 14 need to be accompanied by an adult if they are not with their therapist.

| | |
|---|---|
| **Signature of Client** | **Date** |
| **Signature of Parent/Guardian** | **Date** |
| **Signature of Staff/Witness** | **Date** |

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MIPIT

Client Name:

**Consent for Release of Confidential Information**

Name of Person Whose Information Will Be Shared | Date of Birth | Telephone Number

Address | City | State | Zip

**Scope & Purpose For Sharing Information**

The purpose of this authorization is to allow _____ to share my protected health information as set forth below, for reasons in addition to those already permitted by law. The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include but is not limited to, hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

**How Information Can Be Shared**

| | | | |
|---|---|---|---|
| ☐ Verbally – in person | ☐ By Telephone | ☐ Electronic – fax, email | ☐ Written – includes photocopies |

**Purpose for Sharing**

| | | | |
|---|---|---|---|
| ☐ Continuance of Care | ☐ Advocacy | ☐ Arranging Additional Services | ☐ Insurance or Billing |

**Person/Organization Receiving Information and Purpose for Sharing**

**Agency or Name and Title of Person Receiving and/or Exchanging Information**

**Address** | **City** | **State** | **Zip** | **Telephone Number**

**Information To Be Shared**

| | | | |
|---|---|---|---|
| ☐ Progress Notes | ☐ Psychometric Testing | ☐ Psychosocial & Family History | ☐ Discharge Summary |
| ☐ Psychological Evaluation | ☐ Dates of Service | ☐ Diagnosis | ☐ General Progress & Condition |
| ☐ Alcohol or Drug Abuse Records | ☐ History and Physical | ☐ Treatment Plan | ☐ Academic Information, IEP |
| ☐ Medication History | ☐ Laboratory Reports | ☐ Radiology Reports | ☐ Registration Information |
| ☐ Other | | | |

Time Frame of Information to be Disclosed: From _____ To _____

This Authorization Will Expire: ☐12 months from the date signed **OR** ☐Other (insert date or event) _____

I understand that my mental health and alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. This consent expires one year from the date of signing. I understand I may change this authorization at any time by writing to the address listed at the top of this form. I understand I cannot restrict information that may have already been shared based on this authorization. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

Signature of Patient or Legal Representative | Date

Signature of Witness | Date

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Client Name:

**Metro family therapy Treatment Advocate From**

(a) All adult mental health consumers being served by a licensed mental health professional shall be informed by the LMHP or the mental health treatment facility that the consumer has the right to designate a family member or other concerned individual as a treatment advocate. The program shall have written policies and procedures ensuring this provision.

(b) The consumer shall not be coerced, directly or indirectly, into naming or not naming a Treatment Advocate or choice of Treatment Advocate or level of involvement of the Treatment Advocate. Any individual so designated shall at all times act in the best interests of the consumer and comply with all conditions of confidentiality.

(c) No limitation may be imposed on a consumer's right to communicate by phone, mail or visitation with his or her Treatment Advocate, except to the extent that reasonable times and places may be established.

(d) The Treatment Advocate may participate in the treatment planning and discharge planning of the person being served to the extent consented to by the consumer and permitted by law.

(e) The consumer and Treatment Advocate shall be notified of treatment and discharge planning meetings at least 24 hours in advance.

(f) All LMHPs or mental health treatment facilities shall use a Treatment Advocate Designation form which will minimally include:

the consumer's choice to name or not name a Treatment Advocate.

_____ yes, I would like to name an advocate

_____ No, I would not like to name an advocate

(2) identify any specifically named person;

_____

(3) indicate the level of involvement the identified Treatment Advocate shall have.

_____

(4) Treatment Advocate will indicate his or her intention of serving according to the consumer's specifications;

_____

(5) The Treatment Advocate agrees to comply with all standards of confidentiality;

_____

Treatment Advocate Signature/Date

_____

Client Signature/Date

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# Brief Mental Status Exam (MSE) Form

| | |
|---|---|
| 1. Appearance | ☐ casual dress, normal grooming and hygiene<br>☐ other (describe) |
| 2. Attitude | ☐ calm and cooperative<br>☐ other (describe) |
| 3. Behavior | ☐ no unusual movements or psychomotor change<br>☐ other (describe) |
| 4. Speech | ☐ normal rate/tone/volume w/out pressure<br>☐ other (describe) |
| 5. Affect | ☐ reactive and mood congruent ☐ normal range<br>☐ labile ☐ depressed<br>☐ tearful ☐ constricted<br>☐ blunted ☐ flat<br>☐ other (describe) |
| 6.Mood | ☐ euthymic ☐ anxious<br>☐ irritable ☐ depressed<br>☐ elevated<br>☐ other (describe) |
| 7. Thought Processes | ☐ goal-directed and logical<br>☐ other (describe) |
| 8. Thought Content | **Suicidal Ideation:** ☐ none ☐ passive ☐ active<br>If active: yes no<br>Plan ☐ ☐<br>Intent ☐ ☐<br>Means ☐ ☐<br>**Homicidal ideation:** ☐ none ☐ passive ☐ active<br>If active: yes no<br>Plan ☐ ☐<br>Intent ☐ ☐<br>Means ☐ ☐<br>☐ delusions ☐ obsessions/compulsions<br>☐ phobias<br>☐ others (describe): |
| 9. Perception | ☐ no hallucinations or delusions during interview<br>☐ other (describe): |
| 10. Orientation | Oriented ☐ time ☐ place ☐ person ☐ self<br>☐ other (describe): |
| 11.Memory/Concentration | ☐ short term intact ☐ long term intact<br>☐ other (describe): ☐ distractible/inattentive |
| 12.Insight/Judgment | ☐ good ☐ fair ☐ poor |

Revised 10/2014 Client Name: _____

# Adverse Childhood Experience (ACE) Questionnaire

## Finding your ACE Score ra hbr 10 24 06

**While you were growing up, during your first 18 years of life:**

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 that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** ...
   Push, grab, slap, or throw something at you?
   **or**
   **Ever** hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

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?
   Yes No If yes enter 1 _____

4. Did you **often** feel that ...
   No one in your family loved you or thought you were important or special?
   **or**
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   **Often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

**Now add up your "Yes" answers: _____ This is your ACE Score**

# Ask Suicide-Screening Questions Age 6-12

NIMH Toolkit

**Ask the patient:**

1. In the past few weeks, have you wished you were dead?
   - ◯ Yes
   - ◯ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
   - ◯ Yes
   - ◯ No
3. In the past week, have you been having thoughts about killing yourself?
   - ◯ Yes
   - ◯ No
4. Have you ever tried to kill yourself?
   - ◯ Yes
   - ◯ No

   If yes, How:

   _____

   _____

   When:

   _____

   _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?**
   - ◯ Yes
   - ◯ No

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# Suicide Screening 12- 18 PQ9

Name_____

Date_____

Over the past 2 weeks, how often have you been bothered by any of the following problems

| | Not at all | Several Days | More Than Half Days | Nearly Every Day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| Add Columns | | | | |

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

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?

- Somewhat difficult
- Very difficult
- Extremely difficult



PHQ-9 Patient Depression Questionnaire

Metro Family Therapy

# COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann


RISK ASSESSMENT

**Interview** Instructions: **Check all risk and protective factors that apply. To be completed following the patient, review of medical record(s) and/or consultation with family members and/or other professionals.**

| Past 3 Months | Suicidal and Self-Injurious Behavior | Lifetime |
|---|---|---|
| ☐ | **Actual suicide attempt** ☐ **Lifetime** | ☐ |
| ☐ | **Interrupted attempt** ☐ **Lifetime** | ☐ |
| ☐ | **Aborted or Self-Interrupted attempt** ☐ **Lifetime** | ☐ |
| ☐ | **Other preparatory acts to kill self** ☐ **Lifetime** | ☐ |
| ☐ | **Self-injurious behavior *without* suicidal intent** | ☐ |

| Suicidal Ideation<br>Check Most Severe in Past Month | |
|---|---|
| ☐ | **Wish to be dead** |
| ☐ | **Suicidal thoughts** |
| ☐ | **Suicidal thoughts with method (but without specific plan or intent to act)** |
| ☐ | **Suicidal intent (without specific plan)** |
| ☐ | **Suicidal intent with specific plan** |

| Activating Events (Recent) | |
|---|---|
| ☐ | **Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)** |
| **Describe:** | |
| ☐ | **Pending incarceration or homelessness** |
| ☐ | **Current or pending isolation or feeling alone** |

| Treatment History | |
|---|---|
| ☐ | **Previous psychiatric diagnoses and treatments** |
| ☐ | **Hopeless or dissatisfied with treatment** |

| Clinical Status (Recent) | |
|---|---|
| ☐ | **Hopelessness** |
| ☐ | **Major depressive episode** |
| ☐ | **Mixed affective episode (e.g. Bipolar)** |
| ☐ | **Command hallucinations to hurt self** |
| ☐ | **Highly impulsive behavior** |
| ☐ | **Substance abuse or dependence** |
| ☐ | **Agitation or severe anxiety** |
| ☐ | **Perceived burden on family or others** |
| ☐ | **Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)** |
| ☐ | **Homicidal ideation** |
| ☐ | **Aggressive behavior towards others** |
| ☐ | **Method for suicide available (gun, pills, etc.)** |
| ☐ | **Refuses or feels unable to agree to safety plan** |
| ☐ | **Sexual abuse (lifetime)** |
| ☐ | **Family history of suicide (lifetime)** |
| Protective Factors (Recent) | |
| ☐ | **Identifies reasons for living** |
| ☐ | **Responsibility to family or others; living with family** |
| ☐ | **Supportive social network or family** |
| ☐ | **Fear of death or dying due to pain and suffering** |

 **Client Name:** _____

| | | | |
|---|---|---|---|
| ☐ | **Non-compliant with treatment** | ☐ | **Belief that suicide is immoral; high spirituality** |
| ☐ | **Not receiving treatment** | ☐ | **Engaged in work or school** |
| Other Risk Factors | | Other Protective Factors | |
| ☐ | | ☐ | |
| ☐ | | ☐ | |
| ☐ | | ☐ | |
| Describe any suicidal, self-injurious or aggressive behavior (include dates) | | | |



Client Name: _____

Client Name:

*Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation.)*

# Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months. "Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs. The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

| Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right. **In the past 12 months... Circle** | | | |
|---|---|---|---|
| 1. | Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. | Do you abuse more than one drug at a time? | Yes | No |
| 3. | Are you unable to stop abusing drugs when you want to? | Yes | No |
| 4. | Have you ever had blackouts or flashbacks as a result of drug use? | Yes | No |
| 5. | Do you ever feel bad or guilty about your drug use? | Yes | No |
| 6. | Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 7. | Have you neglected your family because of your use of drugs? | Yes | No |
| 8. | Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 9. | Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes | No |
| 10. | Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)? | Yes | No |
| **Scoring:** Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point. | | | **Score:** |
| | | | |

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Client Name:

# CREDIT CARD AUTHORIZATION FORM

*****It is policy of this office to keep debit/credit card on file. You may pay by check or cash however, card must still be kept on file****

Name on Card _____

I authorize Moore Family Counseling to charge my credit/debit card for professional services as follows

• All visits for which payment was not made at time of visit • To charge my card the regular session fee for each no-show or late cancellation (less than 24-hour notice per informed consent and cancellation policy agreement.) • Denied insurance claims after 30 days

Type of card: Check one of the following

_____Visa _____Mastercard _____Discover _____Amex

Credit Card Number _____ CVV Number (On back)_____ Expiration Date_____ Card Holders Billing Address_____

_____

Card Holder Signature/Date _____

*Prohibition on Redisclosure of Confidential Information*

*This notice accompanies a disclosure of information concerning a client in mental health treatment, made to you with the consent of the client. This information has been disclosed to you from records whose confidentiality is protected by federal confidentiality rules (42 C.F.R., Part 2 and 45 C.F.R. parts 160 and 164). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.*