Therapeutic Life Choices, Tohi Usti Gvnvnv Edasdi, LLC.Client _____
1728 S. Carson Ave., Tulsa, OK 74119 I.D.# _____
Office: 918-406-3420 Fax: 918-280-0310

Intake Assessment

GENERAL INFORMATION

Client Name: (F, MI, L) _____Maiden_____

Intake Date(s): _____Intake Time(s):_____

Intake Participants:_____

Referral Source(s):_____

Referral source-(Self, Parent/Guardian, DHS, School/Daycare, Church/Clergy, Court, Other)

CLIENT INFORMATION

Parent/Guardian Name(s): _____Relationship: _____Phone: _____

Address: _____City, State, Zip_____

Phone/Type: _____Email: _____

Alternate/Emergency Contact Name/Number(s): _____

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

Ins. Provider: _____Ins ID #:_____

Highest Grade Completed: _____ Marital Status:_____#Yrs in MH/SA treatment_____

Previous Treatment Type/Diagnosis: _____

Military Status: ☐ None ☐ Veteran ☐ Active Duty Preferred Language:_____

MH Admissions/Dates/Reasons: _____

ER Admissions/Dates/Reasons:_____

Youth Suspensions:_____Youth Runaways:_____

Ethnicity/Race: _____ Hispanic/Latino ☐ Yes ☐ No Citizenship: ☐ Yes ☐ No

Special Ed: ☐ Yes ☐ No In School: ☐ Yes ☐ No Probation: ☐ Yes ☐ No

ECONOMIC RESOURCES

*Family's annual income? _____ *How many people share this income? _____
(Dependents in household)

Does anyone else contribute to you/your family financially?

☐ Yes ☐ No ☐ SSI ☐ SSDI ☐ SED ☐ SMI ☐ Other _____

ADDITIONAL RESIDENCE INFORMATION

County of Residence: _____ Res. Type: ☐ Permanent ☐ Temporary ☐ Homeless

☐ Other_____

Living Situation: Lives ☐ Alone ☐ w/ family ☐ w/non-related

Incarcerated: ☐ Yes ☐ No Legal Status: ☐ Voluntary Admission ☐ Court Ordered

☐ Other_____

Custody (IH/DHS/OJA/DOC or N/A): _____Date of Placement:_____

DHS/OJA Worker: _____ Phone: _____

Child Placement: ☐ Residential ☐ Foster Care ☐ Group Home (Specialized ☐Yes ☐No) ☐ None

☐ Other_____

Disabled: ☐ Yes ☐ No Disability:_____

PRESENTING REASONS FOR SEEKING SERVICES

Please check all that apply and describe below.

☐ Abuse (Neglect, Physical, Psychological, Sexual, etc.)
☐ Behavioral (Assaultive, ADHD, Domestic Abuse(r), Homicidal, OJA, ODD, PTSD, Runaway)
☐ Emotional (Anxiety/Panic, Depression, Eating Disorder, Emotional Disturbance)
☐ Gambling (Self, Family Member)
☐ Social Performance (Social, Family, Outside Immediate Family)
☐ Substance Abuse (Drugs, Alcohol, Relapse Risk, Family Member a User)
☐ Suicidal/Self-Abusive
☐ Thought Disorders (Disorientation, Psychotic Symptoms, and Perceptual Problems)

Describe current and historical concerns regarding presenting problems.
(II) History of presenting problems

EDUCATION

Are you presently a student? ☐ Yes ☐ No ☐ Full-time ☐ Part-time

Do you have a degree or any special training? ☐ Yes ☐ No what area?_____

*Days suspended from school in past 90 days? _____ Reason?_____

*Days in restrictive placement in past 90 days?_____Reason?_____

*Absences (NOT suspensions) from school, past 90 days? _____

*Days not permitted in day care in past 90 days? _____ Reason?_____

*List past or present educational concerns: _____

EMPLOYMENT

(Skip this section if client is under 14)

*Are you working now? ☐ Yes ☐ No ☐ Part-time ☐ Full-time ☐ Volunteer ☐ Not in Labor Force

Employer: _____How long?_____Position:_____

Satisfied with job?_____Problems at work?_____

If not working, how long?_Why?_____

What kind of work would you prefer?_____

Age _____ and type of first job: _____# of jobs held:_____Longest Job:_____

How do/did you get along with your co-workers?_____

Are you currently, or have you ever served in the military? If so, how long and what branch?

_____

HOUSEHOLD RELATIONSHIPS

Present living arrangements

Client lives with: ☐ Family/Relatives ☐ Non-Related Persons Number of people in household_____
List all people living in the home and their ages and relationship to the client.

	Name	Age	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	

Current and past marital or significant other relationship(s).
Please include their name, length of time together, marriage date (if applicable), and reason relationship ended:
(XII) Marital or significant other relationship history

Name	Length of Time together	Marriage date	Reason relationship ended
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How do you get along with the family member(s) you live with? If the answer is not well, give examples and frequency. _____

How do family members treat you? If the answer is not well, then give specific examples and frequency.

_____

SUPPORT SYSTEM

Current support system including peer and other recovery supports.

Who do you include in your support system?

☐ Husband ☐ Wife ☐ Significant Other ☐ Mother ☐ Father ☐ Siblings
☐ Friends/Other (Please List)

_____ _____
_____ _____

Attended any self-help/support groups in the last 30 days? ☐ Yes ☐ No

Where?_____

RECREATION/LEISURE

Recreation and leisure history

What are your hobbies, recreational or leisure activities?_____

LEGAL ASSESSMENT

Legal or criminal record, including the identification of key contacts, (i.e. attorneys, probation officers, etc.)

Have you ever been arrested? ☐ Yes ☐ No How many times in: past 30 days _____ past 12 mos. _____

Please list details: _____

Are you currently on probation/parole/OJA? ☐ Yes ☐ No

Name & number of Probation/Parole Officer: _____

Do you have any legal charges pending? ☐ Yes ☐ No

Describe: _____

Attorney Name/Contact Info:_____

MENTAL HEALTH HISTORY

Previous psychiatric treatment history, include treatment for psychiatric; substance abuse; drug and alcohol addiction; and other addictions

Are you presently attending any mental health services or being seen by a psychiatrist? ☐ Yes ☐ No
If yes, who, where, why?

Who	Where	Why
_____	_____	_____

Ever been treated for mental health, substance abuse, drug addiction, or alcohol addiction? ☐ No ☐ Yes
If yes, when, where, why, how long, outcome:

When	Where	Why	How Long	Outcome
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has anyone in your family ever had any mental health problems? ☐ Yes ☐ No

Who?_____

HEALTH INFORMATION FORM

Health history and current biomedical conditions and complications

To the best of your knowledge, have you (client) had any problem with the following?

Condition	No	Yes	Comment if "Yes"
Allergies (food, insects, drugs, latex)	☐	☐	
Allergies (seasonal)	☐	☐	
Asthma or breathing problems	☐	☐	
Developmental problems	☐	☐	
Dental problems	☐	☐	
Diabetes	☐	☐	
Hearing problems or deafness	☐	☐	
Heart problems	☐	☐	
Vision problems	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease (not trait)	☐	☐	
Speech problems	☐	☐	
Muscular problems	☐	☐	
Other	☐	☐	

Describe any other important health-related information
(i.e., Recent physical complaints and medical conditions; Chronic conditions; Communicable diseases; Handicaps or restriction on physical activities, if any etc.): ☐ None

Past serious illnesses, serious injuries, surgeries and hospitalizations (dates, reasons): ☐ None

To what degree does/do the client's current condition(s) impact daily functioning (relationships, work, household responsibilities, self-care)? ☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely
Explain

List all prescription and over-the-counter medications the client takes or has taken in the past, the reason taken, and their side effects if any. (xvi) Pharmaceutical information to include the following for both current and past medications; (I) Name of medication; (II) Strength and dosage of medication; (III) Length of time on the medication; and (IV) Benefit(s) and side effects of medication.

Medication	Dosage	Frequency	Length of use	Benefits	Side Effects	Current	Past
						☐	☐
						☐	☐
						☐	☐
						☐	☐

If extra lines are need, add to comments section.

Wellness is not the absence of disease, illness, and stress but the presence of: Purpose in life; Active involvement in satisfying work and play; Joyful relationships; A healthy body and living environment; Happiness.

The following is a list of the 8 Dimensions of Wellness.
Please check the dimensions, if any, that you are interested in incorporating into your treatment plan. A staff member will follow up with you regarding strengths and needs you have in these areas.

Physical Wellness involves the maintenance of a healthy body, good physical health habits, good nutrition and exercise, and obtaining appropriate health care.

Intellectual Wellness involves lifelong learning, application of knowledge learned, and sharing knowledge.

Environmental Wellness involves being and feeling physically safe, in safe and clean surroundings, and being able to access clean air, food, and water. Includes both our micro-environment (the places where we live, learn, work, etc.) and our macro-environment (our communities, country, and whole planet.)

Spiritual Wellness involves having meaning and purpose and a sense of balance and peace.

Social Wellness involves having relationships with friends, family, and the community, and having an interest in and concern for the needs of others and humankind.

Emotional Wellness involves the ability to express feelings, enjoy life, adjust to emotional challenges, and cope with stress and traumatic life experiences.

Financial Wellness involves the ability to have financial resources to meet practical needs, and a sense of control and knowledge about personal finances.

Occupational Wellness involves participating in activities that provide meaning and purpose, including employment.

HISTORY OF ABUSE

Has the client ever experienced or been the perpetrator of: trauma, physical, sexual, or emotional abuse, sexual assault, domestic violence, assault etc.? If so, list event dates and details below.

Event Date	Details

Was it reported? ☐ Yes ☐ No When? _____ To Whom?_____
*Protective Order: ☐ Yes ☐ No
Did DHS become involved? ☐ Yes ☐ No If so, please describe their involvement.

SEXUAL HEALTH AND REPRODUCTICE HISTORY

Has the client been sexually active? ☐ Yes ☐ No How long?_____

Are/have you (client) ever been pregnant? ☐ Yes ☐ No How many times?_____Due Date?_____

Any sexually communicable diseases (HIV, AIDS, STDs)? ☐ Yes ☐ No What?_____

Does the client engage in at-risk behaviors? ☐ Yes ☐ No What?_____

List all family members and extended family members with a history of drug or alcohol problems, trauma, abuse, neglect, anxiety, depression or other mental health issues, self-destructive behavior, or legal problems.

CULTURAL ORIENTATION FAITH AND SPIRITUALITY

With which cultural, racial, ethnic, and/or social group(s) do you identify? _____

Have you ever been involved in Satanic/Cult/Gang activities? ☐ Yes ☐ No How long?_____

What are your thoughts about spirituality?

_____

Do/have you attended church? ☐ Yes ☐ No If so, where?_____

Special Groups or clubs you belong to: _____

Historical Summary

Additional Comments:

Client Assessment Record (CAR) Data

Domain 1 Feelings/Mood/Affect _____ CAR Score

Problem Areas ☐ Mood Lability (frequent or intense mood changes) ☐ Suicidal/homicidal plan ☐ Euphoria ☐ Anxiety
☐ Coping Skills ☐ Change in sleep patterns ☐ Change in eating patterns ☐ Anger ☐ Depression

In the past month, has the client:	Never	Occasionally	Often	Very Often	N/A
had unstable or rapid mood swings?	☐	☐	☐	☐	☐
seemed depressed or sad?	☐	☐	☐	☐	☐
had difficulty controlling anger/negative emotions?	☐	☐	☐	☐	☐
seemed anxious or on edge?	☐	☐	☐	☐	☐
bite fingernails, hair, objects?	☐	☐	☐	☐	☐
seemed to become angry or easily irritated?	☐	☐	☐	☐	☐
acted verbally or physically aggressive?	☐	☐	☐	☐	☐
*had thoughts of or attempted suicide?	☐	☐	☐	☐	☐
Have current plan? ☐ Yes ☐ No *Explain below					
caused harm/injury to self or engaged in risky behaviors?	☐	☐	☐	☐	☐
*had thoughts or attempted to harm/kill someone else?	☐	☐	☐	☐	☐
Have current plan? ☐ Yes ☐ No *Explain below					
had changes or odd eating habits?	☐	☐	☐	☐	☐
had changes, odd sleeping habits, or nightmares?	☐	☐	☐	☐	☐
had moods that affected job/household responsibilities?	☐	☐	☐	☐	☐

***NOTES:**

***If yes to suicidal or homicidal ideation, will need to assess for lethality**

Domain 2 Thinking/Mental Process _____ CAR Score

Problem areas: ☐ Cognitive Process ☐ Judgment ☐ Belief System ☐ Impulse Control
☐ Delusions/Hallucinations ☐ Memory ☐ Obsessions ☐ Poor Concentration ☐ Learning Disabilities
Orientated x _____

In the past month, has the client:	Never	Occasionally	Often	Very Often	N/A
experienced any difficulties with memory?	☐	☐	☐	☐	☐
had someone tell them they have problems understanding what the person is trying to say?	☐	☐	☐	☐	☐
been slow to respond to questions/requests?	☐	☐	☐	☐	☐
experienced any difficulties with concentration?	☐	☐	☐	☐	☐
felt or were told they used poor judgment or made poor decisions?	☐	☐	☐	☐	☐
had persistent negative thoughts or fears that made it difficult to concentrate on other things?	☐	☐	☐	☐	☐
had thoughts that people are against or out to get them?	☐	☐	☐	☐	☐
heard voices or saw things that others didn't hear or see?	☐	☐	☐	☐	☐
been told that they have a learning disability or think they have problems with learning or thinking?	☐	☐	☐	☐	☐
acted impulsively? acted/reacted without considering consequences?	☐	☐	☐	☐	☐

NOTES:

A score of 40 or more in this domain must include a statement indicating the member's ability to participate in treatment planning and benefit from the OP services requested

Domain 3 Substance Abuse - (V) Alcohol, Drug, and/or other addictions history **CAR Score**

☐ None reported ☐ Current user ☐ Currently in rehab

☐ Live(d) with a substance abuser ☐ Rx substance abuse

Please complete the following information chart for every drug that you've ever used
(*other than tobacco, 2 or more refer for SA Assessment)

Type of drug	Used in past month	How much	How often	Age first used	Last Use	Method	Reason for use and means of access.
*Tobacco	☐Y ☐ N						
Alcohol	☐Y ☐ N						
Marijuana/Hash	☐Y ☐ N						
Opiates/Oxi	☐Y ☐ N						
Cocaine/Crack	☐Y ☐ N						
Ecstasy	☐Y ☐ N						
Heroin	☐Y ☐ N						
Methamphetamine	☐Y ☐ N						
List Others:							
	☐Y ☐ N						
	☐Y ☐ N						

The MHP informed the client that the use of illegal drugs & prescription medications together could be harmful and advised that they notify their PCP/Psychiatrist of such usage. ☐ Yes ☐ No

Do you feel that you are an addict? ☐ Yes ☐ No

Are you in need of any other drug/alcohol support? ☐ Yes ☐ No

How has substance use impacted your daily functioning (relationships, work, household responsibilities, health)?

_____

What do you do to keep from using (If attends AA/NA meetings how often)?

_____

How much time do you spend on these activities? _____

NOTE:

The use of substances by family members is recorded in domain #5, as it relates to the family's ability to operate as a functional unit

Domain 4 Medical/Physical _____ **CAR Score**

SEE CLIENT HEALTH ASSESSMENT (Also includes medication list) Impact of condition.

Description of current condition:

Include how the medical condition limits the member's day-to-day function for score of 20 and above

Domain 5 Residing Family _____ **CAR Score**

Resides with: ☐ Biological ☐ Adoptive ☐ Foster ☐ Alone
☐ Other _____

Difficulty with: ☐ Parenting ☐ Conflict ☐ Sibling ☐ Marital
☐ Communication ☐ Abuse/Violence ☐ Parent/Child

In the past month, has the client:	**Never**	**Occasionally**	**Often**	**Very Often**	**N/A**
had conflicts with parents?	☐	☐	☐	☐	☐
witnessed family conflict?	☐	☐	☐	☐	☐
verbally and/or physically fought with others?	☐	☐	☐	☐	☐
called others stupid/dumb?	☐	☐	☐	☐	☐
yelled and screamed?	☐	☐	☐	☐	☐
gotten along well with siblings?	☐	☐	☐	☐	☐
had marital conflict in the home?	☐	☐	☐	☐	☐
had someone absent from home?	☐	☐	☐	☐	☐
ran away from home?	☐	☐	☐	☐	☐

NOTES:

For adults, note and score current, ACTIVE family problems only. For children report and score the behavior of the current family as it affects the child

Domain 6 Interpersonal _____ **CAR Score**

Problem areas: ☐ Peers/Friends ☐ Make/Keep Friends ☐ Conflict
☐ Social interactions ☐ Withdrawal

Does the client:

have close friends? ☐ Yes ☐ No How many: _____ How long: _____

If yes, does client find current friendships satisfying? ☐ Yes ☐ No

Explain: _____

If no, does client want close friends? ☐ Yes ☐ No

What are some things that might be interfering with client developing close friendships?

Does the client:	**Never**	**Occasionally**	**Often**	**Very Often**	**N/A**
make friends easily?	☐	☐	☐	☐	☐
keep friends?	☐	☐	☐	☐	☐
gets along well with friends?	☐	☐	☐	☐	☐
like to be the life of the party?	☐	☐	☐	☐	☐
destroy toys/property/or other items?	☐	☐	☐	☐	☐
withdraw from a group?	☐	☐	☐	☐	☐

NOTES:

Relationships with family members are reported in domain # 5

Domain 7 Role Performance _____ CAR Score

Problem areas: ☐ Employment/Volunteer ☐ School/Daycare ☐ Home Management
☐ Other _____

For more data, see EMPLOYMENT and EDUCATION sections of the intake.

Does the client:	**Never**	**Occasionally**	**Often**	**Very Often**	**N/A**
like school?	☐	☐	☐	☐	☐
make good grades?	☐	☐	☐	☐	☐
complete homework or projects and turn in on time?	☐	☐	☐	☐	☐
stay organized?	☐	☐	☐	☐	☐
get along with teachers?	☐	☐	☐	☐	☐
get in trouble at school? **(Explain below)***	☐	☐	☐	☐	☐
had detention in the last month?	☐	☐	☐	☐	☐
been suspended or expelled in last month? **(Explain below)***	☐	☐	☐	☐	☐
completes chores/responsibilities within the home?	☐	☐	☐	☐	☐

The following questions are for adult clients or those responsible for their own care.

Is the client currently responsible for managing the home? ☐ Yes ☐ No If yes, answer the following:
Paid bills on time during the past month? ☐ Yes ☐ No
How late? _____ Consequences? _____
Able to keep house clean? ☐ Yes ☐ No Explain below how dirty, frequency, and obstacles to keeping house clean?*
Are there children living in the home? ☐ Yes ☐ No

If yes, answer the following regarding the client:	**Never**	**Occasionally**	**Often**	**Very Often**	**N/A**
prepares and serves nutritious meals?	☐	☐	☐	☐	☐
maintains a safe and sanitary living environment?	☐	☐	☐	☐	☐
meets their basic needs? (food, clothing, shelter, etc.)	☐	☐	☐	☐	☐

*NOTES:

Identify and assess only the member's primary role. Family role would be described in domain 5

Domain 8 Social Legal CAR Score

Problem areas: ☐ Ability to follow rules/laws ☐ Authority issues ☐ Legal issues
☐ Aggression ☐ Abides by ethics/moral values ☐ Probation/Parole ☐ Antisocial behaviors

In the past month, has the client:	**Never**	**Occasionally**	**Often**	**Very Often**	**N/A**
been perceived as an honest person?	☐	☐	☐	☐	☐
broken the law or been accused of breaking the law?	☐	☐	☐	☐	☐
broken the rules or been accused of breaking the rules?	☐	☐	☐	☐	☐

hurt anyone? (family, friend, stranger, animal, etc.)	☐	☐	☐	☐	☐
been thought to be aggressive or dangerous?	☐	☐	☐	☐	☐
lied to get out of trouble?	☐	☐	☐	☐	☐
stolen to get what they wanted?	☐	☐	☐	☐	☐
ran from police or authority?	☐	☐	☐	☐	☐
had close family member in jail or on parole?	☐	☐	☐	☐	☐

NOTES:

Since danger to others is a clear component of scores of 30 and over, a clear statement as to the member's danger to others must be included in the request

Domain 9 Self-Care/Basic Needs CAR Score

Problem areas: ☐ Hygiene ☐ Food ☐ Clothing
☐ Shelter ☐ Transportation ☐ Medical/Dental needs

Is the client 18 or older? If so, please answer the following:

In the past month, has the client:	**Yes**	**No**	**Explain difficulties:**
maintained adequate housing for self and children if any?	☐	☐	
purchased and prepared adequate food?	☐	☐	
been able to meet dietary requirements to promote health?	☐	☐	
purchased and maintained clothing/laundry?	☐	☐	
earned money?	☐	☐	
arranged transportation without difficulty?	☐	☐	
taken medication as prescribed?	☐	☐	
been able to maintain proper hygiene?	☐	☐	

NOTES:

For children under the age of 18, questions should be asked based on the developmental appropriateness for the age group of the child being assessed. When rating a child in this domain, rate on child's functioning only, without regard to adequacy of parent's provisions for basic needs. The developmental level of the child must also be considered

Domain 10 Communication

☐ Non-verbal ☐ Uses Mechanical device ☐ Signs ☐ Speech impaired ☐ Fluency
☐ Hearing impaired ☐ Uses interpreter ☐ ESL ☐ Has speech therapist ☐ No notable concerns

NOTES:

Mental Status Exam

Mental status and Level of Functioning information, including questions regarding: (I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.; (II) Affective process, such as mood, affect, manner and attitude, etc.; (III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory,

Physical Presentation:	
Appearance	☐ Neat ☐ Casual ☐ Disheveled ☐ Poor Hygiene ☐ Other:
Age:	☐ Looks Age ☐ Looks Younger ☐ Looks Older ☐ Other:
Motor Activity	☐ Normal ☐ Restless ☐ Tics ☐ Slowed ☐ Other:
Attention/Alertness	☐ Attentive ☐ Distractible ☐ Hypervigilent ☐ Other:
Speech	☐ Normal ☐ Pressured ☐ Loud ☐ Slow ☐ Other:
Eye Contact	☐ Normal ☐ Intense ☐ Avoidant ☐ Other:
Comments:	

Affective Process	
Mood (ask client)	☐ Normal ☐ Elevated ☐ Depressed ☐ Angry ☐ Irritable ☐ Anxious ☐ Other:
Affect (observed)	☐ Congruent to mood ☐ Depressed ☐ Sad ☐ Happy ☐ Euphoric ☐ Normal Range ☐ Irritable ☐ Anxious ☐ Flat ☐ Fearful ☐ Angry ☐ Labile ☐ Other:
Manner/ Attitude	☐ Cooperative ☐ Uncooperative ☐ Friendly ☐ Guarded ☐ Angry ☐ Suspicious ☐ Evasive ☐ Other:
Comments:	

Cognitive Process	
Orientation	☐ Time ☐ Place ☐ Person ☐ Situation ☐ Other:

Sample questions: What's your full name?/Who am I?; Where are we?;Why are we here today?; What is today's date?/approximate time of day?

Intellectual Ability	***Estimated IQ***: ☐ Above Average ☐ Average ☐ Below Average		
Concentration:	☐ Normal ☐ Brief	Serials: ☐ 7 ☐ 3 or ☐ DLROW	Digit Span: ☐ < 5 ☐ ≥ 5
Memory Impairment	☐ None ☐ Short-term ☐ Long-term ☐ Other:		
Thought Processes	☐ Coherent ☐ Incoherent ☐ Logical ☐ Illogical ☐ Goal –directed ☐ Circumstantial ☐ Tangential (diverges suddenly from a train of thought) ☐ Perseveration (pathological repetition of sentence or word) ☐ Neologism (use of new expressions, phrases, words) ☐ Loose Associations ☐ Flight of Ideas ☐ Word Salad ☐ Confabulation ☐ Blocking (sudden cessation of flow of thinking & speech related to strong emotions) ☐ Other:		
Thought Content	☐ Unremarkable ☐ Depressive cognition (guilt, worthlessness, hopelessness) ☐ Obsessions (persistent, unwanted, recurring thought) ☐ Ruminations (compulsively focused attention on the symptoms of one's distress) ☐ Delusions (false belief kept despite no supportive evidence) ☐ Phobias ☐ Magical Ideation ☐ Grandiosity ☐ Paranoia		
Suicidal Ideation	☐ None ☐ Yes ☐ Plan ☐ Intent to enact plan ☐ Means		
Homicidal Ideation	☐ None ☐ Yes ☐ Plan ☐ Intent to enact plan ☐ Means		
Hallucinations	☐ None ☐ Auditory ☐ Visual ☐ Olfactory ☐ Gustatory		
Judgment	☐ Good ☐ Fair ☐ Poor (capacity to make sound, reasoned and responsible decisions)		
Insight	☐ Good ☐ Fair ☐ Poor (person's understanding of his or her mental illness)		
Impulse Control	☐ Good ☐ Fair ☐ Poor (acts without thinking)		
Comments:			

STRENGTHS NEEDS ABILITIES PREFERENCES

Identification of the member's strengths, needs, abilities and preferences

Everyone has strengths like patience, education, faith, a good home or other things that they can use to help them reach their goals. Some of my (the client's) strengths are:

No one's life is perfect and we might have needs that make our lives harder or keep us from reaching our goals. I (the client) need(s):

We all have abilities or special skills or talents like writing, arts, sports or hobbies that we are good at doing. These can make our lives better. Some of my (the client's) talents or abilities are:

Having choices or preferences makes changing or reaching goals a little easier. Choices could include things like when or where I have my appointments, if I want to have BHR services, if my providers are male or female. My choices or preferences are: ☐ IT ☐ FT ☐ GT ☐ IR ☐GR ☐ CM

☐ Other:_____

MISCELLANEOUS INFORMATION

Please list three (3) wishes:

1.
2. _____
3. _____

_____

What do you want accomplished through treatment?

INTERPRETIVE SUMMARY/CLINICAL IMPRESSION

LBHP's interpretation of findings and diagnosis

DIAGNOSIS (IV) Full Five Axes DSM diagnosis

Axis I: _____

Axis II: _____

Axis III: Medical issues:_____

Axis IV:

Primary support group	Placement	Health Care
Social Relationships	Education	Legal
Living Situation	Health	Economic
Occupational	Other _____	

Axis V GAF Current _____ Axis V GAF High _____ Principle Axis _____

Additional Information:

Discharge Plan:

The client will be discharged when symptoms have been reduced to a level agreed upon by (check all that apply):

☐ Client ☐ Parent ☐ Family ☐ Guardian ☐ Therapist

☐ and/or family terminates services.

Counselor's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Therapeutic Life Choices, LLC.
1728 S Carson Ave
Tulsa, OK 74119

Client _____
ID# _____

Parent/Caregiver Acceptance Form- Informed Consent For In-Home Services

I, _____(PARENT/GUARDIAN), agree to accept In-Home Services from Therapeutic Life Choices, LLC (TLC) staff for _____(CLIENT).

By signing this agreement, I understand that:

•An in-home/community/school counselor will typically be coming weekly. Although appointments are usually made once per week, some sessions may be more or less frequent depending on the needs of the family/child/client. Appointments will ordinarily be 60 / 90/ 120 minutes in duration and possibly longer in crisis situations. If a cancellation is required, we ask that you give us 24 hours' notice. Additionally, your MHP/BHRS/CM will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional (MHP) covering their practice.

• I will/have received copies of the mission statement, confidentiality limitations, grievance procedure, emergency procedures and other relevant documents.

• I will be an active part of the treatment process, and am thereby expected to work cooperatively with the assigned MHP/BHRS/CM, and I will keep them updated of phone number/address changes. I will also be expected to participate in discharge planning, as the goal of TLC is for you/client to complete your goals and objectives.

•Psychotherapy (counseling) has both benefits and risks. Because the process of psychotherapy often requires discussing the unpleasant aspects of life, the client may be as risk of experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and/or helplessness. Psychotherapy has been shown to have benefits for individuals who do undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems, but a guaranteed outcome cannot be given. Psychotherapy requires a very active effort on your part in order to be most successful. This means you will have to work on skills presented in counseling sessions, outside of the sessions via homework.

• Office hours are from 9am-4pm, Mon.-Fri., or by appointment. The agency phone number is listed above. Crisis Intervention/ Emergency Services will be available to consumers. TLC staff will be available 24 hours-a-day for crisis intervention and an appropriate referral will be made to community emergency services as needed. If the MHP/BHRS/CM is not immediately available to take your telephone call, you may leave a message on their confidential voice mail, and your call will be returned as soon as possible. You may also email your MHP/BHRS/CM. Please be patient as return calls/emails may take a day or two for non-urgent matters. If, for any number of unseen reasons you do not hear back from your MHP/BHRS/CM and you feel you cannot wait for a return call, please call them again. If for any reason you feel unable to keep yourself safe, 1) Call 911 immediately, 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call.

• Per mutual agreement, the child (client) may be taken on outings with the MHP-counselor/BHRS/CM. Scheduling and goal of such outings will be predetermined by MHP/counselor and client/family. If required I authorize tlc staff to assist in medical treatment in a medical emergency and this includes transportation to a hospital, physician offices and/or treatment by medical personnel.

•If I am unhappy with what is happening in treatment, I am free to talk with the MHP/BHRS/CM and/or the Grievance Coordinator so my concerns may be addressed and handled with care and respect. I may also request to be referred to another therapist and am free to end therapy at any time. I also have the right to ask questions about any aspects of therapy and about the MHP/BHRS/CM's specific training and experience.

_____	_____
Client Signature if 14 or older	*Date*
_____	_____
Parent/Legal Guardian Signature	*Date*
_____	_____
Treatment Advocate Signature	*Date*
_____	_____
MHP/Counselors Signature	*Date*

File Copy

Client ____________________
ID# ____________________

The following areas of Orientation to Therapeutic Life Choices have been reviewed and any questions and/or clarifications have been adequately addressed

1. Informed Consent
2. Mission Statement Overview & Confidentiality practices for individuals receiving services
3. Consumer Right, Treatment Advocate Information, Agency Grievance Procedures
4. Recipients Rights to Appeal & Fair Hearing

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Mission Statement

Therapeutic Life Choices, LLC. is a community-based mental health agency operating in the state of Oklahoma. Our Agency prides itself in providing quality, legitimate services to the community, schools, families, children, adolescents, teens and adults through case-specific competent intervention plans, individual and family therapy, case management and crisis intervention when required.

The agency seeks to fulfill its mission in creative partnerships with other human service programs and other helping/supportive agencies in the state of Oklahoma in the best interests of the communities/families we serve. The main goal is to provide options for safe, nurturing, family-centered treatment interventions, with a therapeutic focus.

Our goal and Mission is respect the dignity and worth of all our clients, employees and associates and to help maintain the mental stability of our communities/families with emotional disturbances in their homes and community by providing support and therapy services.

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Limits On Patient Confidentiality

Therapeutic Life Choices, LLC (TLC) is required to disclose confidential information if any of the following conditions exist within the family:

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your counselor was appointed by the courts to evaluate you.
4. Your contact with your counselor is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. The contact is one in which your counselor must file a report to a public employer or as to information required to be recorded in a public office, if such report or record is open to public inspection.
7. You are a senior citizen and your counselor believes you are the victim of physical abuse. Your counselor may disclose information if you are the victim of emotional abuse.
8. You file suit against your counselor for breach of duty.
9. You have filed a suit against anyone and have claimed mental/emotional abuse.
10. You waive your rights to privilege or give consent to limited disclosure by your counselor.
11. Your insurance company paying for services has the right to review all records.

* If you have any questions about these limitations, please discuss then with your counselor.

________________________________ ____________________
Client Signature if 14 or older *Date*

________________________________ ____________________
Parent/Legal Guardian Signature *Date*

________________________________ ____________________
Treatment Advocate Signature *Date*

________________________________ ____________________
MHP/Counselors Signature *Date*

File Copy

Client _____
ID# _____

OUTPATIENT CONSUMER RIGHTS

(c) Programs providing treatment or services without the physical custody or where consumers do not remain for round-the-clock support or care, or where the facility does not have immediate control over the setting where a consumer resides, shall support and protect the fundamental human, civil, and constitutional rights of the individual consumer. Each consumer has the right to be treated with respect and dignity and will be provided the synopsis of the Bill of Rights as listed below.

(1) Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

(2) Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation Unofficial Copy: OAC Title 450:15 24 Effective 07/01/2013

(3) No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.

(4) Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each consumer shall have the right to the following:

(A) Allow other individuals of the consumer's choice participate in the consumer's treatment and with the consumer's consent;

(B) To be free from unnecessary, inappropriate, or excessive treatment;

(C) To participate in consumer's own treatment planning;

(D) To receive treatment for co-occurring disorders if present;

(E) To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and

(F) To not be discharged for displaying symptoms of the consumer's disorder.

(5) Every consumer's record shall be treated in a confidential manner.

(6) No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.

(7) A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

(8) Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.

(9) No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

Consumers 18 and older have a right to Designate a Treatment Advocate. Consumers have the right to appeal Grievance Outcomes

Agency Grievance Procedure: If you have any concerns regarding your care with TLC please contact the office at: 918-960-1735 and ask to speak with TLC Grievance coordinator – J.M. Kirk PhD, LADC.

At any time you may call:

ODMHSAS Consumer Advocacy	1-866-699-6605	(405)-521-4256
ODMHSAS Office of Inspector General	1-877-426-4058	(405)-522-4058

I understand that upon request, I may receive a full bill of rights.

_____ _____

Client Signature if 14 or older *Date*

_____ _____

Parent/Legal Guardian Signature *Date*

_____ _____

Treatment Advocate Signature *Date*

_____ _____

MHP/Counselors Signature *Date*

File Copy

Client ______________________
ID# ______________________

Agreement to Follow Rules of Conduct

Upon my acceptance for services with Therapeutic Life Choices, LLC (TLC)),
I agree to follow the rules of conduct as follows:

- To cooperate with admission procedures this includes Intake Interview, Verification of Funding Eligibility, Intake Assessment, Treatment Planning and Program Acceptance Form.
- To wear a seat belt when riding with Therapeutic Life Choices, LLC (TLC)staff.
- In spite of Oklahoma being an open/concealed carry weapon state NO weapons of any kind will be allowed in Therapeutic Life Choices, LLC (TLC) offices, vehicles, while riding with Therapeutic Life Choices, LLC (TLC) staff members, or while staff is visiting in the home.
- No alcohol, illegal substances or smoking of any kind will be allowed while at Therapeutic Life Choices, LLC (TLC) offices, or while riding in a vehicle in which I am receiving transportation from Therapeutic Life Choices, LLC (TLC)staff members or while staff is visiting in the home.

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The Recipient's Right To Appeal And Fair Hearing

- Any decision affecting Medicaid-covered services may be appealed to the Department of Human Services.
- Individual must be notified in writing of the right to a hearing and the procedure for requesting a hearing.
- Individual has the right to have this right and procedure explained to them in a language that they understand.
- If a service is terminated or decreased, the recipient must receive written notification of the pending action within 10 days except for the following:
- Advance notice will be reduced to 5 days if the facts indicate the action is necessary because of probable fraud.
- Advance notice does not need to be sent if: 1) the recipient has stated in writing that he/ she no longer wishes to receive Medicaid services; 2) the recipient has been admitted to an institution where he or she is ineligible for services under the OK State Plan for assistance; 3) the recipient moves to another state and has been determined eligible for Medicaid in the new jurisdiction; 4) the recipient's whereabouts are unknown.

* Therapeutic Life Choices, LLC (TLC) will assist you with re-application if that is an option.*

You may appeal this decision by notifying in writing to **Oklahoma Department of Mental Health and Substance Abuse Services.** 1200 NE 13th Street, PO Box 53277, Oklahoma City, OK 73152-3277. This written request for an appeal must be filed within thirty (30) days of this notification. If you file an appeal before the effective date of this action, (date), services may continue during the appeal process. However, if this decision is upheld by the Appeals Division, you will be required to reimburse Medical Assistance Program for services provided after the (date).

________________________________	____________________
Client Signature if 14 or older	*Date*
________________________________	____________________
Parent/Legal Guardian Signature	*Date*
________________________________	____________________
Treatment Advocate Signature	*Date*
________________________________	____________________
MHP/Counselors Signature	*Date*

File Copy
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Treatment Advocate Designation Form

Client name_____

Each client or consumer of Therapeutic Life Choices (18 and older) has a right to assistance by a Treatment Advocate. A treatment advocate is a family member or other concerned individual designated by the consumer to participate in treatment and discharge planning. The treatment advocate acts in the best interest of the consumer and serves as the consumer's advocate.

I would like to request a treatment advocate. **YES NO**

I would like to name _____ as my treatment advocate. I would like my treatment advocate involved in_____

_____

_____.

My right to choose a Treatment Advocate was reviewed with me and I have listed my choice above.

_____ _____
Client Sig nature Date

I accept the role of treatment advocate for the consumer named above. I will advocate for this consumer in the areas listed above. I will respect this consumer's confidentiality and will follow the confidentiality guidelines and other applicable Policies and Procedures set forth by Therapeutic Life Choices, LLC.

_____ _____
Printed name of Advocate Phone Number

_____ _____
Signature of Advocate Date

_____ _____
TLC Staff signature Date

File Copy

Therapeutic Life Choices, LLC
1728 S Carson Ave • Tulsa, OK 74103 • Office: 918-406-3420 Fax 918-280-0310

Client _____
ID# _____

TLC Consumer Grievance Concerns / Documentation / Submission / Procedures/Outcomes/Appeals

TLC written policies and procedures for consumer grievance concerns require documentation and reporting of unusual grievances and analysis of the contributors to the grievance and reporting unusual grievances and attention to issues that would allow opportunities for program improvement.
If an out-of-the ordinary grievance occurs during work hours with a consumer/family the consumer will contact the grievance coordinator listed in the consumer admissions/intake packet.
The grievance coordinator will be asked to report the concern immediately to the Program Director and the Clinical Director. The grievance coordinator will then contact the consumer within 48 hours of the consumer contact and determine if the information can be gathered via a phone call or face-to-face. The grievance coordinator will get the following information for the consumer grievance report. The grievance report will include:

1) Facility, the name(s) of the consumer(s), staff member(s) or property involved.
2) Returning means of contact preference for the consumer
3) The time, date and physical location of the consumer concern.
4) The time and date the grievance was reported and name of the staff person within the facility to whom it was reported too.
5) A description of the grievance;
6) Resolution or action taken, date action taken, and signature of appropriate staff.
7) Notification of the consumer regarding action taken
8) Explanation of appeals process two consumer

*The local advocate will assist the consumer with anything regarding the grievance needed including:
a). filing the grievance.
b). serve as resource for consumers for questions or information dissemination about the facility, admission and discharge process, or other basic human needs while in treatment: and
c). make contact with consumers involved in or who witness incidents.

If you have any concerns regarding your care with TLC please contact the office at 918-406-3420 and asked to speak to the TLC Grievance Coordinator Dr. J.M. Kirk, LADC. Grievance decisions will be completed by the Coordinator, Executive Director, and Clinical Director and written notification will be made to the client within 24 hours of the decision. The decision maker will be the Executive Director, Chris Taylor. He can be reached at 918-406-3420.

**Grievance Procedure Received: Name: _____ Date: _____

_____ _____
Client Signature if 14 or older *Date*

_____ _____
Parent/Legal Guardian Signature *Date*

_____ _____
Treatment Advocate Signature *Date*

File Copy