



QUEST CENTER  
for Integrative Health  
MH: BEHAVIORAL HEALTH REGISTRATION FORM

Registration Updated 01/01/2011

**DEMOGRAPHICS**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ AKA \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

(\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_  
Home Phone # Work Phone # Cell/Message Phone # Email address

Check the numbers we may leave a message on: [ ] Home number [ ] Work number [ ] Cell/Message number

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_ Gender \_\_\_\_\_ Ethnicity \_\_\_\_\_ Military Status \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone Number \_\_\_\_\_ Employer Address, City, State, Zip \_\_\_\_\_

Do you have a legal guardian? Yes [ ] No [ ] Parent/Guardian Name \_\_\_\_\_ Parent/Guardian Phone Number \_\_\_\_\_

Parent/Guardian Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Would you like to be on our mailing list? Yes [ ] No [ ]

**EMERGENCY CONTACT INFORMATION or NEXT OF KIN**

Name of Emergency Contact Person or Next of Kin \_\_\_\_\_ Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**MEDICAL INFORMATION**

Primary Care Physician \_\_\_\_\_ Clinic Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**EMERGENCY MEDICAL AND DENTAL INFORMATION**

Emergency Care Dentist \_\_\_\_\_ Clinic Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Emergency Care Physician \_\_\_\_\_ Clinic Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**RED ALERTS**

Medical Allergies \_\_\_\_\_ Medical Problems \_\_\_\_\_ Hospital of Choice \_\_\_\_\_

**BILLING INFORMATION Who do we bill:**

- [ ] Client/Patient (stop here - sign below)
- [ ] Private Insurance\* (fill out insurance portion and sign below)
- [ ] OHP\* (fill out insurance portion and sign below)
- [ ] Medicare\* (fill out insurance portion and sign below)
- [ ] Veteran's Benefits\* (fill out insurance portion and sign below)
- [ ] Ryan White (stop here - sign below)
- [ ] Client/Patient Bills Insurance (stop here - sign below)
- [ ] Other Third Party (fill out and sign below)

\* Please provide us with your insurance card in order that we make a photocopy for our records

Primary Insurance Carrier's Name \_\_\_\_\_ Policy Holder's Name (if different than clients) \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

(\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_  
Insurance Carrier's Phone Number Policy ID/Subscriber # Group # Secondary Insurance Carrier's Name, if applicable

Claim # (for Motor Vehicle Accidents only) \_\_\_\_\_ Claim's Adjuster (for Motor Vehicle Accidents only) \_\_\_\_\_ Claim's Adjuster's Phone Number \_\_\_\_\_

Attorney's Name (if applicable) \_\_\_\_\_ Attorney's Phone Number \_\_\_\_\_ Attorney's Address \_\_\_\_\_

**RYAN WHITE /HEP ENROLLMENT and ELIGIBILITY INFORMATION**

Household Gross Monthly Income: \$ \_\_\_\_\_ # in Household \_\_\_\_\_

I certify that the above information is true and accurate.

Client/Patient's Signature (or Parent/Guardian) \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Acknowledgement, Consent, Confidentiality, Office Policy and Rights and Responsibilities

I understand that **Project Quest** will use and disclose health information about me.

I understand that my health information may include information both created and received by **Project Quest**, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that **Project Quest** may use and disclose my health information in order to:

- Make decisions about, and plan for, my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for, quality, cost-effective health care.

I understand that if applicable, my health information, both created and received by **Project Quest**, may be used within the context of mandatory and necessary reporting related, but not limited to, statistics, funding or grants, that may be required by local, state and/or federal agencies.

I also understand that I have the right to receive and review a written description of how **Project Quest** will handle health information about me. This written description is known as a *Notice of Privacy Practices* and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of **Project Quest**, and my rights regarding my health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time, and that I am entitled to receive a copy of any revised *Notice of Privacy Practices*. I also understand that a copy of the most current version of **Project Quest's** *Notice of Privacy Practices* in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some, or all of my health information not be used or disclosed in the manner described in the *Notice of Privacy Practices*, and I understand that **Project Quest** is not required, by law, to agree to such requests.

**Client Confidentiality Agreement:** As a client of Project Quest, you may learn of confidential information relating to both potential and existing clients within an alcohol and drug recovery environment, as well as any other services that Project Quest provides inside and outside a clinical setting. You may be exposed to protected health information, including, but not limited to, general and specific client-related information, personal information, financial information that is related to employment or disability, or other information not generally disclosed by Project Quest to the public. This information may be in written or verbal form, electronically generated or created by any other means of transmission. Unauthorized access, discussion, review, disclosure, transmission, alteration, dissemination, or destruction of such information, except as required to fulfill the responsibility of Project Quest, is absolutely prohibited.

**Purpose:** To ensure that personal and protected health information is safeguarded so that individuals are not afraid to seek health care or other services that Project Quest may provide. To also ensure that personal health information is protected during its collection, use, disclosure, storage and destruction within Project Quest.

**Definitions:** Protected Health information is defined as all information recorded or exchanged that relates to an individual's health, or health care history, including genetic information, about the individual, or the individual's family.

Protected health Information is described as the following:

Patient Name	E-Mail Addresses	Vehicle or Other Device Serial Numbers
Patient Address	Social Security Number	Web URL's
City & County of Residence	Medical Record Number	Internet Protocol Addresses (IP)
Zip Code	Health Plan Beneficiary Number	Finger or Voice Prints
Names of Relatives & Employers	Account Numbers	Photographic Images
Birth Date	Telephone & Fax Numbers	

Protected Health Information also includes conduct or behavior that may be a result of illness or the effect of treatment.

**Policies:** In accordance with this policy, you agree to protect and not to disclose confidential information. You agree that you have the responsibility to respect the confidentiality of the clients of Project Quest.

**Grievance Policy:** If you have a complaint or grievance, please ask to speak with the QA/QI Committee Chair Person or fill out a grievance form. The forms are located in the informational rack in the lobby, across from the restrooms. You may have a representative of your choice help you fill out the grievance form or request a Quest Center staff person to help you fill out the form. You will receive a formal response within 30 calendar days (for non-urgent issues) from the day you speak with the QA/QI Committee Chair Person or return your grievance form to Quest Center and 3 calendar days for urgent/emergent issues. If you feel your complaint is urgent please indicate this when speaking with the QA/QI Committee Chair Person or indicate it on your grievance form. You also have the right to request a hearing as stated in the rights and responsibilities listed below.

**Consent to treatment:** I hereby voluntarily consent to the provision of medical and/or mental health care services at Project Quest Integrative Health Center as may be deemed medically advisable or necessary. I request that my health care practitioner(s) provide any care they think is necessary and consistent with my instructions except \_\_\_\_\_. I understand this care may include tests, examinations, medical and minor surgical treatment and related anesthesia. I acknowledge that the health care practitioners treating me may be

independent contractors or employees of Project Quest. If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by my health care practitioner(s) during each visit. I understand that if special procedures or operations are needed, my health care provider will discuss this with me and my additional consent will be required. I understand that I have the right to participate in the development and periodic review of my individualized treatment plan, be informed of my diagnosis (after the assessment has been completed) and the purpose of any prescribed medication and potential side effects of the medication. I understand that some of Project Quest practitioners are involved in teaching and I consent to having student practitioners and others involved with my care. I understand that I may revoke my consent at any time, but action taken by Project Quest before that time will remain covered by this authorization.

**Medical records policy:** Your medical records are the property of Project Quest. Information may be shared among practitioners of Project Quest for purposes such as treatment or other health care operations, including quality assurance activities, utilization review activities, and peer review. If you are referred to practitioners outside of Project Quest, any necessary information may be shared with them as well, in order to facilitate and coordinate your health care. In addition, we will provide necessary documentation to your insurance company for purposes of claims review and payment. All of this is done pursuant to your consent, as indicated by your signature at the bottom of this page.

**Consent to release information:** I consent to allow Project Quest to release my confidential health information for purposes of treatment, payment and health care operations. In particular, I consent to the release of my confidential health information for the following purposes: (1) for the diagnosis, treatment and/or evaluation of any health condition, including the sharing of information by and among Project Quest practitioners and outside health care practitioners; (2) as required by my insurance carrier for the purposes of reviewing and paying claims for services rendered by Project Quest practitioners; (3) for the performance of quality assurance, utilization review, and/or peer review activities; (4) for the determination of eligibility under my insurance health plan; (5) as required by any governmental agency or any entity responsible for processing or paying my claims for medical benefits, including Worker's Compensation claims; and (6) as otherwise authorized by law. I understand that I may revoke my consent at any time, but action taken by Project Quest before that time will remain covered by this consent. I understand that information from my medical record may be reviewed or released while I am receiving care or after discharge and this information will be held confidential except as allowed by law.

#### **Office Policy:**

**General:** You are free to receive health care from any practitioners of your choice, either within or outside of Project Quest. As a patient of Project Quest, you will have the opportunity and choice to see one of our medical and mental health practitioners, according to your identified health care needs. Practitioners at Project Quest are either independent contractors with, or employees of, Project Quest. Each practitioner is solely responsible for any health care decisions and recommendations he or she may make. While all practitioners will be practicing within the scope of their individual licenses, some of the treatments they discuss with you may be considered experimental, new, or "alternative". You are solely responsible for deciding which treatment you will choose, although your practitioner(s) will assist you in reaching an informed decision. No guarantee is made as to the results that may be obtained from their examination or treatment.

**After hours care:** We recommend that you maintain a relationship with a primary care physician who can provide emergency care, since at this time, **Project Quest does not offer emergency services, or after hours care.** If an emergency arises, contact your primary care provider, call 911 or go to the nearest emergency room. If you have an urgent mental health issue, call the mental health crisis line at 503-988-4888, or call our on-call mental health therapist line at 503- 702-8409.

**Cancellation policy:** We request 48 hours notice if you must cancel your appointment; appointments scheduled for Monday must be cancelled by Friday. Last minute cancellations may incur a missed visit fee of \$35. This fee does not apply to clients receiving services under Ryan White, Medicare clients, and Medicaid clients (in accordance with OAR 309-016-0105). Patients who miss two or more appointments will need to be seen on a same day only basis – i.e., we will not reserve an appointment for you, but you may call in the morning to see if any appointments are available for that day.

**Insurance billing and payment for services:** If you choose to have us bill insurance for you, we require that your deductible be met and that your co-payment or your portion of the bill be paid at the time of each visit. In the event that your insurance carrier determines that the services provided to you are not a covered benefit under your health care plan, you are responsible for the total amount due, as well as any applicable co-payment or deductible. A \$20 fee will be charged for any returned checks. You may choose to purchase any recommended nutritional supplements, health care products, books, etc. at this location or elsewhere. In most cases, non-prescription pharmacy items are not covered by insurance and you will need to provide payment for these items at the time you receive them. **You are responsible for updating us on any changes** in your insurance carrier or policy status, as well as any changes in your address, telephone number, name, or other relevant information. Your signature below authorizes payment to be made directly to Project Quest or its practitioners of all insurance or health plan benefits.

**Medicare:** At this time, most Project Quest practitioners are not authorized participating providers in the Medicare program and, therefore are unable to bill for or accept direct payment from Medicare. If while you are a patient at Project Quest, you become eligible for Medicare, you must immediately inform the receptionist of this.

**Workers Compensation:** At this time, Project Quest practitioners are not accepting any worker's compensation claims. You must notify your practitioner and Project Quest receptionist if your visit is due to an injury covered by Worker's Compensation.

**Services:** As a client you have the right to; be given information concerning potential risks and benefits of service procedures including side effects of any prescribed medication, the right to help in developing and approving your treatment plan as well as periodic reviews of your individualized treatment plan. You have the right to be informed of your diagnosis (upon completion of the mental health assessment).

**Past due accounts:** For accounts over 30 days past due, a monthly rebilling fee of \$15 on the unpaid amount will be charged. You will be charged any necessary collection cost, including attorney's fees or collection agency fees, both at trial and on appeal, and whether or not a lawsuit is filed.

## MENTAL HEALTH: Client Rights & Responsibilities

### YOU HAVE THE RIGHT TO:

- Be treated with respect, courtesy, and dignity in a humane service environment with protection from harm and that affords reasonable privacy in a setting under conditions that are least restrictive to liberty, least intrusive to the client and which provides the greatest degree of independence
- Be given information about mental health needs and treatment and have this information explained in a manner that is understandable to the member
- Participate in choosing a mental health provider
- Refer oneself directly to a provider for covered services without first having to gain approval from another provider
- Have access to covered services and obtain covered preventive services, which at least equals access available to other persons served by provider
- Participate in planning and decisions about treatment including information about his/her condition and covered/non-covered services to allow an informed decision about proposed treatment(s)
- Have a friend, family member, or advocate present during appointments and at other times as needed
- Talk to providers and expect that what is said will be kept confidential
- Have a clinical record maintained which documents conditions, services received, and referrals made
- Have access to one's own clinical record, unless restricted by statute and to request that the record be amended or corrected as specified in 45 CFR part 164
- Have a copy of his/her clinical record transferred to another provider
- Get mental health care without a long delay
- Receive information about rights, responsibilities, benefits available, how to access services covered by the Oregon Health Plan and what to do in an emergency
- Provide consent to treatment or refuse care and talk with provider about what this might mean
- Receive necessary and reasonable services to diagnose the presenting condition
- A second opinion, at no cost from a qualified healthcare professional within the network or outside the network if a qualified healthcare professional is not available
- Know how to make a complaint or file a grievance about your provider and receive a timely response
- Request a Department of Human Resources hearing, including an Expedited Hearing if they feel the problem is urgent or emergent and cannot wait for the normal hearing process
- Request Continuation of Benefits until a decision in a hearing is rendered; however, the member may be required to repay any benefits continued if the issue is resolved in the favor of the provider
- Receive mental health care regardless of age, race, religion, national origin, gender, or sexual orientation
- Receive emergency mental health care 24 hours a day, 7 days a week
- Change primary mental health provider
- Have someone to help talk to providers if language interpretation is needed, or are hearing or speech impaired at no cost to the consumer. An interpreter can be available during appointments.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation and have the freedom from abuse as defined in ORS 430.735 by an employee of Project Quest
- Receive in writing, a 30-day notice in a readable format, when a service or benefit is cancelled reduced or changed. This is called a Notice of Action
- Appeal when a service has been denied if they are the person consenting to treatment
- Receive no services without written consent
- Have adverse consequences of a service refusal explained verbally to me and my guardian if applicable
- Not be terminated without being notified of available resources for continued services
- Access and communicate privately with a rights protection program or advocate
- To informed consent to fee-for-service
- Receive materials in an alternate format appropriate to my needs
- Receive gender appropriate services and/or culturally appropriate services
- Receive notification of mandatory abuse reporting if there is reasonable cause to believe that I have suffered abuse
- Receive services in compliance with the Americans with Disabilities Act
- Receive a notice of an appointment cancellation in a timely manner
- Execute a statement of wishes for treatment, including the right to accept or refuse treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990-Patient Self-Determination Act

### YOU HAVE THE RESPONSIBILITY TO:

- Choose a mental health provider
- Help provider get old mental health records or fill out new ones
- Honestly share concerns about mental health needs
- Ask questions about things that are not clear
- Help decide treatment plan and approve the plan before it starts
- Treat provider and staff with respect and courtesy
- Keep appointments and be on time. Call provider when late or can't keep the appointment.
- Bring your medical card/insurance card whenever care is needed
- Pay your monthly OHP Premium on time if so required
- Use only selected provider for mental health needs, in an emergency, services from someone else may be needed • If emergency mental health services are used when out of the area; members must let your provider and insurance know within three days
- Tell provider if there are changes to address or phone number

**These Member Rights and Responsibilities are in accordance with OAR 410-141-0320**

By signing below, I agree that I have read and fully understand the terms and conditions outlined herein regarding the office policy and use and/or disclosure of my health information. I understand and accept the policies listed in this agreement. I have reviewed and understand the permitted disclosures and give my consent to use my health information as named above. I have asked questions about anything not clear to me, and I am satisfied with the answers I have received. I also certify that the information given to me is correct and I have read and consent to the terms of this policy, including payment for these services. I am the patient, or authorized as the patient's agent or representative to execute the above and accept the terms on behalf of the patient, and I assume individually all financial responsibility by signing below. I understand I may revoke this consent at any time.

**Notice of Privacy Practices & Additional Rights:**

\_\_\_\_\_ I acknowledge that I have received a written copy of Project Quest's Notice of Privacy Practices.  
*(Patient's Initials)*

\_\_\_\_\_ I acknowledge that I have read and received a copy of Quest Center's Client Rights and Responsibilities.  
*(Patient's Initials)*

\_\_\_\_\_ I acknowledge that I have read and received a copy of Quest Center's an overview of program services that are available and related fees when applicable.  
*(Patient's Initials)*

\_\_\_\_\_  
*Client's Printed Name*

\_\_\_\_\_  
*Client's Signature*

\_\_\_\_\_/\_\_\_\_\_  
*Date Signed*

## CHEMICAL DEPENDENCY INITIAL INTAKE

Client Name: \_\_\_\_\_

The following information is confidential and will not be used to deny services, so please be honest. Please use the chart below to describe your drug use. Complete the “yes or no” boxes for each drug listed. If “yes” is answered, please answer the remaining questions on the line listed for that drug. This is for non-prescription drugs.

Have you ever used?	Yes	No	Last Used	Method	Frequency
Alcohol					
Do you think you have a problem with alcohol?					
If no alcohol use, how long have you been sober?					
Marijuana/Hash					
Cocaine/Crack					
Crystal Meth/Amphetamines/Speed					
Heroin					
Codeine					
Barbiturates/Downers					
Tobacco					
Do you struggle with taking pain medications or anti-anxiety medications as prescribed?					
Do you struggle with or feel that you may have a gambling problem?					

# Quest Center for Integrative Health Behavioral Health Services

## MENTAL HEALTH

Quest Center's Integrative Mental Healthcare program serves adults, offering a comprehensive menu of evidence-based outpatient mental health care practices from a variety of disciplines. Our services are client centered, collaborative, and tailored specifically to meet and focus on individual needs and strengths.

Recognized for our warm and effective care, our licensed, credentialed, and experienced staff strives to develop a community which nurtures support, wellness, and self-empowerment.

The Integrative Mental Healthcare services are used widely throughout all of Quest's programs, and include:

- Assessments \$235
- Individual Therapy \$152
- Family/Couples Therapy \$180
- Group Therapy \$50 - \$300
- Medication Evaluation \$235
- Medication Management \$80
- Individual Therapy with Medication Management \$144

## SUBSTANCE ABUSE TREATMENT

Quest Center's Finding and Sustaining Recovery is based on the belief that all people who *want to* can achieve a clean and sober life. Quest Center's supportive, nurturing, accepting community is key to aiding in people's recovery.

FSR is an abstinence based alcohol and drug program that uses evidence-based approaches to develop and maintain clean and healthy lifestyles.

Each client undergoes a screening and assessment to determine what level of care is needed. Individual treatment plans are developed with each client.

This client centered approach helps people to develop and support a culture and community of recovery through the following services:

- Eligibility Screening \$165
- Assessments \$330
- Individual Therapy \$102 — 227
- Group Therapy \$50 - \$300
- Case Management \$57 — 228
- Crisis Intervention \$77 - \$308
- Group Acupuncture \$40 - \$74

If you are covered by the Oregon Health Plan and the above services are not covered by the Oregon Health Plan for any reason you have the right to self-pay for these services. Applicable paperwork called an **Advance Beneficiary Notice (ABN form)** must be completed before services are provided. If interested on how to proceed with self-pay options please contact our Business Office at 503-238-5203 x326. Quest Center requires that payment is made upon checking in for your appointment. Thank you.

Client Name: \_\_\_\_\_

**MENTAL HEALTH**

Are you having problems with any of the following? (please circle all that apply)

- |                            |                           |                              |
|----------------------------|---------------------------|------------------------------|
| <i>Anger</i>               | <i>Impulse Control</i>    | <i>Relationship problems</i> |
| <i>Anxiety</i>             | <i>Indecisiveness</i>     | <i>Restlessness</i>          |
| <i>Appetite, excessive</i> | <i>Lack of motivation</i> | <i>Sleeplessness</i>         |
| <i>Appetite, low</i>       | <i>Low energy</i>         | <i>Stress</i>                |
| <i>Concentrating</i>       | <i>Memory loss</i>        | <i>Suicidal thoughts</i>     |
| <i>Crying Frequently</i>   | <i>Mood Swings</i>        | <i>Thought control</i>       |
| <i>Depressed moods</i>     | <i>Nervousness</i>        | <i>Too much energy</i>       |
| <i>Domestic violence</i>   | <i>Nightmares</i>         | <i>Too much guilt</i>        |
| <i>Extreme tiredness</i>   | <i>Oversleeping</i>       | <i>Weight control</i>        |
| <i>Feeling Worthless</i>   | <i>Panic attack</i>       | <i>Worrying too much</i>     |
| <i>Hopelessness</i>        | <i>Racing thoughts</i>    | <i>Hearing voices</i>        |

What precipitated these feelings? \_\_\_\_\_

What was happening around that time? \_\_\_\_\_

Are there any specific behaviors, actions or habits that you would like to change? Please describe. \_\_\_\_\_

What feelings would you like to experience more often? \_\_\_\_\_

What feelings would you like to experience less often? \_\_\_\_\_

Describe your image of a completely "safe place". \_\_\_\_\_

**REVIEW OF DEVELOPMENTAL PERIOD**

It is important to know about you past as well as your present life situation. The following questions are related to your childhood and early adult life. Please check "yes" or "no".

- |                              |                             |   |                              |                             |                    |
|------------------------------|-----------------------------|---|------------------------------|-----------------------------|--------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Frequent moves (of residence)           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexual Abuse       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Serious physical illness in your family | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems in School |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Death of a family member                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Running Away       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Abuse by Parents or Others              |                              |                             |                    |

Client Name: \_\_\_\_\_

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**RECENT STRESSES**

Changes in your life often produce emotional stress. During the past year have you experienced any of the following changes?

- |                              |                             |   |                              |                             |                                |
|------------------------------|-----------------------------|---|------------------------------|-----------------------------|--------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Death or illnesses of family or friends | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Family Problems                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Work problems or work changes           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Legal Problems                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Personal Health Problems                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexual Problems                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Change in Living Situation              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eating Disorder                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Alcohol or Drug Problems                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gambling Problems              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Financial Problems                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other Significant Life Changes |

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**MEDICAL INFORMATION**

Are you taking any medications prescribed by a doctor or over the counter drugs?  Yes  No To the best of your knowledge, please list your medications and dosages.

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Please list any significant health conditions: \_\_\_\_\_

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Do you have any medical concerns?  Yes  No If yes, what are they? \_\_\_\_\_

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**FAMILY HISTORY**

Do you have a supportive network of family and friends?  Yes  No

Are you in contact with your family?  Yes  No  Supportive  Conflicts  Other \_\_\_\_\_

Are you a survivor of abuse?  Yes  No

Did your mother or father abuse alcohol or drugs?  Yes  No  Unsure

Do you have any children?  Yes  No If yes, please state their name, age and gender starting with the oldest.

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Who is parenting them now?  Self  Other parent  Family  Other \_\_\_\_\_

Client Name: \_\_\_\_\_

**INCOME**

Do you receive an income from any of the following?  G.A.  SSI  SSD  Work  Other: \_\_\_\_\_

How much do you receive per month? \_\_\_\_\_

If you are employed, do you work  Part-Time  Full-Time  Irregular

Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_ Type of work done in the past \_\_\_\_\_

**LEGAL ISSUES**

Have you ever been arrested?  Yes  No If yes, please give details. \_\_\_\_\_

Have you been convicted in a court of law?  Yes  No If yes, please give details. \_\_\_\_\_

Do you have a parole or probation officer?  Yes  No

Name of P.O. \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

**OTHER INFORMATION**

How many years of education do you have? \_\_\_\_\_

Religion as a child. \_\_\_\_\_ Religion as an adult \_\_\_\_\_

Do you have any religious or cultural needs? \_\_\_\_\_

What do you wish to accomplish as a result of participating in Project Quest groups and activities? \_\_\_\_\_

Why are you here? ( May want to list problems and goals). \_\_\_\_\_

Who referred you? \_\_\_\_\_ Why? \_\_\_\_\_

Is there anything else you would like to tell us? \_\_\_\_\_

Client Printed Name

Client Signature

Date

