Brighter Dimensions LLC
Children and Family Counseling Center

Consumer Name: _____

Identifier: _____

CONSENT FOR TREATMENT

Application is hereby made by the undersigned for voluntary admission to the services of Brighter Dimensions, LLC, as a voluntary consumer under the provision of OS 43A. Section 9-101

I certify that I am eighteen (18) years of age or over. Voluntary admission may be made for any person eighteen (18) years of age or over on his/her own signature. Any person at least sixteen (16) years of age may be admitted with the consent of such person and the consent of the person's parent or guardian, OS 43A. 5-304.

I have read, or had read to me, the following information about my rights.

All persons receiving services from this facility shall retain the rights, benefits, and privileges guaranteed by the laws and constitutions of the State of Oklahoma and the United States of America, except those specifically lost through due process of law. OS 43A, Section 1-103(h).

All persons shall have the rights guaranteed by OK Dept of Mental Health and Substance Abuse Consumer's Bill of Rights, unless an exception is specially authorized to these standards or an order of a court of competent jurisdiction.

I have been given a summary or full copy of my rights as a consumer and fully understand the content of this document.

I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate services delivered.

I understand that OS 43A, Section 4-201 requires that each consumer of the agency be charged for care and treatment provided. An individual will not be refused needed treatment because of inability to pay, OS 43A, Section 4-202.

Date of Birth _____ Social Security # _____ Male ___ Female ___

Ethnicity Hispanic/Latino ___

Race: White ___ Black/African American ___ American Indian ___ Asian ___ Native Hawaiian/Pacific Island ___

Address: _____ County: _____

City, State, Zip: _____ Phone Number: _____

Referred by: _____

Guardian Name: _____ Relationship to Consumer: _____

Guardian Phone Number: _____

Name and credentials of clinician(s) that will be providing services: _____

I, _____, wish to transfer mental health services from all other providers to Brighter Dimensions, LLC.

Signature of Consumer: _____ Date: _____

Signature and Printed Name of Parent or Guardian: _____ Date: _____

Signature of Witness (Clinician): _____ Date: _____

Revised 9.28.2016

THIS PAGE IS TO BE RETAINED BY BRIGHTER DIMENSIONS AND PLACED IN THE CONSUMER RECORD.

CONSENT FOR FOLLOW-UP

Upon termination of services from this program, we may want to contact you regarding your status and for you to answer some questions concerning satisfaction regarding services received. This purpose of this information is to assure the continuity of care and provide Brighter Dimensions with pertinent statistical information. You may revoke permission for follow-up at any time by giving this agency a written notice or by refusing to participate in any follow-up questionnaire. Follow-up will be the same with all persons served regardless of referral status.

CONSENT: I hereby (circle one) GIVE DO NOT GIVE

permission to Brighter Dimensions to contact me by telephone or letter for follow-up and to answer questions concerning my satisfaction with services and my current status.

ACKNOWLEDGEMENT OF RECEIPT OF CONSUMER HANDBOOK

Do you or significant other wish to receive: (Check if Yes)

HIV/AIDS/STD Education

HIV/AIDS/STD Testing

HIV/AIDS/STD Counseling

Please initial to verify receipt of the following: _____ Code of Ethics _____ Consumer Bill of Rights _____ Consumer Expectations

____ Confidentiality of Consumer Rights _____ Complaint/Grievance Procedure _____ Orientation Information

_____HIPAA Notice ____HIV/AIDS/STD Education ____HIV/AIDS/STD Referral Information

Do you want to receive the full Bill of Rights	Yes	No
Is consumer under the age of 21	Yes	No
If Yes, does Brighter Dimensions have permission to see him/her at School?	Yes	No
Does Brighter Dimensions have permission to check out or pick up client from school if needed?	Yes	No
Does Brighter Dimensions have permission to transport child for the purpose of receiving services?	Yes	No

In the event that a medical emergency occurs while my child is with a Brighter Dimensions representative, and is not possible for me to consent to medical treatment, I hereby authorize any Brighter Dimensions representative to seek appropriate medical treatment for my child. I also give permission for attending personnel to execute on my behalf, permission forms or other medical documents, and to act on my behalf if I am unable to do so.

The undersigned has read the above consent and release and acknowledges that this document has been signed voluntarily.

Brighter Dimensions, LLC is a Medicaid fee for service provider and all fees are covered by Medicaid if consumer is eligible.

On occasion it may be necessary for a mental health provider to reassess and/or update clinical information regarding your plan of treatment. Your signature below acknowledges your permission for this MHP to see you.

The undersigned acknowledges that he/she has received a copy of the Consumer Handbook which has been communicated to him/her in a meaningful way. Furthermore, he/she has read and understands this document in its entirely and further certifies that he/she agrees to the terms and provisions stated herein.

Consumer Name:_____Medicaid # _____

Signature of Consumer:_____Date: _____

Signature of Parent or Guardian:_____Date: _____

Witness:_____Date:_____

TREATMENT PLAN DEVELOPMENT SIGNATURE PAGE

I/We (client guardian) have actively participated in the development of this service plan and understand the treatment goals and objectives. I have the following comments / response:

_____

_____

_____

I / We (____Agree) (____Disagree) with this service plan.

_____ _____

Client Signature, 14 or older Date Parent/Guardian Signature Date

Witness:_____Date_____ Relationship to client:_____

If unable to sign, document reason:

_____

TREATMENT TEAM:

_____ _____

Responsible MHP Date Physician Date

☐ Physician signature not required

(Date must match date of Treatment Plan Development)

Brighter Dimensions LLC
Children and Family Counseling Center

Consumer Name: _____

Identifier: _____

Consumer Orientation Checklist

Transfer of Services/ Consent for Treatment Form	☐ Yes
Right to Name Treatment Advocate	☐ Yes
Consent for Release of Confidential Information	☐ Yes
Consumer Handbook and Acknowledgement of Receipt	☐ Yes
Bio-Psychosocial Assessment	☐ Yes
Has Consumer been educated about the availability of an Advance Directive	☐ Yes ☐ No
Did the Consumer utilize the Advance Directive	☐ Yes ☐ No
Is Brighter Dimensions collaborating with another agency or LBHP provider	☐ Yes ☐ No
If Yes, who?	

After your intake is completed, we will develop a treatment plan using the information you give us about your preferences and needs. Your therapist will go over this plan with you, including the discharge criteria, when it is ready to sign

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for all benefits, for services rendered and for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Signature: _____ Date: _____

Guardian: _____ Date: _____

Witness: _____ Date: _____

Brighter Dimensions LLC
Children and Family Counseling Center

Client Name: _____

Identifier: _____

Right to Name a Treatment Advocate

All adult mental health consumers being served by a licensed mental health professional have the right to designate a family member or other concerned individual as a Treatment Advocate. The choice to name an advocate is the consumer's alone. In the event an advocate is chosen, the level of involvement of the advocate is to be determined by the consumer and no limitation may be imposed on the consumer's right to communicate by phone, mail, or visitation with the established Treatment Advocate. The Treatment Advocate may participate in the treatment planning and discharge planning of the person being served to the extent consented by the consumer and permitted by law.

Would you like to name a Treatment Advocate? ☐ Yes ☐ No

Please list the name and phone number of the person you wish to choose as a Treatment Advocate:

Name: _____ Phone: _____

Please indicate the level of involvement the identified Treatment Advocate shall have:

☐ Should the advocate be present during intake?

☐ Would you like the advocate to help you with the treatment planning?

☐ Do you want the written treatment plan information provided to the advocate?

☐ Should we notify the advocate only if there are changes to the treatment plan?

☐ Would you like the advocate to be present at all of your sessions?

☐ Other: _____

_____ _____

Signature of Consumer Date

For the Treatment Advocate:
I intend to serve as Treatment Advocate for the above named consumer. I have received a copy of the Brighter Dimensions confidentiality standards and I agree to serve according to the consumer's specifications and comply with all standards of confidentiality.

_____ _____

Signature of Treatment Advocate Date

The consumer may revoke the designated of a treatment advocate at any time and for any reason.

Signature of person entering this form in consumers chart: _____

Printed Name of Staff: _____

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Date of Birth _____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
Avoidance
( ) Loss of interest
Hallucinations
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( )
( )
( ) Suspiciousness
( ) _____
( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No. If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Please describe when, where and by whom: _____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____ Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

_____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			
Sedative/Hypnotics			
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			
ADHD medications			
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other			
Antianxiety medications			
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Other			

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other			_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No

Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____ In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

What kind? _____ How often per day on average? _____ How many years? _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason	Date Hospitalized	Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

	Dates	Dosage	Response/Side-Effects
Antidepressants			
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			
Mood Stabilizers			
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

Signature _____ Date _____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____ Date _____

Reviewed by _____ Date _____

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

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

   Attempt or actually have oral, anal, or vaginal intercourse 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 <u>often</u> 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 <u>ever</u> separated or divorced?

   ☐ Yes ☐ No If Yes, enter 1 _____

7. Were any of your parents or other adult caregivers:

   <u>Often</u> pushed, grabbed, slapped, or had something thrown at them?

   Or

   <u>Sometimes or often</u> kicked, bitten, hit with a fist, or hit with something hard?

   Or

   <u>Ever</u> 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 _____

ACE SCORE (Total "Yes" Answers): _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

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

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, 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	☐
☐	Interrupted attempt	☐
☐	Aborted or Self-Interrupted attempt	☐
☐	Other preparatory acts to kill self	☐
☐	Self-injurious behavior ***without*** suicidal intent	☐

	Suicidal Ideation **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
☐	Non-compliant with treatment
☐	Not receiving treatment

	Other Risk Factors
☐	
☐	
☐	

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
☐	Belief that suicide is immoral; high spirituality
☐	Engaged in work or school

	Other Protective Factors
☐	
☐	
☐	

Describe any suicidal, self-injurious or aggressive behavior (include dates)

ADULT

Brighter Dimensions LLC
FAMILY COUNSELING CENTER

Client Name_____
Member ID _____

Tobacco Use Questionnaire

Current Tobacco Use

1.Have you ever tried any form of tobacco? YES NO

2. How long have you used tobacco _____ years _____months

3. What kind of tobacco products do you use?
Cigarettes _____
Smokeless Tobacco (Snuff or Chew) ☐_____
Other (please describe): _____

4. How many cigarettes do you usually smoke per day? (1 pack = 20 cigarettes) ___cigarettes

5. How much smokeless tobacco (snuff/chew) do you usually use per day? ____dips

6. How soon after you wake up do you use tobacco? ☐ Within 30 minutes ☐ After 30 minutes

7. How many people in your household use tobacco? _____ people

QUITTING TOBACCO

8. How many times have you tried to quit using tobacco in the past? _____times

9. What is the longest time that you have gone without using tobacco? _____year(s) _____month(s) _____day(s) _____hour(s)

10. Do you want any help quitting tobacco? YES NO

Signature:_____ Date: _____

Oklahoma Tobacco Helpline
1 800 QUIT NOW
1-800-784-8669 OKhelpline.com