



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: _____

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 entirety 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)



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: _____

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)

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

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 (nortriptyline) _____

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

Adverse Childhood Experience (ACE) Questionnaire

Your family didn't look out for each other, feel close to each other, or support each other?

Yes No

If Yes, enter 1 _____

5. Did you often feel that:

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

Or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No

If Yes, enter 1 _____

6. Were your parents ever separated or divorced?

Yes No

If Yes, enter 1 _____

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

Often pushed, grabbed, slapped, or had something thrown at them?

Or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

Or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No

If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

Yes No

If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes No

If Yes, enter 1 _____

10. Did a household member go to prison?

Yes No

If Yes, enter 1 _____

ACE SCORE (Total "Yes" Answers): _____

Child Checklist of Characteristics

Name: _____ Date: _____

Age: _____ Person completing this form: _____

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first please mark all of the items that apply to your child on the "Adult Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

- Affectionate
- Argues, "talks back," smart-alecky, defiant
- Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- Cheats
- Cruel to animals
- Concern for others
- Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- Complains
- Cries easily, feelings are easily hurt
- Dawdles, procrastinates, wastes time
- Difficulties with parent's paramour/new marriage/new family
- Dependent, immature
- Developmental delays
- Disrupts family activities
- Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- Distractible, inattentive, poor concentration, daydreams, slow to respond
- Dropping out of school
- Drug or alcohol use
- Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- Exercise problems
- Extracurricular activities interfere with academics
- Failure in school
- Fearful
- Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- Fire setting
- Friendly, outgoing, social
- Hypochondriac, always complains of feeling sick
- Immature, "clowns around," has only younger playmates
- Imaginary playmates, fantasy
- Independent
- Interrupts, talks out, yells
- Lacks organization, unprepared

(cont.)

- Lacks respect for authority, insults, dares, provokes, manipulates
- Learning disability
- Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- Likes to be alone, withdraws, isolates
- Lying
- Low frustration tolerance, irritability
- Mental retardation
- Moody
- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Obedient
- Obesity
- Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- Oppositional, resists, refuses, does not comply, negativism
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors—biting or hitting self, head banging, scratching self
- Speech difficulties
- Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, blasphemes, bathroom language, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics—involuntary rapid movements, noises, or word productions
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Underactive, slow-moving or slow-responding, lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothes
- Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics:

- _____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it? _____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.
