Healing Perspectives:Time Well Spent, Counseling and Resource Center, LLC
Laurel Jean Rebenstock, LMSW, CAADC
5600 West Maple Rd. Suite B-212
West Bloomfield, MI 48322
Call/Text: 248-605-5049 Fax: 844-371-7126 Case ID:____
Email: laurelreb@HPtimewellspent.com Website: http://www.HPtimewellspent.com

CONSENT TO TREATMENT

I request that Healing Perspectives:Time Well Spent, Counseling and Resource Center, LLC provide psychological services and psychiatric support to me and/or my child. This form is to document my consent for treatment.

1. I understand that the goal of treatment is to reduce my distress, increase my understanding of the sources of my difficulties, and increase my ability to function in my life in adaptive ways. I understand that the goal of a psychological assessment is to attempt to identify specific strengths and weaknesses that may affect my emotional, cognitive and/or behavioral functioning, as well as to increase my understanding of the source of my concerns and/or difficulties.

2. I understand that psychotherapy is not an exact science so that predictions of benefits, outcomes, or duration are not precise or guaranteed. Many factors, including the consistency and intensity of my participation may affect both the duration and outcome of treatment. I further understand that psychological assessment may result in findings and/or recommendations that may be distressing to me, and that suggestions will be made to address my concerns.

3. I agree to be financially responsible for the entire cost of this treatment, which will be billed to me at the contracted or private pay rate of $_____ per ___ minute session. I understand that payment is due at the time of each session, *unless I leave a credit card number on file with Healing Perspectives:Time Well Spent, Counseling and Resource Center, LLC for automatic charging of fees.*

4. I understand that if I do not choose to leave a credit card number on file for automatic charging of fees and my account balance becomes more than 21 days past due, I must make and abide by a payment agreement that brings my account balance to zero within the next 14 days. If I fail to do so, I understand and agree that services may be suspended and/or my account may be referred to a collection agency. I understand that I am free to discontinue treatment at any time, but that I will still be responsible for timely payment for those services rendered prior to ending the treatment.

5. I understand that appointment times are reserved for me and that failure to keep an appointment without a *24 hour notice of cancellation* will result in being charged a $70 fee for that missed appointment.

6. I understand that my insurance company *may* be billed at my request, and that any amount over- paid by me will be promptly refunded by Healing Perspectives:Time Well Spent, Counseling and Resource Center, LLC upon receipt. Alternatively, I may leave that amount on account against further payments. I am also free to pursue reimbursement independently from a carrier if I choose to do so. Healing Perspectives:Time Well Spent, Counseling and Resource Center, LLC will provide an itemized statement on a monthly basis that is suitable for this purpose.

7. I understand that my treatment shall be kept confidential unless I have given written permission to discuss my case with specific parties. This shall be waived without written consent under the following circumstances:

- There is sufficient reason to suspect, or to believe, that child or elder abuse/neglect of or by the patient has occurred which, under State of Michigan law, requires immediate notification of an appropriate public authority.
- The patient presents an immediate danger to himself/herself or to others which requires notification of a responsible individual/authority for the protection of all concerned.
- In some cases of legal litigation, a judge may order the release of your records, and/or my therapist might be subpoenaed for testimony by other parties to the litigation.

By signing below, I indicate that I have read, understood and agreed to the contents of this Consent To Treatment form.

_____
Child's Name (if applicable)

_____ _____ _____
Signature of Client/Parent/Guardian Printed Name Date

By signing below, I also acknowledge that I have received a NOTICE OF PRIVACY PRACTICES:

_____ _____
Signature Date

_____ _____
Witness Date

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SIGNATURE AND ASSIGNMENT FORM

PATIENT NAME: _____

I, the undersigned, and/or my child, have insurance coverage with:

_____
(name(s) of insurance company)

and assign directly to **Healing Perspectives:Time Well Spent, Counseling and Resource Center, LLC,** all mental health benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by the above stated insurance(s). I understand that if I have two insurances and do not present both cards at the time of service, I am responsible for any balance due. I hereby authorize the provider to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all my insurance submissions.

_____
(Signature of Client or Parent or Guardian)

_____
(Date signed)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our staff uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of this practice.

How We May Use or Disclose Your Health Information For Treatment: We may use your health information to provide you with mental health treatment or services. For example, information obtained by a mental health provider such as a psychiatrist, psychologist, social worker, or sober person providing mental health services to you will record information as necessary for mental health to determine what treatment you should receive. Mental health providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.
For Payment: We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you of a third-party payer, such as an insurance company or health plan. The information on the bill may obtain information that identifies you, your diagnosis, treatment, or supplies used in the course of treatment or service.
For Health Care Operations: We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the clinical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of staff
- Assess the quality of care and outcomes in your case and similar cases.
- Learn how to improve our facilities and services and
- Determine how to continually improve the quality and effectiveness of the mental health care that we provide.

Appointments: We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Patient Follow-up: We may use your information to contact you after treatment termination in order to assess the effectiveness of treatment and/or to determine a current state of mental health in order to provide recommendations that may be of assistance in maintaining or improving your mental health status.
Required by Law: We may be obligated to disclose information about you as required by law or court order. These may include:

- For judicial and administrative proceedings pursuant to legal authority.
- To report information related to victim of abuse, neglect, domestic violence or immediate threat of violence

Public Health: Your health information may be used or disclosed to public health authorities or other legal authorities to prevent or control disease, injury, or disability or for other health oversight activities.
Patient Death: Health information may be disclosed to funeral directors or others to enable them to carry out their lawful duties.
Organ/Tissue Donation: Your health information may be used or disclosed for cadaveric organ, eye, or tissue donation.
Research: We may review your mental health information to determine if your protected health information is needed for research projects. To the extent that information is needed, a review board or privacy board will review the research proposal and established protocols to insure your privacy.
Health and Safety: Your health information may be disclosed to avert a serious threat to the health and safety of you or any other person pursuant to applicable law.
Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.
Other Uses: Other uses and disclosures will be made only with your written authorization. You may revoke the authorization except to the extent we have relied on it.
Your Health Information Rights: You have the right to:

- Request restriction on certain uses and disclosures on you information as provided; however, we are not required to agree to a requested restriction.
- To obtain a paper copy of our Privacy Practices upon request.
- Inspect and obtain a copy of your health record as provided by law
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use of disclose health information except to the extent we have already taken action based upon your authorization.
- Receive an accounting of disclosures made of your health information.

If you have any questions or complaints, please contact the Privacy Official, Laurel Jean Rebenstock at 248-605-5049. You may also complain to the Department of Health and Human Services if you believe that your privacy rights have been violated. We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Revised notices with be made available to you. 05/2021

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Authorization to Disclose Protected Health Information

I, _____(client/guardian),
hereby authorize **Laurel Jean Rebenstock, LMSW, CAADC** of **Healing Perspectives: Time Well Spent, Counseling and Resource Center, LLC (Provider)** to disclose to and/or receive information from:

Name _____

Address _____

_____

_____

Phone _____ Fax _____

To include the following protected health information:

____ Entire File ____ Psychotherapy Notes ____ Session Start/Stop Times
____ Diagnosis ____ Treatment Plan ____ Recommendations
____ Progress to Date ____ Dates of Treatment
____ Other _____

I understand that I have a right to receive a copy of this authorization and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective. I authorize the disclosure of the health information described above for the following purpose:

_____
_____

The specific uses and limitations on the uses of my health information by Recipient are as follows:

_____
_____

I understand that Provider cannot condition treatment upon me signing this authorization. I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable Michigan law.

Provider is authorized to disclose the protected health information specifically listed above until:
_____(authorization expiration date or case closure).

By: _____/_____ Date: _____
(Signature of Patient or Patient's Representative)/Printed Name
*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:
_____

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In order for Laurel Jean Rebenstock, LMSW, CAADC to accept and bill your credit card, please complete all fields below, sign and date. All information kept on file is strictly confidential.

Contact/Billing Information: (as shown on credit card)
Client name if different from cardholder _____
Cardholder Name (as shown on card) _____
Address: _____
City: _____ State _____ Zip _____
Phone: _____Email: _____
Credit Card Type: _____ Visa _____ MasterCard
Credit Card # _____ Exp. Date _____
Credit Card Security code: _____ Amount authorized: $_____

Please check the appropriate paragraph:

_____ One Time Use: I hereby authorize Laurel Jean Rebenstock, LMSW, CAADC to charge the indicated credit the amount indicated above. This is a one-time charge authorization. I am not authorizing Laurel Jean Rebenstock, LMSW, CAADC to setup my account within a recurring billing system; rather, I prefer to pay by check or cash on all future billings. I understand that if I want Laurel Jean Rebenstock, LMSW, CAADC to charge any balances to my credit card in the future, I will need to submit another authorization form at that time, or choose the selection below.

_____ Recurring Billing: I hereby authorize Laurel Jean Rebenstock, LMSW, CAADC to charge the indicated credit card on a periodic basis for the amount due on this client account. This Recurring Payment Authorization / Periodic Charge shall remain in force until cancelled by me in writing.

Authorization: I hereby authorize Laurel Jean Rebenstock, LMSW, CAADC to charge the indicated credit card. I am aware that there is a policy of requiring 24 hours notice to cancel an appointment, else a $70 fee is charged to the client account, and that my medical insurance, if any, cannot be charged for missed sessions. I agree that this is either a one-time or periodic charge that will be made as indicated above, and will not dispute it in the future. In addition, I agree to reimburse Laurel Jean Rebenstock, LMSW, CAADC for any cost involved with any dispute attempt regardless of outcome. To terminate the recurring billing process, if selected, I must cancel in writing.

I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this one time or recurring billing agreement with Laurel Jean Rebenstock, LMSW, CAADC.

Signature of Card Holder (required)_____ Date _____

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Electronic Communication Agreement and Consent for Use

As a client (or parent/guardian of a client) of Laurel Jean Rebenstock, LMSW, CAADC, I acknowledge that any electronic communication sent or received on my (or my child's) behalf may become a part of my legal medical record. This includes texts, phone calls, emails, and videoconferencing.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that therapy sessions or other communication could be disrupted or distorted by technical problems, power outages, lost signals, etc. or could be accessed by unauthorized persons.

I further acknowledge that I willingly accept this risk associated with using any or all forms of electronic communication and will not hold Laurel Jean Rebenstock, LMSW, CAADC or Healing Perspectives: Time Well Spent, Counseling and Resource Center, LLC responsible for breaches of security that happen as a result.

I understand that the dissemination of any personally identifiable images or information from a Telehealth interaction to any other entities shall not occur without written consent. I understand that while there are many benefits, Telehealth results cannot be guaranteed.

I have a right to confidentiality with Telehealth under the HIPAA laws that protect medical information for in-person psychotherapy. Exceptions include mandatory reporting of child, elder, and dependent adult abuse and any serious threats of violence I may make towards another person or myself.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to Laurel Jean Rebenstock, LMSW, CAADC at any time.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I hereby consent to participating in Teletherapy with: Laurel Jean Rebenstock, LMSW, CAADC

Client Cell Phone _____ Client Home/Other Phone _____

Email Address _____

Client Name _____

Signature _____ Date _____
(Client or Parent/Guardian)

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REGISTRATION FORM

Today's Date

Name:	Nickname:	Date of Birth:	Age:
Cell Phone:	Home Phone:	Work Phone	
Voicemail OK? ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Address:			
Email:			
Emergency Contact/Relationship/Phone:			
Referred by:	Phone/Email		

Race/Ethnicity:	Religion:	1st Language:
Gender: ☐ Male ☐ Female ☐ Non-binary/trans_____ Do you consider yourself a member of the LGBTQ community? ☐ Yes ☐ No _____ Are you? ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Are you pregnant/expecting? ☐ Yes ☐ No		
Highest Level of Education Completed: Currently Attending School:	Areas of Interest:	
☐ Employed ☐ Retired ☐ Stay At Home Parent ☐ Disabled ☐ JobSeeking ☐ Volunteering ☐ F/T ☐ P/T How Long? Where?	Occupation:	
Living Arrangement: ☐ House ☐ Apt ☐ Condo ☐ College Housing ☐ Transitional Living ☐ Group Home ☐ Senior Housing ☐ Homeless ☐ Other:		
☐ Alone ☐ With Family of Origin ☐ With Significant Other/Spouse ☐ With Family		

Health Insurance	Name of Insured	DOB of Insured	ID #	Group #	Mental Health Provider Phone # (on back)

Why are you seeking counseling now (Presenting Problems)?

_____

_____

_____

What are your initial expectations entering counseling (Hoped For Solutions)?

_____

_____

_____

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COMPREHENSIVE ASAM and DSM-5 ALIGNED ADULT/ADOLESCENT PSYCHOSOCIAL ASSESSMENT

With Whom Do You Live (Include other close family/adult children, who live elsewhere)?

Name	Role	Age	Address, if different or Email

Adopted? ☐ Yes ☐ No When? Where?
Ever lived away from parents as a child (foster care, boarding school, relatives)? ☐ Yes ☐ No When?

Please list current medical provider(s):

Physician Name	Specialty/Date of Last Visit	Contact Information

Please list all current medication(s, including psychiatric, medical, vitamins, etc.):

Medication	Prescriber	Reason/Dose		Medication	Prescriber	Reason/Dose

Please list past medical hospitalizations/surgeries:

Year	Reason	Hospital Name

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Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential

Substance Use History:	Used Past Year	Prior Use	Route	How Often	Amount	Duration Age Began	Last Use
Caffeine	☐	☐				Age___Never ☐	
Nicotine: Smoke☐ Chew☐ Vape☐	☐	☐				Age___Never ☐	
Alcohol: Beer☐ Wine☐ Liquor☐ Longest Clean Time? When?	☐	☐				Age___Never ☐	
Over-the-Counter Meds	☐	☐				Age___Never ☐	
Marijuana/Cannabinoids	☐	☐				Age___Never ☐	
Cocaine☐ Crack☐ Longest Clean Time? When?	☐	☐				Age___Never ☐	
Stimulants: Diet Pills ☐ DXM ☐ Ritalin ☐ Adderall ☐ Meth ☐ Vyvance ☐	☐	☐				Age___Never ☐	
Opioid Pain Meds: Longest Clean Time? When?	☐	☐				Age___Never ☐	
Heroin ☐ Fentanyl ☐ Kratom ☐ Longest Clean Time? When?	☐	☐				Age___Never ☐	
Ketamine ☐ Benzos ☐ Sleeping Pills ☐	☐	☐				Age___Never ☐	
Hallucinogens PCP ☐ Acid☐ Mushrooms ☐	☐	☐				Age___Never ☐	
Inhalants: Nitrous ☐ Other☐	☐	☐				Age___Never ☐	
Anabolic Steroids ☐	☐	☐				Age___Never ☐	
Ecstasy☐/Molly☐/MDMA ☐	☐	☐				Age___Never ☐	
K-2 ☐/Spice ☐/Bath Salts ☐	☐	☐				Age___Never ☐	
Methadone ☐ Suboxone ☐ Naltrexone ☐ Vivitrol ☐ Antabuse ☐ Campral ☐	☐	☐				Age___Never ☐	
Addictive Eating: Anorexia/Restricting ☐ Bulimia/Binging/Purging ☐ Compulsive Overeating ☐ Laxative Usage ☐ Over-Exercising ☐ Body Dysmorphia ☐	☐	☐				Age___Never ☐	
Compulsive Gambling	☐	☐				Age___Never ☐	
Sex☐ Porn☐ Addiction	☐	☐				Age___Never ☐	
Sell drugs/steal/prostituting	☐	☐				Age___Never ☐	
Hoarding ☐/Other_____	☐	☐				Age___Never ☐	

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Do you find yourself using more alcohol and/or drugs than you intend to? ☐ Yes ☐ No
Do you get physically ill when you stop using alcohol and/or drugs? ☐ Yes ☐ No
Do you ever take something to prevent the onset of withdrawal symptoms? ☐ Yes ☐ No
Are you currently experiencing withdrawal symptoms? ☐ Yes ☐ No
Do you have a history of serious withdrawal, seizures, etc? ☐ Yes ☐ No
Do you find yourself using more alcohol and/or drugs in order to get the same high? ☐ Yes ☐ No
Has your alcohol/drug use changed recently (increase/ decreased, changed route of use)? ☐ Yes ☐ No
Do you continue to engage in problem behaviors despite having it affect you negatively? ☐ Yes ☐ No

Family history of alc/drug use: ☐ Mother ☐ Father ☐Step-parent ☐ If Adopted, Bio-parent
☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother
☐ Paternal Grandfather ☐ Aunts/Uncles ☐ (Adult/Adolescent) Children

Was a parent using at the time of conception/pregnancy with you? ☐ Yes ☐ No ☐ Unknown
Any type of complications related to your birth/early development? ☐ Yes ☐ No
Please describe: _____
Have you received help for addiction in the past? ☐ Yes ☐ No
Meetings? ☐ Yes ☐ No Sponsor? ☐ Yes ☐ No Steps? ☐ Yes ☐ No
Please list addiction treatment provider(s):

Date	Length of Care	Provider Name Inpatient/Outpatient	Contact Information

Dimension 2: Biomedical Conditions and Complications
Have you ever had any of the following medical conditions:
☐ Heart Problems ☐ Seizure/Neurological ☐ Muscle/Joint Problems ☐ Diabetes
☐ High Blood Pressure ☐ Thyroid Problems ☐ Vision Problems ☐ Sleep Problems
☐ High Cholesterol ☐ Kidney Problems ☐ Hearing Problems ☐ Chronic Pain
☐ Blood Disorder ☐ Liver Problems ☐ Dental Problems ☐ Asthma/Lungs
☐ Stomach/Intestinal Problems ☐ Sexually Transmitted Disease(s): _____
☐ Cancer (specify type[s]):_____ ☐ Infection(s): _____
☐ Allergies: _____ ☐ Other: _____

Do any of these conditions significantly interfere with your life? ☐ Yes ☐ No
Any other handicapping conditions or special health considerations? ☐ Yes ☐ No
Do you have any life threatening medical symptoms or require immediate medical attention? ☐ Yes ☐ No
In the past six months, has there been a change in your weight, appetite, or sleeping patterns? ☐ Yes ☐ No
Have you ever been taken to the emergency room for medical reasons? ☐ Yes ☐ No
Have you ever suffered any type of head injury? ☐ Yes ☐ No
Have you ever experienced any convulsions or seizures? ☐ Yes ☐ No
Do any immediate family members have any significant medical conditions? ☐ Yes ☐ No
Please explain any yes answers:_____

_____

_____

How often and what type of exercise do you enjoy?
_____
What is your usual sleeping pattern?
_____
How would you describe your eating habits?
_____
What recreational activities bring you joy and how often do you do them?
_____
Do you consider yourself religious or spiritual?
_____
Are you involved in a faith community? How often?
_____
What is your current overall health status? POOR FAIR GOOD VERY GOOD EXCELLENT

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Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	None	Slight 1-2 Days	Mild Some Days	Mod. Most Days	Severe Daily
I	1. Little interest or pleasure in doing things?	0	1	2	3	4
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4
II	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
III	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
VI	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
	7. Feeling panic or being frightened?	0	1	2	3	4
	8. Avoiding situations that make you anxious?	0	1	2	3	4
V	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
VI	11. Thoughts of actually hurting yourself?	0	1	2	3	4
VII	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
VIII	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4
IX	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
X	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
XI	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
XII	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
XIII	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4

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Have you ever experienced any of the following?
☐ TBI ☐ Cognitive Impairment ☐ Isolation/Loneliness ☐ Bullying/Bullied
☐ ADHD ☐ Learning Disabilities ☐ Autism Spectrum Disorder ☐ Poor Grades
Abuse: ☐As Child ☐ As Adult ☐ Physical ☐ Sexual ☐Mental/Emotional ☐ Neglect ☐ Ever Accused of
CPS Ever Involved ☐ Yes ☐ No Caseworker Name/Number_____
Recent Death/Suicide of Family Friend/Relative _____
Other Trauma _____
Conflicts with ☐ Parents ☐Steps ☐ Siblings ☐ Peers ☐ BF/GF/Spouse ☐ Children ☐ Authority
Your Parents Were: ☐ Generally Healthy, Safe, High Functioning Mentally, Physically, Emotionally OR
☐ Argued Too Much ☐ Violent ☐ Psychiatric Problems
☐ Legal Problems ☐ Job Instability ☐ Housing Instability
☐ Financial Stress ☐ Relationship Stress ☐ Caregiving Stress
☐ Too Strict ☐ No rules/boundaries ☐ Abused or Abusive
Have you ever been diagnosed with a mental illness? ☐ Yes ☐ No _____
Does your mental/emotional concern or addiction affect any of the following?
☐ Physical Health ☐ School ☐ Relationships ☐ Mood ☐ Self-esteem
☐Concentration ☐Sleep ☐ Everyday Tasks ☐ Hygiene ☐ Recreational Activities

Please list past/current mental health provider(s)/hospitalization(s):

Dates	Reason/Was it helpful?	Provider Name	Contact Information

Dimension 4: Readiness to Change
___Precontemplative--I don't think I have a problem and/or I am not ready to make significant lifestyle changes.
___Contemplative--I think I may have a problem and I think I may be ready to make significant lifestyle changes.
___Preparation--I know I have a real problem and I am busy preparing to make significant positive lifestyle changes.
___Action--I am actively working to resolve my problem and have been making significant positive lifestyle changes.
___Maintenance and Prevention--I accept my problem and my solution and continue to use effective strategies to prevent the recurrence of my problem.

Dimension 5: Relapse, Continued Use, or Continued Problem Potential
Are you currently involved with the legal system (CPS, court mandated, probation, parole)? ☐ Yes ☐ No

Probation/Parole/CPS Name	Contact Info	Court	Charges

Ever been arrested/jailed or placed in state custody/foster care in the past? ☐ Yes ☐ No Parents?: ☐ Yes ☐ No

Dates	Name of Facility	Reason

Ever been suspended/expelled/dropped out of school? ☐ Yes ☐ No
Ever been at risk of job loss/fired/laid off? ☐ Yes ☐ No
Ever been homeless/evicted/kicked out/foreclosed/bankrupt? ☐ Yes ☐ No
What is the longest period of time that you have gone without using/problem behaviors? _____
Do you spend a lot of time planning/sneaking/hiding/faking normalcy to cover up problems? ☐Yes ☐ No
Do you feel that you will continue to have problems without treatment or additional support? ☐ Yes ☐ No
What Triggers Your Problem Behaviors? ☐ Don't know
1. 2. 3.
Please describe any attempts to either control or cut down on your problem behaviors on your own?
_____

Healing Perspectives:Time Well Spent, Counseling and Resource Center, LLC
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Email: laurelreb@HPtimewellspent.com Website: http://www.HPtimewellspent.com

Dimension 6: Recovery/Living/Occupational Environments

Types of Social Support	How Many?	How Often Do You Contact Them? Daily Weekly Monthly Yearly Rarely	How Do You Connect? F-F, Phone, Online, Etc.
Best Friends			
Good Friends			
Out of Town Friends			
Local Friends			
Neighbors/Acquaintances			
Work Buddies			
Small Group Activities/Clubs			
Large Community Organizations			
Trusted Mentors/Teachers/Gurus			
Pets/Animals			

Level of Job Satisfaction? ☐ Love It ☐Like It ☐ So-So ☐ Not So Much ☐Hate It

Do you currently live in an environment where others are using drugs/alc or are acutely mentally ill? ☐ Yes ☐ No

Do you currently work or attend school where others are using drugs/alc or are acutely mentally ill? ☐ Yes ☐ No

Are you currently involved with people/situations that pose a threat to your safety or are abusive? ☐ Yes ☐ No

Ever been suspended/expelled/dropped out of school? ☐ Yes ☐ No

Ever been at risk of job loss/fired/laid off? ☐ Yes ☐ No

Ever been homeless/evicted/kicked out/foreclosed/bankrupt? ☐ Yes ☐ No

What relationships are supportive of your recovery/healthy living?

_____

What relationships are <u>not</u> supportive of your recovery/healthy living?

_____

What places are supportive of your recovery/healthy living?

_____

What places are <u>not</u> supportive of your recovery/healthy living?

_____

What situations/things are supportive of your recovery/healthy living?

_____

What situations/things are <u>not</u> supportive of your recovery/healthy living?

_____

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Top 10/5 and 0-10 Level of Motivation To Address The Problem In Therapy (0=Not Motivated, 10=All In!!!)

10 Strengths	5 Problems	5 Goals Related To Problems	5 Obstacles	0-10
1 2	1	1	1	
3 4	2	2	2	
5 6	3	3	3	
7 8	4	4	4	
9 10	5	5	5	

In the space below, please feel free to share anything else you would like me to know or any questions you have or concerns or expectations regarding any aspect of beginning therapy.

_____

_____

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Client Signature Date

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Therapist-Only Section Below

Severity Rating- Dimension 1 (Substance Use, Acute Intoxication and/or Withdrawal Potential)

0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
No signs of withdrawal or intoxication present	Mild/moderate intoxication, interferes with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs/symptoms. Presents danger, i.e. seizures. Continued use poses an imminent threat to life.

Severity Rating- Dimension 2 (Biomedical Conditions and Complications)

0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Fully functional/able to cope with discomfort or pain.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.	Some difficulty tolerating physical problems. Acute, non-life threatening problems present, or serious bio-medical problems are neglected.	Serious medical problems neglected during outpatient or intensive outpatient treatment. Severe medical problems present but stable.Poor ability to cope with physical problems.	Incapacitated with severe medical problems.

Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)

0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Good impulse control and coping skills. No dangerousness, good social functioning and self-care, no interference with recovery.	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment.	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning.	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting.	Severe EBC. Requires acute level of care. Exhibits severe and acute life-threatening symptoms (posing imminent danger to self/others).

Dimension 4 (Readiness to Change)

0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Willing to engage in treatment.	Willing to enter treatment, but ambivalent to the need to change.	Reluctant to agree to treatment. Low commitment to change. Passive engagement in treatment.	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

Dimension 5 (Relapse, continued Use, or Continued Problem Potential)

0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Low/no potential for relapse. Good ability to cope, when stressed.	Minimal relapse/problem potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition of risk for relapse. Able to self-manage with prompting.	Little recognition for risk of relapse/problem, poor skills to cope with relapse/recurrence.	No coping skills for addiction/mental health problems. Substance use/behavior, places self/other in imminent danger.

Severity Rating- Dimension 6 Recovery/Living Environment

0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Able to cope in the environment/ supportive.	Passive/disinterested social support, but still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment, difficulty coping even with clinical structure.	Environment toxic/hostile to recovery/healthy living. Unable to cope and the environment may pose a threat to safety.

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Summary of Multidimensional Assessment Dimension Severity Rating (Based on Ratings Above)	0 None	1 Mild	2 Moderate	3-4 Severe	Rationale
Dimension 1 Substance Use/WithdrawalPotential/Prevention	☐	☐	☐	☐	
Dimension 2 Biomedical Conditions and Complications	☐	☐	☐	☐	
Dimension 3 Emotional, Behavioral, or Cognitive Conditions/ Complications	☐	☐	☐	☐	
Dimension 4 Readiness to Change	☐	☐	☐	☐	
Dimension 5 Relapse Risk or Continued Problem Potential	☐	☐	☐	☐	
Dimension 6 Recovery/Living/Occupational Environment	☐	☐	☐	☐	

Diagnostic Criteria for Substance Use Disorders DSM-5 (ICD 10)

_____ Alcohol Use Disorder
305.00 (F10.10) Mild 2-3 symptoms
303.90(F10.20) Mod. 4-5
303.90(F10.20) Severe 6+

_____Phencyclidine Use Disorder
305.90 (F16.10) Mild 2-3 symptoms
304.60 (F16.20) Mod 4-5
304.60 (F16.20) Severe 6+

_____Inhalant Use Disorder
305.90 (F18.10) Mild 2-3 symptoms
304.60 (F18.20) Moderate 4-5
304.60 (F18.20) Severe 6+

_____Cannabis Use Disorder
305.20 (F12.10) Mild 2-3 symptoms
304.30 (F12.20) Moderate 4-5
304.30 (F12.20) Severe 6+

_____Tobacco Use Disorder
305.10 (Z72.0) Mild 2-3 symptoms
304.10 (F17.20) Moderate 4-5
304.10 (F17.20) Severe 6+

_____Stimulant Use Disorder
Mild: Presence of 2-3 symptoms
305.70 (F15.10) Amphetamine-type sub
305.60 (F14.10) Cocaine
305.70 (F15.10) Other or unspecified

Moderate: Presence of 4-5 symptoms
304.40 (F15.20) Amphetamine-type sub
304.20 (F14.20) Cocaine
304.40 (F15.10) Other or unspecified

Severe: Presence of 6+
304.40 (F15.20) Amphetamine-type sub
304.20 (F14.20) Cocaine
304.40 (F15.10) Other or unspecified

____Other Hallucinogen Use Disorder
305.30 Mild Presence of 2-3 symptoms
304.50 Moderate Presence of 4-5
304.50 Severe Presence of 6+

_____Opioid Use Disorder
305.50 (F11.10) Mild 2-3 symptoms
304.00 (F11.20) Moderate 4-5
304.00 (F11.20) Severe 6+

_____Sedative, Hypnotic, Anxiolytic Use Disorder
305.40 (F13.10) Mild 2-3 symptoms
304.10 (F13.20) Moderate 4-5
304.10 (F13.20) Severe 6+

Specifiers:
Early remission/Sustained remission
In a Controlled Environment

Clinical Summary:

Appearance:
Mood:
Affect/Intensity:
Mental Status/Insight:
High Risk Concerns:
Treatment Interfering Behaviors:
Readiness For Change:
Initial Rapport and Response To Interventions:

ICD 10 Code and Diagnosis _____

ICD 10 Code and Diagnosis _____

ICD 10 Code and Diagnosis _____

ICD 10 Code and Diagnosis _____

_____ _____
Laurel Jean Rebenstock, LMSW, CAADC **Date Completed**