

# Cow Creek Behavioral Health Program

## Consent to Treatment

Initials

\_\_\_\_\_ I hereby authorize and give voluntary consent to treatment at Cow Creek Behavioral Health program. I am, in my opinion in need of services.

\_\_\_\_\_ The right to actively participate in the formulation and development of a Service & such planning if the client is a minor or mentally disabled. The following information will be discussed:

- a) The training or treatment to be undertaken;
- b) Alternative training or treatment methods available;
- c) Benefits reasonably to be expected;
- d) Risks that may be involved in the treatment, if any.

\_\_\_\_\_ I understand that I (or my guardian) may voluntarily withdraw from services offered by Cow Creek Behavioral Health program.

\_\_\_\_\_ I understand that I may be required to submit to staff monitored urine tests in conjunction with my treatment.

\_\_\_\_\_ I understand information shared with a counselor is confidential and will not be shared outside this agency without my written consent **except under the following conditions:** Any information I disclose regarding threat of harm to self or another, or harm done to a child, elder or disabled person will be disclosed to law enforcement or other appropriate agencies. My counselor may be court ordered to testify about my treatment at Cow Creek.

\_\_\_\_\_ I further understand that I will adhere to the Confidentiality rules stating I will at no time discuss the treatment of any individual who is, or has been, in Cow Creek Behavioral Health program.

\_\_\_\_\_ I have been offered/given a copy of Cow Creek Behavioral Health Patient rights and responsibilities, grievance procedure, Cow Creeks Privacy policy and philosophy of substance abuse and have had any questions answered.

\_\_\_\_\_ I understand that a Declaration for Mental Health Treatment form is available upon request.

\_\_\_\_\_ If I have questions regarding my treatment I may speak openly about them with my counselor. If problems persist I may request a treatment review by the Behavioral Health manager and/or the Health/Medical Director.

\_\_\_\_\_ If I am under 14 years of age. A guardian must consent to treatment services.

\_\_\_\_\_ I understand that if I am in violation of the Cow Creek Band of Umpqua Tribe of Indians employment policies HR will be notified.

\_\_\_\_\_  
Signature of guardian or person receiving services

\_\_\_\_\_  
Counselors signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_ MALE FEMALE

**CHILDREN HEALTH HISTORY**

What is our main concern about your child?

Mother's Name:

Father's Name:

Mother's Age:

Number of Children:

This child is number:

Parents are (Circle One) Single Married Divorced Separated

Is this child under medical care now? (Circle One) NO YES Physician:

Date last seen:

If yes, for what condition?

Does your child have dental problems? (Circle One) NO YES Dentist:

Date last seen:

**PREGNANCY AND BIRTH**

Was pregnancy normal? YES/NO

If no, explain:

Was delivery normal? YES/NO

If no, explain:

Birth weight of this child:

**NUTRITION**

Is our child having feeding problems? NO/YES

If yes, explain:

Do you have questions about feeding? NO/YES

If yes, explain:

Is your child's appetite usually good? NO/YES

If yes, explain:

Do any foods disagree with your child? NO/YES

If yes, explain:

Do you think your child is overweight? NO/YES

Do you think your child is underweight? NO/YES

Does your child take vitamins routinely? NO/YES

Does your child have problems with constipation? NO/YES

Please circle all of the following that apply to your child:

Breast, Bottle, Formula-brand of formula: \_\_\_\_\_ Cereal, Fruit, Juice, Vegetable, Eggs, Meat

**DEVELOPMENT**

Please circle if your child has or has had in the past, difficulty with:

Sitting up Walking Talking Seeing Hearing Learning

**FAMILY HISTORY**

Check ( ✓ ) if child's blood relatives have had any of the following:

<input type="checkbox"/>	Asthma/Lung Disease	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Birth Deformities	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	

**CHILD'S MEDICAL HISTORY**

Check ( ✓ ) if child has had any of the following:

<input type="checkbox"/>	Rubeola (Hard or Red Measles)	<input type="checkbox"/>	Serious Injury/Illness	<input type="checkbox"/>	Wheezing/Coughing
<input type="checkbox"/>	Rubella (3 day or German Measles)	<input type="checkbox"/>	Frequent colds/Sore throats	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Reaction to Medication
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	High Fever (104-105)	<input type="checkbox"/>	Surgery
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Hospitalizations
<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	

*I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.*

Signature: \_\_\_\_\_ Reviewed by: \_\_\_\_\_  
(Parent or Guardian)

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

**ADULT HEALTH HISTORY**

Reason for this visit: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

**CONDITIONS:** (Check (√) conditions you have or have had in the past)

AIDS	Chemical Dependency	High Cholesterol	Prostate Problem
Alcoholism	Chicken Pox	HIV Positive	Psychiatric Care
Anemia	Diabetes	Kidney Disease	Rheumatic Fever
Anorexia	Emphysema/COPD	Liver Disease	Scarlet Fever
Appendicitis	Epilepsy/Seizures	Measles	Stroke
Arthritis	Glaucoma	Migraine Headaches	Suicide Attempt
Asthma	Goiter	Miscarriage	Thyroid Problems
Bleeding Disorders	Gonorrhea	Mononucleosis	Tonsillitis
Breast Lump	Gout	Multiple Sclerosis	Tuberculosis
Bronchitis	Heart Disease	Mumps	Typhoid Fever
Bulimia	Hepatitis	Pacemaker	Ulcers
Cancer	Hernia	Pneumonia	Vaginal Infections
Cataracts	Herpes	Polio	Venereal Disease

**FAMILY HISTORY:** (Fill in health information about your family)

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH	Check (√) if your blood relatives had any of the following: DISEASE	RELATIONSHIP TO YOU
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease	
Sisters					Stroke	
					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
				Other		

**HOSPITALIZATIONS/SURGERIES/SERIOUS INJURIES:**

YEAR	REASON	HOSPITAL/OUTCOME
	TONSILLECTOMY	
	GALL BLADDER REMOVAL	
	HYSTERECTOMY TOTAL/PARTIAL	
	HERNIA REPAIR	
	OTHER (List)	

**PREGNANCY HISTORY:**

YEAR OF BIRTH	SEX OF BIRTH	COMPLICATIONS, IF ANY

**HABITS:**

DO YOU DRINK ALCOHOL?	NO/YES
If yes, do you feel you should cut down?	NO/YES
do you feel guilty about it?	NO/YES
do you drink early in the day?	NO/YES
DO YOU USE CAFFEINE?	NO/YES
DO YOU USE DRUGS?	NO/YES
DO YOU USE TOBACCO?	NO/YES

Have you ever had a blood Transfusion? NO/YES, YEAR?  
 Have you had your Cholesterol checked in the past 5 years? NO/YES  
 Do you have periods of weakness, numbness, inability to talk? NO/YES  
 Do you have: (Circle) Chest Pain? Shortness of breath? Joint pains?  
 Stomach problems? Heartburn?

Do you have problems with falling, or doing routine daily tasks? NO/YES MARITAL STATUS M/ S/ D

*I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.*

Signature: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

# INTAKE QUESTIONNAIRE

<b>LAST NAME:</b>		<b>FIRST NAME:</b>		<b>MI:</b>	
<b>DOB:</b>		<b>HRN:</b>		<b>MEDCAID#</b>	
<b>RACE:</b>		<b>ETHNICITY:</b>		<b>GENDER:</b>	
<b>VETERAN: Y N</b>		<b>MARITAL STATUS?</b>		<b>EMPLOYMENT: FT PT RET STUDENT</b>	
<b>LIVING ARRANGEMENTS: PRIVATE RESIDENCE / OTHER</b>					
<b>COUNTY OF RESIDENCE:</b>			<b>COUNTY OF RESPONSIBILITY:</b>		
<b>TODAY'S DATE:</b>			<b>ZIP CODE:</b>		
<b>GROSS HOUSEHOLD INCOME:</b>			<b>SOURCE OF INCOME:</b>		
<b>SOURCE OF PAYMENT (INSURANCE):</b>			<b>TOTAL # OF DEPENDENTS:</b>		
<b># CHILDREN IN HOME:</b>			<b>PRIMARY HEALTH INSURANCE:</b>		
<b>REFERRED FROM:</b>			<b>REFERRED TO:</b>		
<b>TRIBAL AFFILIATION:</b>			<b>HIGHEST GRADE COMPLETED:</b>		
<b>TOBACCO USE: Y N</b>			<b>PREGNANT: Y N N/A</b>		
<b>SUBSTANCE USE LAST 90</b>			<b>LEGAL STATUS:</b>		
<b>#ARRESTS PAST MONTH:</b>			<b>TOTAL ARRESTS:</b>		
<b>#DUI ARRESTS PAST MONTH:</b>			<b>TOTAL DUI ARRESTS:</b>		
<b>ATTENDING SCHOOL: Y N</b>					
<b>OFFICE USE ONLY:</b>					
<b>IMPROVEMENT: IN ATTENDANCE</b>		<b>Y</b>	<b>N</b>	<b>ACADEMICS</b>	
				<b>Y</b>	<b>N</b>
				<b>BEHAVIORAL</b>	
				<b>Y</b>	<b>N</b>
<b>DIAGNOSIS CODES:</b>					
<b>INFECTIOUS DISEASE RISK ASSESS: LOW/MODERATE, MODERATE/HIGH NO REFERRAL, MODERATE/HIGH REFERRAL MADE</b>					
<b>TREATMENT PLAN INDICATOR: ALWAYS, OTHER</b>					
<b>PRIMARY SUBSTANCE:</b>					
<b>AFU:</b>					
<b>CURRENT FREQUENCY OF USE:</b>					
<b>USUAL ROUTE:</b>					
<b>SECONDARY SUBSTANCE AND SAME AS ABOVE:</b>					
<b>AFU:</b>		<b>FREQ-</b>		<b>UR:</b>	
<b>TERTIARY SUBSTANCE AND SAME AS ABOVE:</b>					
<b>AFU:</b>		<b>FREQ-</b>		<b>UR:</b>	
<b>POSITIVE UDS PAST REPORTING 3 MONTHS?</b>					
<b>FREQUENCY OF ATTENDANCE IN SELF-HELP PROGRAMS:</b>					
<b>MEDICATION ASSISTED TX:</b>					
<b>ADDICTION ASSESSED LOC:</b>					
<b>CURRENT ADDICTION LOC:</b>					
<b>NOTES:</b>					