A New Leaf
Mental Health and Wellness Center

5925 Council St NE Suite 117
Cedar Rapids, IA. 52402
Phone: (319) 804-0098

# New Leaf Mental Health and Wellness Center

## CLIENT INTAKE INFORMATION

| **Name** | | **Date** | | | |
|---|---|---|---|---|---|
| **Address:** | | **City** | | **State** | |
| **County/ZIP** | **Sex:** ☐ **Male** ☐ **Female** | **AGE** | | **DOB** | |

**Ethnicity:** Not Spanish/Hispanic/Latino Mexican Other Hispanic or Latino

**Race:** Caucasian Black/African American American Indian Asian

| **PHONE:** | **Work:** | **SSN#:** |
|---|---|---|
| **E-Mail:** | | |

**MARITAL STATUS:** ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed**

**Living arrangements:** ☐ Alone ☐ With parents ☐ With significant other ☐ With significant other and children ☐ With children alone ☐ Other adult ☐ Jail/Correctional facility ☐ Homeless

**SPOUSE'S NAME:**
**ADDRESS IF DIFFERENT:**

| **NUMBER OF CHILDREN:** (Living in the home) | **# GIRLS:** | **#BOYS:** |
|---|---|---|
| **EMPLOYER NAME:** | **JOB TITLE:** | **PHONE:** |

**EMPLOYER ADDRESS:**
**Monthly Gross Income:**

**Do you currently or have you ever served in the United States Armed Forces?** ☐ Yes ☐ No ☐ I prefer not to say

**If "Yes", in what capacity?**

| **CONTACT INFORMATION** | | |
|---|---|---|
| EMERGENCY CONTACT: | RELATIONSHIP: | PHONE #: |
| ADDRESS: | | |
| | | |

| **REFERRAL SOURCE INFORMATION** | |
|---|---|
| REFERRED BY: | |
| ADDRESS: | |
| PHONE NUMBER: | |
| **REASON FOR REFERRAL** | |
| RECOMMEDATIONS: | REFERRING AGENCY: |

| Other Recommendations/Referrals |
|---|
| |
| |
| |

| Intake Staff Signature | Date |
|---|---|
| | |

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New Leaf Mental Health and Wellness Center
Medical History Form

Name: ____________________________________ Date of Birth: __________________________
(Last, First, Middle)
Sex ☐ Male ☐ Female

Are you currently under a doctor's care: ☐ Yes ☐ No
If yes, explain: ______________________________________________________________

Physician: ________________________Specialty: _________________________________
Address: _____________________________________ Phone: _______________________

___________________________________________________________________________

Do you take any medications on a regular basis? ☐ Yes ☐ No
If yes, please list medications and reasons for taking:

| **List of Medications:** | **Reasons:** |
|---|---|
| _____________________________ | _____________________________ |
| _____________________________ | _____________________________ |
| _____________________________ | _____________________________ |
| _____________________________ | _____________________________ |
| _____________________________ | _____________________________ |

Have you been hospitalized in the last 12 months ☐ Yes ☐ No
If yes, explain: _________________________________________________________________
_________________________________________________________________
_________________________________________________________________

**List all known medical conditions**

| | | |
|---|---|---|
| ☐ Arthritis | ☐ Diabetes | ☐ Phlebitis or Swelling |
| ☐ Asthma | ☐ HIV/AIDS | ☐ Rheumatic fever |
| ☐ Abnormal heart rhythm | ☐ High blood pressure | ☐ Blood clots in veins or lungs |
| ☐ Stroke or "mini" stroke (TIA) | ☐ Thyroid disorder ☐ Low ☐High | ☐ Tuberculosis |
| ☐ Easy bruising or bleeding | ☐ High Cholesterol or triglycerides | ☐ Stomach/intestinal ulcers |
| ☐ Anemia or blood disorder | ☐ Liver problems/hepatitis | ☐ Menopause |
| ☐ Heart failure | ☐ Heart murmur | ☐ Vascular disease |
| ☐ Cancer | ☐ Kidney disorder | |
| ☐ COPD/ Emphysema | ☐ Heart attack | |

Additional Conditions Not Listed:

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1. Do you have a Life Directive (Living Will)? □Yes □No
2. Have you ever been tested for Hepatitis A, B, or C? □Yes □No if yes was it □Positive or □Negative. Which hepatitis virus? ___________
3. Have you ever been tested for HIV? □Yes □No
4. Have you had a TB test? □Yes □No If yes □Positive or □Negative
5. Are you now or have you ever been an IV drug user? □ Yes □ No
6. Do you smoke? □ Yes □ No □ Yes, but I quit

   (If Yes) Packs per day __________ for __________years.

   (If you quit) How long did you smoke? Years _____ Months _____
7. Are you pregnant? □ Yes □ No
8. In the last 10 years have you been in a substance abuse treatment program: □ Yes □ No

   How many? __________# of months since last discharge_____________
9. Have you been arrested in the last 30 days for non-drug/alcohol reasons: YES or NO

If yes, explain:

10. Have you had an OWI in the last 12 months (including current charges): YES or NO
11. Have you had any other alcohol/drug related legal issues in the last 12 months: YES or NO

I have answered these questions to the best of my knowledge.

Signature: _____________________________________ Date: __________________________

Witness: ________________________________________Date: __________________________

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## ACKNOWLEDGEMENT OF RECEIPT OF PROVIDER'S NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I acknowledge that I have received a copy of or have been offered a copy of the Notice of Privacy Practices that summarizes the ways my identifiable health information may be used and disclosed by this provider, and also states my rights with respect to my medical information. I understand that this provider has the right to revise and to amend the Notice of Privacy Practices. I have been informed that in the event this provider revises the Notice of Privacy Practices, a revised Notice of Privacy practices will be posted by my service provider. I may obtain a current notice at any time from my service provider. I also acknowledge that I have received a copy of the Client Rights and Responsibilities/Explanation of Services that details the ways I will be treated, my responsibilities, and an explanation of the services I will receive.

Patient Initials: ______

## CONFIDENTIALITY AGREEMENT

I agree and understand that confidentiality is necessary for me to express myself without fear of disclosure outside the treatment center unless there are circumstances in which it is required that my counselor/therapist is required by Federal, State, or Local laws to disclose.
I agree to keep the confidentiality of others that I may come in contact with while participating in treatment. My discussing their presence of issues would be a breach of confidentiality and could result in my discharge from the program.

Patient Initials: _____

## CONSENT FOR TREATMENT

I hereby give my consent for evaluation/treatment to be administered to by the employee(s) of this service provider. For persons under the age of 18, I give this consent with or without my presence. I understand that if I do not revoke my Consent for Treatment, it will expire automatically one year from the date of signature.

Patient Initials: ______

## INSURANCE INFORMATION

Please provide your Insurance card at your first appointment. I authorize my insurance benefits to be paid directly to my service provider. I understand that I am financially responsible for any balance. I also authorize my service provider to release any information required to process my claims.

Patient Initials: ______

_________________________________________ _________________________

***Client Signature*** ***Date***

_________________________________________ _________________________

***Counselor Signature*** ***Date***

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## CLIENT RIGHTS AND RESPONSIBILITIES/EXPLANATION OF SERVICES

**Counseling is a collaborative process with your therapist/counselor that involves…….**
• Exploring the issues that brought you to therapy.
• Building a trusting relationship with your therapists.
• Deciding upon specific goals and objectives.
• Working toward these goals and objectives
• Evaluating your progress on a regular basis.

**I understand…..**
• That I have chosen to receive treatment services and I may terminate my therapy/counseling at any time, unless ordered by the court.
• That there is no assurance that I will feel better.
• That during the course of my treatment, material may be discussed that is upsetting in nature. This is a part of the therapy/counseling process and may be necessary to resolve my concerns.
• That I may be contacted by my health plan to ensure continuity and quality of therapy/counseling or after the completion of treatment to assess the outcome of treatment.
• That records and information collected during my treatment will be held or released in accordance with Federal and State laws regarding confidentiality of such records and information.
• That State and Local laws require that my therapist report all cases where there exists a danger to self or others.
• That there may be other circumstances in which the law requires my therapist/counselor to disclose confidential information.

**I have the right…….**
• To be treated with dignity, consideration, and respect at all times.
• To expect quality service provided by concerned, trained, professional and competent employees.
• To expect complete confidentiality within the limits of the law and to be informed about the legal exceptions to confidentiality and to expect that no information will be released without the client's knowledge and written consent.
• To appropriate information regarding employee education, training, skills, license, and practice limitations and to request and receive referrals to other clinicians when appropriate.
• To be a collaborative partner with my therapist/counselor in the development of treatment plans and goals.
• To obtain information about case records and to have this information explained clearly and directly.
• To request information and/or consultation regarding the conduct and progress of services.
• To refuse any recommended services and to be advised of the consequences of this action.
• To a safe environment free of emotional, physical, and sexual abuse.
• To a client grievance procedure, including requests for consultation and/or mediation and to file a complaint with a supervisor and/or the appropriate credentialing body.
• To make an informed decision about whether to accept or refuse treatment.
• To contact and consult with counsel at my expense.
• To a clearly defined ending process and to discontinue services at any time.

**I am responsible for…….**
• Being on time for my appointments.
• To cancel appointments that I am unable to keep within 24 hours or there will be a $30 No-Show Fee
• Contacting my therapist to confirm my appointment on days when the weather is inclement.

______________________________ _________________________
Client Signature Date

______________________________ _________________________
Witness Signature Date

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**The Alcohol Use Disorders Identification Test: Self-Report Version**

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

| Questions | 0 | 1 | 2 | 3 | 4 | |
|---|---|---|---|---|---|---|
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week | |
| How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more | |
| How often do you have six or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |
| | | | | | Total | |

Patient Initials: _________

For Internal Use Only

Interpretation: ___________________________

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# DAST-10 Questionnaire

Here is a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

| **These questions refer to the past 12 months.** | No | Yes |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons? | 0 | 1 |
| 2. Do you abuse more than one drug at a time? | 0 | 1 |
| 3. Are you always able to stop using drugs when you want to? (If never use drugs, answer “Yes.” | 1 | 0 |
| 4. Have you had "blackouts" or "flashbacks" as a result of drug use? | 0 | 1 |
| 5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose “No.” | 0 | 1 |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | 0 | 1 |
| 7. Have you neglected your family because of your use of drugs? | 0 | 1 |
| 8. Have you engaged in illegal activities to obtain drugs? | 0 | 1 |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | 0 | 1 |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? | 0 | 1 |
| Total | | |

Patient Initials: ______

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Interpretation: ___________________________

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**OWI-321J**

## CONSENT TO RELEASE ALCOHOL AND DRUG ABUSE INFORMATION

**I authorize:** New Leaf Mental Health and Wellness Center

5925 Council St. NE Suite 117

Cedar Rapids, Iowa, 52402

**To release the information specified below to:**

**Iowa Department of Transportation**

**Motor Vehicle Division, Park Fair Mall**

**100 East Euclid Avenue**

**Des Moines, Iowa 40309-9204**

| **Information to be released:** | **Yes** | **No** |
|---|---|---|
| Screening/Evaluation Recommendation | ☒ | ☐ |
| Treatment Completion | ☒ | ☐ |

**The only purpose(s) for the disclosure of the above information is:**

☒ To facilitate compliance regarding OWI (321j) and DOT requirements.

☒ Other (Specify) ______Department of Education_____

I voluntarily allow the release of the above-named information. No threat or other coercive measures have induced me to sign this consent form. I understand that this information will not be forwarded to anyone else by the recipient without my written consent. I have been informed concerning current federal confidentiality regulations regarding alcohol and drug abuse patient records.

This authorization is effective for one year after the date it is signed or until _________________ (specify date, event, or condition upon which this consent expires).

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken on the basis of this release. Disclosure of information can be verbal, electronic, or written.

_______________________________________________

Patient signature Date

_______________________________________________

Witness signature Date

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# ATTORNEY OR CLERK OF COURT

## Authorization to release confidential information

Patient's Name: ______________________ Date of Birth: ____________________

Previous Name: ______________________ SSN: ____________________

I request and authorize:

**New Leaf Mental Health and Wellness Center**

Attorney Name or County: ______________________________________________

Address: ______________________________________________

City: ____________________ State: ________ Zip Code: __________

**I give consent for New Leaf Mental Health and Wellness Center to release/receive the following information:**

| | | | |
|---|---|---|---|
| x | Evaluation results and recommendations | x | Status |
| x | Billing and diagnosis information | x | Discharge summary |
| x | Aftercare plan | | Other (Specify): |

**The Purpose of this release is: Please select a box below**

| | | | |
|---|---|---|---|
| | Family/concerned person input | | Transition of care to another facility |
| | Court or probation contact | | Discharge summary |
| | Employer contact | | Attorney contact |
| | Information for personal physician | | Other (specify): |

**Conditions under which this release expires:** This release is in effect for one year from the time it is signed and dated or until: ______________________________________________

**I may revoke this release by writing that request.**

**Notice to persons receiving/releasing this information:** Federal regulation state, "this information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosures of it without the specific written consent from the person to whom this information pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose

Patient Signature: ________________________________ Date Signed: ________________

Witness: ________________________________ Date Signed: ________________

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# E-Therapy Agreement

E-Therapy as provided by New Leaf Mental Health and Wellness Center is subject to all regulations, laws, liabilities, and limitations as face-to-face counseling and therapy. Additionally, e-Therapy has additional limitations and advantages for which New Leaf Mental Health and Wellness Center will not be held responsible. Namely, that the client prior to receiving therapy via electronic means has provided written consent to e-Therapy as agreed upon by the client and the New Leaf Mental Health and Wellness Center clinical director. This may include but is not limited to email exchanges, telephone calls, video conferencing, or other electronic means.

Each client will be screened for suitability and not all clients will receive the same contact methods. As an example, while one client may be doing well and be able to receive services via periodic telephone calls, another client may be required to attend a video conference so the counselor can observe the clients affect during treatment. Under no circumstances will New Leaf Mental Health and Wellness Center be held responsible for lack of connectivity by the client such as loss of cell phone, unpaid telephone bill, or insufficient bandwidth on an internet connection. No refunds for missed appointments or dropped connections during a session will be provided. Furthermore, it is entirely the client's responsibility to provide confidentiality at their location at the time of contact regardless of electronic means used.

Patient: ________________________________________ Date: ________________________

Witness: _______________________________________ Date: ________________________