Adult

Saratoga Center for the Family
Client Information Sheet

Preferred Name: ____ Date of Intake_________________

Legal Name: ____ Gender Identity: _______________

Date of Birth: ________________________________County of Residence: __________________________

Address:____

Telephone (home) _____________________(work)___________________(cell)______________________

May we leave messages at these numbers? (Y/N) (home) _______ (work) ________ (cell) _____

Emergency contact name and number:

____

Email address____

Current Marital Status: ____________________

Employment: Full Time _______ Part Time _____ Unemployed ______

Occupation: ____

Employer: ____

Primary Care Doctor: ____Phone: _____________________

Grade or highest education level completed: ___________________

Ethnicity: ❑ Caucasian/White ❑ African-American ❑ Asian

❑ Hispanic/Latino ❑ Native American ❑ Other: ________________

Yearly Household Income:
❑ $0-9,999 ❑ $10,000-14,999 ❑ $15,000-24,999

❑ $25,000-34,999 ❑ $35,000-49,999 ❑ $50,000 and up

Who referred you/how did you find out about us?
❑ Social Services ❑ Court ❑ Primary Care Doctor ❑ Saratoga County Mental Health

❑ Other: ____

Office Use Only
❑PA ❑SA ❑DV ❑BEH
❑Other
Service:

Adult

Saratoga Center for the Family

Insurance/Payment Information

Client name: ____ Date: __________________

Client date of birth: _______________________________________

Primary care physician: ___________________________________ Phone: __________________

Does the client have health insurance? ___ yes ___ no. *If yes*, complete below. *If no*, speak to the receptionist about our Financial Assistance Program.

Insurance company: ____

Insurance member number: ____

Group number: ____

Name of policy holder: ________________________________ Relationship: _________________

Policy holder date of birth: ____

Policy holder place of employment: _________________________________

I authorize release of any medical or other information to my insurance company as necessary to obtain payment in compliance with the Health Insurance Privacy and Portability Act (1996). I also authorize payment of benefits directly to Saratoga Center for the Family.

Signature: ____ Date: ______________

Relationship to insured: ____

Please notify us and complete a new form if your insurance changes in any way.

Office use only:
Above insurance changed on date: ____________
New form completed on date: _______________

Adult

Authorization to Release Information

Saratoga Center for the Family 359 Ballston Avenue Saratoga Springs, NY 12866 518-587-8008 (phone) **518-587-8241 (fax)**

A. Identifying information about me/the client:
Client Name: ____ Client DOB: ___________________
Client Address: ____ Client Phone: __________________
Parent/guardian of Client (if applicable): ____

B. Primary Care Doctor Name: ____
Doctor's Address: ____
Doctor's Phone: ____ Doctor's Fax: ______________

C. I hereby authorize the source named above to exchange information as indicated in the marked boxes below:

- ☐ Inpatient or outpatient treatment records, evaluations for physical, psychological, psychiatric illness or substance abuse
- ☐ Court orders and legal status reports
- ☐ Treatment plans, recovery plans, aftercare plans, admission and discharge summaries.
- ☐ Academic or educational records.
- ☐ Do not release HIV-related information
- ☐ Do not release drug and alcohol information
- ☐ Information relevant to treatment planning
- ☐ Other ____

D. I authorize the source named above to speak by telephone with the therapist identified in part L, below, about information that can assist with me/the client receiving treatment or being evaluated or referred elsewhere. I give my permission to release/obtain information from any staff member at the aforementioned listed agency as necessary to coordinate services.

E. I understand that no services will be denied me/the client solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the client. The information disclosed may be used in connection with my/the client's treatment.

F. *This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282),* ***which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations.***

G. In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

H. Authorization is in effect until revoked in writing, unless otherwise specified: ____________________________

I. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

J. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

K. Signatures:

______________________________ ______________________________ ____________________
___ client ___parent ___guardian ___representative Printed name Date

______________________________ ______________________________ ____________________
Clients under age 18 offered opportunity to sign Printed name Date

L. I have discussed the issues above with the client and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

______________________________ ______________________________ ____________________
Signature of professional Printed name Date

(Please Check One): ❑ Copy given for client or parent/guardian ❑ Client or parent/guardian refused copy *(revised 11/1/12 CJD)*

Client Name:_________________________ **Date of Birth:**_________________________

HAS THE CLIENT HAD? (Mark Y/N)	Yes	N0	HAS THE CLIENT HAD? (Mark Y/N)	Yes	N0
Recurrent Headache			Epilepsy		
Eye Problem			Seizures		
Ear Problem			Dizziness		
Nose Problem			Fainting with exercise		
Throat Problem			Head Injury		
Thyroid Disorder			Concussion		
Heart Murmur			Bone Injuries		
Heart Disease			Joint Injuries		
Heart Palpitations			Stomach Problems		
High Blood Pressure			Intestinal Problems		
Low Blood Pressure			Diabetes		
Anemia			Eating Disorder		
Sickle Cell			ADD		
Bleeding Disorders: Hemophilia/Other			ADHD		
Hepatitis			Chicken Pox Vaccine		
Kidney Disorders			Chicken Pox Illness		
Bladder Disorders			Mononucleosis		
Pneumonia			Alcohol Abuse		
Bronchitis			Drug Abuse		
Tuberculosis			Sexual Assault		
Seasonal Allergies/Hay Fever			Victim of Violence		
Asthma			Emotional Problems-Specify below:		
Surgeries:					
Hospitalizations:					

If you wish to provide further details about any of the above, please use this space: ______________________________

____

List any medications to which the client is allergic:

____

In general, would you say the client's health is: ☐ Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Does the client get 20 to 30 minutes of exercise at least three times a week? ☐Yes ☐ No

Is the client at a healthy weight as recommended by his/her physician? ☐ Yes ☐ No

You may be answering the following for yourself or, if your child is the client, completing this on his/her behalf. Please base the answers upon what has been experienced in the past month:

	STRONGLY AGREE	*AGREE*	*DISAGREE*	*STRONGLY DISAGREE*
1. The client feels good about him/herself	___	___	___	___
2. The client can deal with his/her problems.	___	___	___	___
3. The client accomplishes the things he/she want	___	___	___	___
4. The client has friends/family that he/she can count on.	___	___	___	___

WARNING: This is privileged and confidential client information. Any unauthorized disclosure is a federal offense. Not to be duplicated. Please handle, store, and dispose of properly. Permission to send these records to you has been given to the Center in writing by the concerned client or his or her guardian. You do not have the legal right to share these records with any other person, agency, organization, or program unless you first obtain written permission to do so from the subject of these records or his or her guardian.

Adult

If an Adult client, please complete the following section. Again, please base the answers upon what has been experienced in the past month:

How much did the following problems bother you?	***Not at All***	***A Little***	***Somewhat***	***A Lot***
1. Nervousness or shakiness	___	___	___	___
2. Feeling sad or blue	___	___	___	___
3. Feeling hopeless about the future	___	___	___	___
4. Feeling everything is an effort	___	___	___	___
5. Feeling no interest in things	___	___	___	___
6. Your heart pounding or racing	___	___	___	___
7. Trouble sleeping	___	___	___	___
8. Feeling fearful or afraid	___	___	___	___
9. Difficulty at home	___	___	___	___
10. Difficulty socially	___	___	___	___
11. Difficulty at work or school	___	___	___	___

If the client is a Child (under age 18), the parent or guardian completes this section about the child. Again, please base the answers upon what has been experienced in the past month:

What best describes the child?	***Never***	***Sometimes***	***Often***
1. Destroyed property	___	___	___
2. Was unhappy or sad	___	___	___
3. Behavior caused school problems	___	___	___
4. Had temper outbursts	___	___	___
5. Worrying prevented him/her from doing things	___	___	___
6. Felt worthless or inferior	___	___	___
7. Had trouble sleeping	___	___	___
8. Changed moods quickly	___	___	___
9. Used alcohol or drugs	___	___	___
10. Was restless, trouble staying seated	___	___	___
11. Engaged in repetitious behavior	___	___	___
12. Needed constant attention	___	___	___

How much have your child's problems caused…?	***Not at All***	***A Little***	***Somewhat***	***A Lot***
1. Interruption of personal time	___	___	___	___
2. Disruption of family routines	___	___	___	___
3. Less attention paid to any family member	___	___	___	___
4. Disruption or upset of relationships within the family	___	___	___	___
5. Disruption or upset of family's social activities	___	___	___	___

Were there any concerns during the mother's pregnancy or the delivery? If "YES", please explain:

____

____

Were developmental milestones met on time? If "NO", please explain:

____

____

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Adult

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ________________________ **Age:** ___ **Sex:** ❑ **Male** ❑ **Female Date:**____________

If this questionnaire is completed by an informant, **what is your relationship with the individual?** ___________________
In a typical week, approximately how much time do you spend with the individual?__________________ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
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	
IV.	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	

Satisfaction with Life Scale

Client Name______________________________ DOB:_____________ Date____________

Below are five statements that you may agree or disagree with. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7- Strongly agree
- 6-Agree
- 5-Slightly agree
- 4-Neither agree nor disagree
- 3- Slightly disagree
- 2-Disagree
- 1-Strongly disagree

______ In most ways my life is close to my ideal.

______ The conditions of my life are excellent.

______ I am satisfied with my life.

______ So far I have gotten the important things I want in life.

_______If I could live my life over, I would change almost nothing.

______ Total

Scoring
- 31-35 Extremely satisfied
- 26-30 Satisfied
- 21-25 Slightly satisfied
- 20 Neutral
- 15-19 Slightly dissatisfied
- 10-14 Dissatisfied
- 5-9 Extremely dissatisfied

The Satisfaction with Life Scale (SWL) Instrument Author: Pavot, W., & Diener, E.
Cite instrument as: Pavot, W., & Diener, E.. (2013) .The Satisfaction with Life Scale (SWL) . Measurement Instrument Database for the Social Science. Retrieved from www.midss.ie

Adult

Score:

TRS

Name

T R A U M A   R E C O V E R Y S C A L E

PART I

___yes___no   I have been exposed to a traumatic event in which ***both*** of the following were present:

a. experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, ***AND***

b. my response involved intense fear, helplessness or horror.

- If **yes** is answered please complete Part II & III;
- If **no** is answered complete Part III (omit Part II)

PART II

Directions: Please read the following list and check all that apply.

	Type Of Traumatic Event	Number of Times	Dates/Age(s)		
# 1.	Childhood Sexual Abuse	_____	_____	_____	_____
# 2.	Rape	_____	_____	_____	_____
# 3.	Other Adult Sexual Assault/Abuse	_____	_____	_____	_____
# 4.	Natural Disaster	_____	_____	_____	_____
# 5.	Industrial Disaster	_____	_____	_____	_____
# 6.	Motor Vehicle Accident	_____	_____	_____	_____
# 7	Combat Trauma	_____	_____	_____	_____
# 8.	Witnessing Traumatic Event	_____	_____	_____	_____
# 9.	Childhood Physical Abuse	_____	_____	_____	_____
# 10.	Adult Physical Abuse	_____	_____	_____	_____
# 11.	Victim Of Other Violent Crime	_____	_____	_____	_____
# 12.	Captivity	_____	_____	_____	_____
# 13.	Torture	_____	_____	_____	_____
# 14.	Domestic Violence	_____	_____	_____	_____
# 15.	Sexual Harassment	_____	_____	_____	_____
# 16.	Threat of physical violence	_____	_____	_____	_____
# 17.	Accidental physical injury	_____	_____	_____	_____
# 18.	Humiliation	_____	_____	_____	_____
# 19.	Property Loss	_____	_____	_____	_____
# 20.	Death Of Loved One	_____	_____	_____	_____
# 21.	Other:__________________	_____	_____	_____	_____
# 23.	Other:__________________	_____	_____	_____	_____
# 24.	Other:__________________	_____	_____	_____	_____
# 25.	Other:__________________	_____	_____	_____	_____

Comments: ____

____

____

____

____

TRS T R A U M A R E C O V E R Y S C A L E J. Eric Gentry

PART III

Place a mark on the line that best represents your experiences during the past week.

1. I make it through the day without distressing recollections of past events.

0% 100% of the time

2. I sleep free from nightmares.

0% 100% of the time

3. I am able to stay in control when I think of difficult memories.

0% 100% of the time

4. I do the things that I used to avoid (e.g., daily activities, social activities, thoughts of events and people connected with past events).

0% 100% of the time

5. I am safe.

0% 100% of the time

I feel safe.

0% 100% of the time

6. I have supportive relationships in my life.

0% 100% of the time

7. I find that I can now safely feel a full range of emotions.

0% 100% of the time

8. I can allow things to happen in my surroundings without needing to control them.

0% 100% of the time

9. I am able to concentrate on thoughts of my choice.

0% 100% of the time

10. I have a sense of hope about the future.

Adult

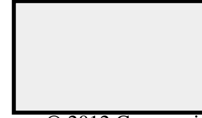
0% ____ 100% of the time

AS – FS

Scoring Instructions: record the score for where the hash mark falls on the line (0-100) in the box beside the item (average 5a with 5b to get score for 5). Sum scores and divide by 10.

Interpretation: 100 – 95 (full recovery/subclinical); 86 - 94 (significant recovery/mild symptoms); 75 – 85 (some recovery/ moderate symptoms); 74 (minimal recovery/severe); below 35 (probable traumatic regression)

Mean Score



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