THE FAMILY CONNECTION™
CHANGING MENTAL HEALTH

Participant Information

Name _____Treatment Start Date _____

Address _____ City _____ State ____ Zip _____

Home/Cell Phone _____ Work Phone _____

Birth date _____Age_____ SSN _____ Marital Status _____

Primary Insurance Provider _____ Insurance ID # _____

Primary Insured Name: _____ Primary Insured DOB _____

Primary Insured SSN _____ Secondary Insurance Provider _____

Secondary Insurance ID # _____ Secondary Insured Name _____

Secondary Insured DOB _____ Secondary Insured SSN _____

Are you presently under a physician's care? YES NO

If yes, for what? _____

Physician's name _____Psychiatrist's name_____

Were you referred to this agency? YES NO

If yes, by whom_____

Do you have a Psychiatric Advance Directive (PAD)? YES NO

If yes would you be willing to provide us a copy for your record? YES NO

If No, would you like us to provide you information on a PAD? YES NO

Medication (s) and dosage (current) _____

_____

Have you received prior counseling? YES NO

If yes, was it: OUTPATIENT INPATIENT

When _____ Where _____

By whom _____ Length of treatment _____

Problem(s) treated _____

Outcome: ☐ Very Successful ☐ Somewhat Successful ☐ Stayed the same ☐ Somewhat Worse ☐ Much Worse

Form Completed By: _____

Emergency Contact:

Name _____ Relationship _____

Address _____

Home/Cell Phone _____ Work Phone _____

Please see back

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Please check any of reasons listed below which resulted in you seeking services

- ❍ Depression
- ❍ Anxiety
- ❍ Issues w/partner
- ❍ Communication Difficulties
- ❍ Relationship enhancement
- ❍ Parent/Child conflict
- ❍ Identity issues
- ❍ Court-ordered for: _____
- ❍ Gambling
- ❍ Personal Growth
- ❍ Medical: _____
- ❍ Alcohol or substance use
- ❍ Difficulty with loss or death
- ❍ Problems at school/work
- ❍ Issues w/Family
- ❍ Trauma/Abuse
- ❍ Child Behavior/Acting Out
- ❍ Divorce
- ❍ Legal problems
- ❍ Parenting
- ❍ Skills Acquisition
- ❍ Other: _____

As you think about the primary reason that brings you here, how would you rate its frequency and your over-all level of concern at this point in time (note: a problem may occur rarely but be of serious concern, or occur frequently, but be of little concern)?

Concern	**Frequency**
❍ No concern	❍ No occurrence
❍ Little concern	❍ Occurs rarely
❍ Moderate concern	❍ Occurs sometimes
❍ Serious concern	❍ Occurs frequently
❍ Very serious concern	❍ Occurs nearly always

On a scale of 0 to 10, how **IMPORTANT** is it for you right now to change?

Not confident at all 0___1___2___3___4___5___6___7___8___9___10 Extremely Confident

On a scale of 0 to 10, how **CONFIDENT** are you that you could make this change?

Not confident at all 0___1___2___3___4___5___6___7___8___9___10 Extremely Confident

On a scale of 0 to 10, how **READY** are you to make this change?

Not confident at all 0___1___2___3___4___5___6___7___8___9___10 Extremely Confident

This form has been completed to the best of my abilities and I attest that the information contained herein in accurate.

X _____ _____

Client/Parent/Guardian Signature Date

WWW.NMFamilyConnection.com
(505) 717-1155

Patient Name _____ DOB _____

Clients' Rights and Responsibilities

- You have a **right** to receive information about The Family Connection, LLC services, therapists, treatment guidelines and your rights and responsibilities.
- You have a **right** to be treated with dignity and respect.
- You have a **right** to privacy and confidentiality. I understand that during couple's session's confidentiality goes to the couple unit.
- You have a **right** to participate with your therapist in making decisions about your treatment planning.
- You have a **right** to access supports outside of your counseling appointments, such as the use of 911 in emergencies or the 24/7 NM Crisis & Access Line at 1-855-662-7474, a free and confidential support service
- You have a **right** to voice complaints about The Family Connection and/or the care provided to you.
- You have a **right** to make recommendations regarding these "Clients' Rights and Responsibilities".
- You have a **responsibility** to provide, to the extent possible, information that The Family Connection, LLC and its therapists need in order to care for you.
- You have a **responsibility** to follow the plans and instructions that you have agreed upon with your therapist.
- You have a **responsibility** to participate, as much as possible, in understanding your behavioral health problems and developing mutually agreed-upon treatment goals.
- You have a **responsibility** to cancel your appointments with a minimum of 24-hour notice.
- You have a **responsibility** to notify and work with your therapist regarding any concerns of safety to yourself or others, including following through on agreed upon safety contracts.

Signature_____ Date_____

Signature_____ Date_____

Behavioral Health Release of Medical Information for Care Coordination with PCP

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name (if applicable):_____ Relationship to patient: _____

The current health care system is complicated. When patients get care, they may interact with any number of providers across multiple settings and if health care providers don't coordinate with each other, the consequences can be harmful to the patient. As a community provider we aspire to ensure that you get the best quality care, which includes providing you the opportunity to allow your care to be coordinated with your primary care provider. Please complete the form below to advise us what information, if any, you would like shared with your primary care provider.

❑ **I DO NOT authorize** information about my physical/behavioral health treatment to be released

❑ **I authorize** The Family Connection, LLC to use and disclose the protected health information as indicated below:

- o All health records related to drug/alcohol/substance abuse
- o All health records related to emotional/mental/developmental disabilities/psychiatric conditions **(excludes psychotherapy notes)**
- o Other: _____

Release of medical information from/to The Family Connection LLC to/from my:

Primary Care Physician: _____
Address: _____
Phone: _____ Fax: _____

I understand that this medical information may be used to coordinate my care.
I understand that I may cancel this authorization, in writing, at any time. I understand that my health care providers may have already released records according to this authorization prior to receiving my notice of cancellation. I understand that this will remain in effect until the end of treatment unless a date of expiration is indicated here: _____

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that this information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative **Date**

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Symptom Distress Scale

Not needed for children under 12

During the last seven (7) days, about how much were you distressed or bothered by:

	Not At All	A Little Bit A	Moderately	Quite A Bit	Extremely
a. Nervousness or shakiness inside……..	1	2	3	4	5
b. Being suddenly scared for no reason……..	1	2	3	4	5
c. Feeling fearful……	1	2	3	4	5
d. Feeling tense or keyed up……	1	2	3	4	5
e. Spells of terror of panic……	1	2	3	4	5
f. Feeling so restless you couldn't sit still……	1	2	3	4	5
g. Heavy feeling in arms or legs……	1	2	3	4	5
h. Feeling afraid to go out of your home alone……	1	2	3	4	5
i. Feeling worthless……	1	2	3	4	5
j. Feeling lonely even when you are with people…	1	2	3	4	5
k. Feeling weak in parts of your body……	1	2	3	4	5
l. Feeling blue……..	1	2	3	4	5
m. Feeling lonely……..	1	2	3	4	5
n. Feeling no interest in things……	1	2	3	4	5
o. Feeling afraid in open spaces or on the street……	1	2	3	4	5
ADD ALL COLUMNS					
				TOTAL (min: 15, max:	

Client Name DOB SS# Date

Scored By Title Date Scored

For Office Use Only:
Scoring: Items rated 3 or higher are considered to indicate serious distress. A total summed score of 25 or above indicated moderate distress; Scores of 33 or above indicate severe distress that requires immediate intervention.

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Name: DOB:

Adult Depression Screening Form

Zung Depression Self-Rating Scale ©

INSTRUCTIONS: Please fill in one response for each of the 20 statements below based upon how you have been feeling over the past two weeks or longer. Then, please respond to the free-standing statement after item 20.

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time	Item Rating
1. I feel downhearted, blue, and sad.	○ 1	○ 2	○ 3	○ 4	
2. Morning is when I feel best.	○ 4	○ 3	○ 2	○ 1	
3. I have crying spells or feel like it.	○ 1	○ 2	○ 3	○ 4	
4. I have trouble sleeping through the night.	○ 1	○ 2	○ 3	○ 4	
5. I eat as much as I used to.	○ 4	○ 3	○ 2	○ 1	
6. I enjoy looking at, talking to, and being with attractive women/men.	○ 4	○ 3	○ 2	○ 1	
7. I notice that I am losing weight.	○ 1	○ 2	○ 3	○ 4	
8. I have trouble with constipation.	○ 1	○ 2	○ 3	○ 4	
9. My heart beats faster than usual.	○ 1	○ 2	○ 3	○ 4	
10. I get tired for no reason.	○ 1	○ 2	○ 3	○ 4	
11. My mind is as clear as it used to be.	○ 4	○ 3	○ 2	○ 1	
12. I find it easy to do the things I used to do.	○ 4	○ 3	○ 2	○ 1	
13. I am restless and can't keep still.	○ 1	○ 2	○ 3	○ 4	
14. I feel hopeful about the future.	○ 4	○ 3	○ 2	○ 1	
15. I am more irritable than usual.	○ 1	○ 2	○ 3	○ 4	
16. I find it easy to make decisions.	○ 4	○ 3	○ 2	○ 1	
17. I feel that I am useful and needed.	○ 4	○ 3	○ 2	○ 1	
18. My life is pretty full.	○ 4	○ 3	○ 2	○ 1	
19. I feel that others would be better off if I were dead.	○ 1	○ 2	○ 3	○ 4	
20. I still enjoy the things I used to do.	○ 4	○ 3	○ 2	○ 1	
				RAW SCORE	
				SDS INDEX	

Patient Signature

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time
I have recently thought of, or am currently thinking of, suicide.	○	○	○	○