



EnSite: Counseling Program

Client Information

Last Name	First	Middle	<input type="checkbox"/> Mr	<input type="checkbox"/> Miss
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former Name)			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Birth date / /	Age
			Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address:				
P.O. Box	City	State	Zip Code	
Social Security No.		Home Phone No. ()	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cell Phone No. ()	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you referred? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who referred you?	
Occupation				
Employer or School name			Employer Phone No. ()	
Have you previously been seen at EnSite? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, When?		
Is this appointment for a DUI? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many?			
Please list others in your household:				

IN CASE OF EMERGENCY

Name of a local friend or relative (not living at same address):	Relationship:	Phone No.: ()
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The above information is true to the best of my knowledge:

Signature: _____



EnSite: Counseling Program

Health Status Questionnaire

Name of Client _____ Age _____ Gender _____

Height _____ Weight _____

How would you describe your overall health? (Please circle one) Excellent Good Fair Poor

Medical Conditions or Complications:

Do you have a history or currently suffer with any of the following conditions or complications?

- | | | |
|-------------------------|---------|--------|
| A. Tuberculosis (TB) | Yes ___ | No ___ |
| B. Hepatitis | Yes ___ | No ___ |
| C. Cirrhosis | Yes ___ | No ___ |
| D. Pancreatitis | Yes ___ | No ___ |
| E. HIV/AIDS | Yes ___ | No ___ |
| F. Heart Disease | Yes ___ | No ___ |
| G. Circulatory Problems | Yes ___ | No ___ |
| H. Hypertension | Yes ___ | No ___ |
| I. Diabetes | Yes ___ | No ___ |
| J. Seizures | Yes ___ | No ___ |

Are you currently experiencing any of the following physical symptoms?

- | | | |
|---------------------------------|---------|--------|
| A. Insomnia | Yes ___ | No ___ |
| B. Tiredness | Yes ___ | No ___ |
| C. Weight gain or loss | Yes ___ | No ___ |
| D. Pain | Yes ___ | No ___ |
| E. Headaches | Yes ___ | No ___ |
| F. Dizziness or Lightheadedness | Yes ___ | No ___ |
| G. Numbness or tingling | Yes ___ | No ___ |
| H. Vomiting | Yes ___ | No ___ |
| I. Rapid heart beat | Yes ___ | No ___ |
| J. Dry mouth | Yes ___ | No ___ |
| K. Excessive sleep | Yes ___ | No ___ |
| L. Loss of memory | Yes ___ | No ___ |
| M. Eating problems | Yes ___ | No ___ |
| N. Constipation | Yes ___ | No ___ |
| O. Other _____ | | |



EnSite: Counseling Program

Health How often have you experienced the following physical, mental, or emotional states in the past year:	Never	Rarely	Occasional	Regularly	Constantly
Presence of physical pain (neck/back, arms, legs etc.)	1	2	3	4	5
Feelings of tension, stiffness, lack of flexibility	1	2	3	4	5
Incidence of fatigue or low energy	1	2	3	4	5
Incidence of headaches	1	2	3	4	5
Incidence of allergies, eczema or skin rash	1	2	3	4	5
Incidence of accident or near accidents, falling, or tripping	1	2	3	4	5
Stress related pain	1	2	3	4	5
Difficulty with sleep (falling asleep, staying asleep)	1	2	3	4	5
Experience depression or lack of interest	1	2	3	4	5
Difficulty concentrating, indecisiveness, restlessness	1	2	3	4	5
Difficulty adjusting to changes in your life	1	2	3	4	5

Stress	None	Little	Some	A Lot	Extreme
How much stress does your general state of being cause you?	1	2	3	4	5
How much stress do your family, loved ones, significant others and friends cause you?	1	2	3	4	5
How much stress does your job cause you?	1	2	3	4	5
How much stress does unemployment or inability to work cause you?	1	2	3	4	5
How much stress do legal issues cause you?	1	2	3	4	5
How often do you experience relaxation, ease and feelings of well-being?	1	2	3	4	5

Have you been hospitalized during the past year? Yes____ No____

If you answered "yes" then please explain: _____

EnSite: Counseling Program

Do you see a doctor or other primary health care professional?

If so, what is the name of that person(s)

Are you prescribed any medication(s)

If you answered yes, please fill in the following:

Medication: _____

Daily Doseage: _____

Taken For: _____

Prescribed By: _____

How long have you been taking this medication?

Have you ever abused this medication?

Taken For: _____

Prescribed By: _____

How long have you been taking this medication?

Have you ever abused this medication?

Taken For: _____

Prescribed By: _____

How long have you been taking this medication?

Have you ever abused this medication?

Do you currently, or have you in the past been under the care of a psychiatrist?

If you answered "yes" then please explain:

Do you currently, or in the past, see a substance abuse of mental health counselor or therapist?

If you answered "yes" then please explain:



EnSite: Counseling Program

Life History Questionnaire (All files are held in strict confidence)

Referred By: _____ Date: _____ Court Case: _____

First Name: _____ MI: _____ Last Name: _____ Maiden: _____

Highest Grade Level Achieved: _____ Currently Employed: _____ Other Info: _____
Elementary Middle High College

Please read the following questions and mark those to which you would respond "yes."

<input type="checkbox"/>	Have you previously been involved in counseling?
<input type="checkbox"/>	Do you currently use alcohol or other non-prescription drugs?
<input type="checkbox"/>	Is there a history of mental health problems in your family?
<input type="checkbox"/>	Have you ever been physically abused?
<input type="checkbox"/>	Have you ever been emotionally abused?
<input type="checkbox"/>	Are your concerns interfering with your academic performance?
<input type="checkbox"/>	Have you ever attempted suicide?
<input type="checkbox"/>	Have you ever been hospitalized for mental health reasons?
<input type="checkbox"/>	Is there a history of alcohol or drug problems in your family?
<input type="checkbox"/>	Have you ever been in legal trouble?
<input type="checkbox"/>	Have you ever been sexually abused or assaulted?
<input type="checkbox"/>	Are you currently taking any prescription medication?
<input type="checkbox"/>	Are your concerns interfering with your ability to stay in school?

Please describe the concerns that you would like to discuss:

How long has this problem persisted?	Under what condition do your problems get worse? Better?
--------------------------------------	--

If in a relationship/married/cohabitating, please describe the relationship.

**Life History Questionnaire
Continued, Page 2**

Please use the following scale to answer the next three questions:		1	2	3	4
		Not at all	Mildly	Moderately	Highly
1. How serious do you consider your present concern(s)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How motivated are you to resolve your concern(s)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How optimistic are you that your concern(s) can be resolved?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family History	Mother's Age: _____	If deceased, how old were you when she died?			
	Father's Age: _____	If deceased, how old were you when he died?			
	If your parents are seperated, how old were you then?				
	Number of brother(s): _____	Age(s): _____			
	Number of sister(s): _____	Age(s): _____			
If you were adopted or raised with parents other than your natural parents please explain:					
Briefly describe your mother's personality:			Briefly describe your father's personality:		
Briefly describe your stepparent(s) personality:					
Briefly describe your past and current relationship with your:					
Mother:			Father:		
Stepmother:			Stepfather:		
Religious Affiliation:	<input type="checkbox"/>	Jewish	<input type="checkbox"/>	None, but I believe in God	
	<input type="checkbox"/>	Catholic	<input type="checkbox"/>	Atheist or agnostic	
	<input type="checkbox"/>	Christian:	<input type="checkbox"/>	Other:	
Is there a history of abuse or are you currently at risk for abuse?					

EnSite: Counseling Program

Life History Questionnaire

Continued, Page 3

Please mark all of the following that apply			
Feelings		Thoughts	
<input type="checkbox"/>	Helpless	<input type="checkbox"/>	Anxious
<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Out of Control
<input type="checkbox"/>	Shameful	<input type="checkbox"/>	Afraid
<input type="checkbox"/>	Angry	<input type="checkbox"/>	Numb
<input type="checkbox"/>	Guilty	<input type="checkbox"/>	Relaxed
<input type="checkbox"/>	Hopeless	<input type="checkbox"/>	Happy
<input type="checkbox"/>	Lonely	<input type="checkbox"/>	Excited
<input type="checkbox"/>	Sad	<input type="checkbox"/>	Hopeful
<input type="checkbox"/>	Stressed	<input type="checkbox"/>	Inferiority Feeling
<input type="checkbox"/>	Unhappy	<input type="checkbox"/>	Mood Shifts
<input type="checkbox"/>	Other		
<input type="checkbox"/>		<input type="checkbox"/>	confused
<input type="checkbox"/>		<input type="checkbox"/>	Unintelligent
<input type="checkbox"/>		<input type="checkbox"/>	Worthless
<input type="checkbox"/>		<input type="checkbox"/>	Unmotivated
<input type="checkbox"/>		<input type="checkbox"/>	Unattractive
<input type="checkbox"/>		<input type="checkbox"/>	Unlovable
<input type="checkbox"/>		<input type="checkbox"/>	Confident
<input type="checkbox"/>		<input type="checkbox"/>	Worthwhile
<input type="checkbox"/>		<input type="checkbox"/>	Homicidal
<input type="checkbox"/>		<input type="checkbox"/>	Other
<input type="checkbox"/>		<input type="checkbox"/>	Racing
<input type="checkbox"/>		<input type="checkbox"/>	Obsessive
<input type="checkbox"/>		<input type="checkbox"/>	Distracted
<input type="checkbox"/>		<input type="checkbox"/>	Disorganized
<input type="checkbox"/>		<input type="checkbox"/>	Paranoid
<input type="checkbox"/>		<input type="checkbox"/>	Suicidal
<input type="checkbox"/>		<input type="checkbox"/>	Sensitive
<input type="checkbox"/>		<input type="checkbox"/>	Honest
Symptoms/Behaviors			
<input type="checkbox"/>	Eating Less	<input type="checkbox"/>	Acting Out Sexually
<input type="checkbox"/>	Procrastinating	<input type="checkbox"/>	Acting Aggressively
<input type="checkbox"/>	Attempting Suicide	<input type="checkbox"/>	Disorganization
<input type="checkbox"/>	Poor Concentration	<input type="checkbox"/>	Impulsivity
<input type="checkbox"/>	Crying	<input type="checkbox"/>	Recklessness
<input type="checkbox"/>	Withdrawing Socially	<input type="checkbox"/>	Intitability
<input type="checkbox"/>	Skiping Classes	<input type="checkbox"/>	Passivity
<input type="checkbox"/>	Binge Drinking	<input type="checkbox"/>	Drug Use
<input type="checkbox"/>	Injuring Self	<input type="checkbox"/>	Alcohol Use
<input type="checkbox"/>	Compulsivity	<input type="checkbox"/>	Being Good to Yourself
<input type="checkbox"/>	Career/Major Choice	<input type="checkbox"/>	Sexual Problems
<input type="checkbox"/>		<input type="checkbox"/>	Socializing
<input type="checkbox"/>		<input type="checkbox"/>	Marital Relationships
<input type="checkbox"/>		<input type="checkbox"/>	Parent/Child Conflicts
<input type="checkbox"/>		<input type="checkbox"/>	Lack of Ambition/Goals
<input type="checkbox"/>		<input type="checkbox"/>	Poor Peer Relationships
<input type="checkbox"/>		<input type="checkbox"/>	Night Mares
<input type="checkbox"/>		<input type="checkbox"/>	Worries About Body Image
<input type="checkbox"/>		<input type="checkbox"/>	Spiritual Problems
<input type="checkbox"/>		<input type="checkbox"/>	Dating Concerns
<input type="checkbox"/>		<input type="checkbox"/>	Finances
<input type="checkbox"/>		<input type="checkbox"/>	Other
Physical Symptoms		Please describe any family history of substance abuse or mental illness:	
<input type="checkbox"/>	Insomnia		
<input type="checkbox"/>	Tired		
<input type="checkbox"/>	Weight Gain or Loss		
<input type="checkbox"/>	Pain		
<input type="checkbox"/>	Headaches		
<input type="checkbox"/>	Tightness in Chest		
<input type="checkbox"/>	Dizziness or Light-headedness		
<input type="checkbox"/>	Numbness or Tingling		
<input type="checkbox"/>	Vomiting		
<input type="checkbox"/>	Rapid Heart Beat		
<input type="checkbox"/>	Dry Mouth		
<input type="checkbox"/>	Excessive Sleep		
<input type="checkbox"/>	Loss Of Memory		
<input type="checkbox"/>	Eating Problems		
<input type="checkbox"/>	Other:		
		Please describe your current and past use of alcohol and/or drugs:	

Effective Date: _____

Notice of privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This notice describes how health information about you (as a client at EnSite) may be used and disclosed and how you can get access to your individually identifiable health information.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practices concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all time, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact EnSite 270-443-1201

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment:** Our practice may use your PHI to treat you.
2. **Payment:** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us.
3. **Health care operations:** Our practice may use and disclose your PHI to operate our business.
4. **Optional Appointment reminders:** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Optional Treatment options:** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Disclosures required by law:** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. Use and disclosure of your PHI in certain circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public health risks:** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
 - Maintaining vital records, such as births and deaths,
 - Reporting child abuse or neglect,
 - Preventing or controlling disease, injury, or disability,
 - Notifying a person regarding potential exposure to a communicable disease,
 - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
 - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
2. **Health oversight activities:** Our practice may disclose your PHI to a health oversight agency for activities authorized by law.
3. **Lawsuits and similar proceedings:** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law enforcement:** We may release PHI if asked to do so by law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
 - Concerning a death we believe has resulted from criminal conduct.
 - Regarding criminal conduct at our offices.
 - In response to a warrant, summons, court order, subpoena, or similar legal process.
 - To identify/locate a suspect, material witness, fugitive, or missing person.
 - In an emergency, to report a crime (including the location or victims(s) of the crime, or the description, identity or location of the perpetrator).
5. **Serious threats to health or safety:** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
6. **Military:** Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
7. **National Security:** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by

6. **Military:** Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
7. **National Security:** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
2. **Requesting restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to EnSite. Your request must describe in a clear concise fashion:
 - The information you wish restricted.
 - Whether you are requesting to limit our practice's use, disclosure or both.
 - To whom you want the limits to apply.
3. **Inspection and copies:** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing record, but not including psychotherapy notes. You must submit your request in writing to EnSite in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request and amendment for as long as the information is kept by or for our practice. To request and amendment, your request must be made in writing and submitted to EnSite. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Right to a paper copy of this notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact EnSite.
6. **Right to file a complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact EnSite. All complaints may be submitted in writing. **You will not be penalized for filing a complaint.**
7. **Right to provide and authorization for other uses and disclosures:** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. *After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.*

I hereby acknowledge that I have received the opportunity to ask questions concerning this Notice of Privacy Practices:

Signature or Patient or Representative

Date

Witness

Date



EnSite: Counseling Program

CLIENT RIGHTS AND RESPONSIBILITIES STATEMENT

It is the policy of this center to provide services to individuals in an effective and efficient manner. Services will be directed toward the individual's health and habilitation and will be provided in the least restrictive setting possible.

An individual receiving services has the following rights:

1. To receive a Notice of Privacy Practices.
2. To not be unlawfully discriminated against in determining eligibility for services.
3. To be treated with consideration and respect for human dignity.
4. To receive quality treatment regardless of race, gender, religion, ethnic background, disability, age, or ability to pay.
5. To give informed consent to treatment and be involved in planning your treatment.
6. To receive individualized treatment, be informed about your treatment process, and review your treatment plan.
7. To obtain one free copy of your records upon written request except as limited by law.
8. To refuse treatment to the extent permitted by law and to be informed about the possible consequences of your actions.
9. To be involved in your discharge and aftercare planning.
10. To be provided confidentiality and protection from any unauthorized disclosure regarding your treatment.
11. To examine and receive an explanation of fees for services.
12. To submit grievances, opinions, and recommendations about the program or the services received through the internal grievance procedure of this center, the Center Ombudsman, if any, or the Cabinet for Health Services Ombudsman.

As an individual receiving service you have the following responsibilities:

1. To arrive on time, attend, and participate in all treatment sessions.
2. To cancel any sessions you are unable to attend.
3. To make up any session you missed.
4. To be alcohol and drug free for all sessions you attend with the understanding that if you arrive under the influence of alcohol and/or drugs appropriate steps will be taken by the center staff to ensure your safety and the safety of others.
5. To refrain from wearing any clothing with drugs or alcohol advertisements.
6. To actively work on your treatment plan goals.
7. To pay for all services with the understanding that if you fail to pay for services received your completed paperwork will not be forwarded to the appropriate agencies and non-payment may result in a report of non-compliance with the court.
8. To protect the confidentiality of all participants in the program.
9. To follow through with all your treatment recommendations.

Client Signature:

Date:

Clinician Signature:

Date:



EnSite: Counseling Program

Education/Treatment Agreement

Client Name: _____

Client ID/SS Number: _____

Agency Name: **EnSite, LLC**

You have selected the above agency/center to provide services at the level of care identified by your assessment. The following provides you with a schedule of times and fees for that service.

_____ Substance Abuse Assessment and Psychosocial

Fee for this service: \$85.00

_____ Group Outpatient Substance Abuse Treatment

Fee for this service: \$20 weekly

_____ Individual Outpatient Substance Abuse Treatment

Fee for this service: \$50.00

_____ DUI Assessment

Fee for this service: \$50.00

_____ DUI 20-hour PRI Program

Fee for this service: \$215 (Includes book)

_____ Anger Management/Domestic Violence Assessment

Fee for this service: \$50.00

_____ Group Anger Management/Domestic Violence

Fee for this service: \$20 weekly

_____ Individual Anger management/Domestic Violence

Fee for this service: \$40

_____ Marijuana Education Class

Fee for this service: \$70.00

I fully understand the schedule of services and fees required for my participation in the identified program.

I agree to pay all fees in full and maintain regular attendance until the completion of my program.

I understand that failure to complete the program or pay the fees assigned will result in a report of non-compliance being sent to the court by this center and may result in a bench warrant being issued by the court.

Signature of Client: _____

Date: _____

Signature of Clinician: _____

Date: _____



EnSite: Counseling Program

Name of Client: _____ Date: _____

Client ID No.: _____

Freedom of Choice Form: My signature on this form indicates that I understand that I have the right to choose the service provider of my choice whether or not I have been assessed at EnSite, LLC. I further understand that I have the right to contact other providers prior to selection of my provider so that I may determine the best provider to service my needs. I also understand that I may at any time choose another provider for this service by notifying my current provider.

Confidentiality Agreement: My signature on this form indicates that I am fully aware that I am prohibited from discussion of treatment and personal issues of others that I may accompany in treatment groups or education classes at this facility. My signature on this form also indicates that I will not use any type of recording device to record individuals in the group or education settings. Further, I will not disclose the names or positions of individuals I see at the facility who may or may not accompany me in group or education class. My signature is indication that failure to abide by this agreement shall be grounds to be found "non-compliant" in treatment or education and will be reported to the appropriate authorities.

Random Screen Consent: The undersigned consents that EnSite, LLC has the right to ask for and conduct random drug/alcohol screenings at my expense.

- a. As part of my treatment plan.
- b. If I am suspected of being under the influence of any mind or mood altering substances while at the center.

I understand that I may revoke this consent at any time, however, if I do revoke my consent, EnSite, has the right to suspend services to me. I further understand that any revocation of this consent must be in writing.

Acceptance of Assessment: I confirm that I have participated in and received the results of my DV or AM assessment and I have been identified as needing the following level of care:

- | | |
|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 20- Hour Education | <input type="checkbox"/> Outpatient Treatment |
| <input type="checkbox"/> Intensive Outpatient Treatment
Detoxification | <input type="checkbox"/> Residential/Inpatient Treatment |

I acknowledge I have been given and HIV/AIDS awareness pamphlet

Signature: _____ Date: _____

Witness: _____ Date: _____

EnSite: Substance Abuse Counseling
Authorization for Release of Clinical/Treatment Information

Client Name: _____ Date of Birth: _____

Dates of Treatment/Assessment (if known) _____ Social Security # _____

The undersigned hereby authorizes the release of information from the medical record of the above named individual. This information may be released by mail, fax, telephone, or in person.

From: _____

To: Mona Hoyle, MS, CADC
611 Broadway
Paducah, Kentucky 42001
Phone 270-443-1201

From: Mona Hoyle, MS, CADC
611 Broadway
Paducah, Kentucky, 42001
Phone 270-443-1201

To: _____

The specific information to be released: (I understand the information released may include psychiatric, psychological, clinical treatment or assessment and drug and alcohol information).

Assessment and/or Discharge Summary
 History of Physical Exam
 Consults
 Entire Medical Record
 Correspondence
 Other (be specific) _____

Physician Notes
 TB Skin Test
 Lab _____

Purpose of Release:

Insurance Claims
 Placement
 Notification of Appointments
 Other: _____

Aftercare
 Facilitation of Treatment
 Legal Purposes

I understand that this authorization for release is subject to revocation at any time in the form of written notification from me except to the extent that action has been taken in reliance thereof. The release will expire, unless otherwise specified, in 1 year after the date it is signed.

Client Signature _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____

Signature of Witness _____ Date _____

AMP

Instructions:

You are completing this inventory to give the staff information that will help them understand your situation and needs.

The statements are numbered and each one should be answered. Do not skip any!

Do not give false information. Your records may be used to check the information you provide.

First, fill in the information at the top of your answer sheet. Then starting with statement one answer every item.

Section 1

The following statements must be answered True or False. If a statement is True, put an X under T for True on your answer sheet. If a statement is False, put an X under F for False. All statements must be answered.

1. There are times when I get frustrated and angry.
2. Most of my friends drink beer, wine, or liquor.
3. I often act impulsively, without a lot of thought.
4. Many of my friends smoke marijuana (pot).
5. Sometimes I get angry and upset when others criticize me.
6. I am a social drinker.
7. People tell me I am an annoying and irritating person.
8. When offered drugs I may or may not use them. It depends on how I feel.
9. Sometimes when people say I am angry I am only irritated or annoyed.
10. It bothers me when I am overlooked or ignored by someone I know
11. People have told me I drink too much.
12. When angry I am usually verbally abusive.
13. I have used drugs more than I should.
14. I have said and done things when angry that I later regretted
15. I have lied to people about my drinking - either minimizing how much I drink or hiding the fact that I drink at all.
16. People tell me I am overly aggressive.
17. Within the last year I have used drugs to relax and feel good.
18. Sometimes I get annoyed and upset at myself.
19. I have been told I have a drinking problem.
20. It takes a lot to provoke or anger me.
21. There have been times when I have felt guilty about my use of drugs.
22. There have been times when I have done something wrong and was not caught.
23. Within the past year my family has been concerned about my drinking.
24. When frustrated I am touchy, irritable, and ill-tempered.
25. I am concerned about my drug use.
26. There are times when I am discouraged and unhappy.
27. To be honest, I am concerned about my drinking.
28. My temper has threatened my happiness.
29. I use and sometimes abuse drugs.
30. There are times when I really worry about myself and my happiness
31. I have admitted to a family member that I have a drinking problem.

Continued on next page

32. I am easily annoyed or irritated.
33. My use of drugs has caused family and social problems for me.
34. I have gotten very upset and angry at a close relative or friend.
35. A close family member asked me to get help for my drinking problem.
36. I get into a lot of heated arguments because I speak my mind.
37. A family member has asked me to get help for my drug problem.
38. People tell me I have a quick temper and a bad attitude.
39. I regret some of the things I have said or done in anger.
40. I need assistance or help to overcome my drinking problem.
41. I have been arrested or incurred legal problems because of my anger.
42. I have lied about my use of drugs, either minimizing how much I really use or hiding the fact that I use drugs at all.
43. Sometimes I worry about what people think or say about me.
44. Drinking has gotten in the way of my happiness and success in life.
45. Two or more of the following apply to me (answer true or false on your answer sheet):
- a. Aggressive and unrestrained
 - b. Forceful and intimidating
 - c. Outspoken and quick tempered
 - d. Quarrelsome and argumentative
 - e. Angry and explosive
46. In the past year using drugs have been a problem for me.
47. I do not always tell the whole truth when asked about my finances or personal life.
48. I admit I have a drinking or alcohol-related problem.
49. My family and friends have expressed concern about my anger.
50. My use of drugs has threatened my happiness and success in life
51. There are times when I worry about my responsibilities and future.
52. To be honest, I have asked for help for my drinking problem.
53. When angered I shout and swear a lot.
54. I have attended Narcotic's Anonymous (NA) or Cocain Anonymous (CA) meetings for my drug problem
55. There are times when I am really down, depressed and discouraged.
56. I have attended Alcoholic's Anonymous (AA) meetings for help with my drinking.
57. I have lost a valued relationship because of my anger.
58. I admit I have a drug problem.
59. When dealing with adversity and misfortune I keep any feelings and emotions under control.
60. There have been times when I have been jealous of other people's happiness and success
61. I often think about revenge and how I can get even.
62. My drinking is more than just a little or minor problem.
63. After losing control I say I will never do it again, but always do.
64. I have gone to someone for help with my drug problem.

Continued on next page

65. When I am really angry I get in the other person's face and say things to hurt them.

66. I have been in chemical dependency treatment before my drinking problem.

67. When angry I often "fly off the handle" and lash out at others.

68. I have had treatment in a chemical dependency program for my drug problem.

69. I have hurt others (e.g. verbally abusive, cursing, or hitting) when I was angry.

70. I am an alcoholic.

71. I have a quick temper and need to learn how to control it.

72. I have been embarrassed at work or school about mistakes I have made.

73. Sometimes I get so angry I can't control myself.

74. I have been embarrassed and uneasy about some of the things I have done.

75. When frustrated, insulted or angered I can be dangerous.

76. There are times when I am concerned that others may think badly of me.

77. There have been times when I have strongly disliked someone.

78. I need help to control my drinking.

79. I am dependent on drugs and may be addicted to them.

80. To be honest, I am an angry person.

81. I become irritated and annoyed when someone lectures me about my anger.

82. I am presently in counseling or treatment for my drug problem.

83. My temper has threatened my relationships with people that are close to me.

84. I have been embarrassed and worried about some of the things I have said and done when I was angry.

85. I am a drug addict.

86. I have a drinking problem.

Section 2

Rate yourself by selecting the number that describes you best. Use one of the following for your answer.

1. Rare or Never	3. Often
2. Sometimes	4. Very often or always

87. Exercise/physical activity

88. Emotionally upset/crying

89. Positive attitude/outlook

90. Quick temper/tantrums

91. Depressed/discouraged

92. Satisfied with self/like self

93. Angry/hostile with others

94. Financially stable/responsible

95. Lonely/unhappy

96. Drinking/alcohol abuse

97. Effectively handle stress

98. Nervous/unable to relax

99. Share my thoughts comfortably

100. Feel inadequate/inferior

101. Anger/explosive/rage

102. Patient/tolerant/understanding

103. Tension/stress/anxiety

104. difficulty with others/friction

105. Dissatisfied with life

106. Explosive/loft of control

107. Directly deal with problems

108. Annoying/irritating

109. Drug abuse/get high

110. Enthusiastic/involved in life

Continued on next page

Section 3

Answer the following statements to describe yourself. Put an X on your answer sheet under the number (1, 2, 3, or 4) that applies to you.

111. How would you describe your temper?

1. A serious problem
2. A moderate problem
3. A slight or minor problem
4. Not a problem

112. How would you describe your anger?

1. A serious problem
2. A moderate problem
3. A slight or minor problem
4. Not a problem

113. How would you describe your drinking?

1. A serious problem
2. A moderate problem
3. A slight or minor problem
4. Not a problem

114. How would you describe your use of drugs?

1. A serious problem
2. A moderate problem
3. A slight or minor problem
4. Not a problem

115. Recovering means having a substance (alcohol or drugs) abuse problem but not drinking or abusing drugs anymore. I am a recovering:

1. Alcoholic
2. Drug Abuser
3. Both 1 and 2
4. None of the above

116. How would you describe your desire to get or continue in an anger management program?

1. I want and need help
2. I need help
3. I am not sure
4. There is no need

117. How would you describe your desire to get or continue in alcohol treatment?

1. I want and need help
2. I need help
3. I am not sure
4. There is no need

118. How would you describe your desire to get or continue in drug treatment?

1. I want and need help
2. I need help
3. I am not sure
4. There is no need

119. How would you describe your desire to get or continue in counseling/therapy (individual or group) for your anger problem?

1. I want and need help
2. I need help
3. I am not sure
4. There is no need

120. Rate your temper on a scale from 1 to 10. One represents a "serious temper problem" and ten represents "no temper problem."

1. Rating 1 or 2 (serious problem)
2. Rating 3 to 5 (occasional problem)
3. Rating 6 to 8 (slight problem)
4. Rating 9 or 10 (no problem)

121. Rate your anger on a scale from 1 to 10. One represents a "severe problem" and ten represents "no problem."

1. Rating 1 or 2 (severe problem)
2. Rating 3 to 5 (occasional problem)
3. Rating 6 to 8 (slight problem)
4. Rating 9 or 10 (no problem)

122. Rate your alcohol abuse on a scale from 1 to 10. One represents a "severe problem" and ten represents "no problem."

1. Rating 1 or 2 (severe problem)
2. Rating 3 to 5 (occasional problem)
3. Rating 6 to 8 (slight problem)
4. Rating 9 or 10 (no problem)

123. Rate your drug abuse on a scale from 1 to 10. One represents a "severe problem" and ten represents "no problem."

1. Rating 1 or 2 (severe problem)
2. Rating 3 to 5 (occasional problem)
3. Rating 6 to 8 (slight problem)
4. Rating 9 or 10 (no problem)

**Check to be sure you answered all the statements. Turn in your inventory booklet and answer sheet to your testing supervisor.
Thanks for your cooperation!**

AAMP

Answer Sheet

Name:									
Last 4 Digits of Your SSN:									
Ethnicity (Race):									
Education (Highest grade completed):									
Marital Status:									
Date of Birth:									
Today's Date:									

Accurately complete the following information. Number is referred to as # and the time frame is within the last 10 years.

1. # of drug-related (DUI/DWI) arrests: _____

2. # of alcohol-related (not DUI/DWI) arrests: _____

3. # of assault arrests: _____

4. # of domestic violence arrests: _____

5. # of "anger management programs attended: _____

Section 1

Answer the following statements True or False. If a statement is True put an X under T for True. If a statement is False put an X under F for False.

	T	F	T	F	T	F	T	F
1.			23.		45.		67.	
2.			24.		46.		68.	
3.			25.		47.		69.	
4.			26.		48.		70.	
5.			27.		49.		71.	
6.			28.		50.		72.	
7.			29.		51.		73.	
8.			30.		52.		74.	
9.			31.		53.		75.	
10.			32.		54.		76.	
11.			33.		55.		77.	
12.			34.		56.		78.	
13.			35.		57.		79.	
14.			36.		58.		80.	
15.			37.		59.		81.	
16.			38.		60.		82.	
17.			39.		61.		83.	
18.			40.		62.		84.	
19.			41.		63.		85.	
20.			42.		64.		86.	
21.			43.		65.			
22.			44.		66.			

Section 2					Section 3				
Rate yourself by selecting the number that describes you best.									
Use one of the following for your answer.									
1. Rare or Never		3. Often							
2. Sometimes		4. Very Often or Always							
Put an X on your answer sheet under the number (1, 2, 3, or 4) that applies to you.					Put an X on your answer sheet under the number (1, 2, 3, or 4) that applies to you.				
	1	2	3	4		1	2	3	4
87.					111.				
88.					112.				
89.					113.				
90.					114.				
91.					115.				
92.					116.				
93.					117.				
94.					118.				
95.					119.				
96.					120.				
97.					121.				
98.					122.				
99.					123.				
100.									
101.									
102.									
103.									
104.									
105.									
106.									
107.									
108.									
109.									
110.									

Check to be sure you answered all the statements.
 Turn in your inventory booklet and answer sheet to your
 testing supervisor.

Thanks for your cooperation!