# ADULT REGISTRATION FORM

**Please complete all information on this form. If you need help, please speak to one of our Staff.**

**Last Name:** ______________ **First Name:** ______________ **Middle:** ______________

**Preferred Name/Nickname:** ______________

**Age:** ______ **Birth Date:** ______________ **Sex:** __________ **SS#:** ______________

**Referred by:** ______________ **Referral Phone:** ______________

**Address:** ______________ **Apt #:** ______ **Phone: Home:** ______________

**City/State/Zip:** ______________ **Work:** ______________

**Email:** ______________ **Contact Preference:** __________ **Cell:** ______________

**Primary Language:** ______________ **Religious Preference:** ______________

**Race:** ☐White ☐Black ☐Asian ☐American Indian ☐Alaskan Native ☐Native Hawaiian ☐Pacific Islander ☐Multi-Racial

**Ethnicity:** **(check one)** ☐Puerto Rican ☐Mexican ☐Cuban ☐Other Hispanic ☐Haitian ☐Mexican American ☐Spanish/Latino ☐None of the Above

**Marital Status:** ☐Never Married ☐Married ☐Widowed ☐Divorced ☐Separated ☐Domestic Partner ☐Legally Separated

**Employment Status:** ☐Active Military ☐Full Time ☐FT Self-Employ ☐Part Time ☐PT Self-Employ ☐Unemployed ☐Disabled ☐Retired ☐Student ☐Homemaker ☐Leave of Absence ☐Criminal Inmate ☐Not Authorized to Work

**Highest School Grade Completed:** ______________

**Have you ever been known by another name or former alias:** ☐ No ☐ Yes **Name:** ______________

**Do you have a case plan with the court system or Eckerd Community Alternatives:** ☐ Yes ☐ No

**Residential Status:** ☐Independent Living Alone ☐Independent Living-with Relatives ☐Independent Living-with Non-Relatives ☐Dependent Living-w/Relatives ☐Dependent Living-w/Non-Relatives ☐Homeless ☐Group Home ☐Jail ☐Assisted Living Facility ☐Mental Health Institute ☐Nursing Home ☐Supported Housing ☐Foster Care ☐DJJ Facility ☐Crisis Residence ☐Children Residential Treatment ☐Limited MH Licensed ALF ☐Other

**Number in Household:** ______ **Have you ever received services here before?** ☐ No ☐ Yes

**Veteran:** ☐ Yes ☐ No **If so, when:** ______________

## IDENTIFY DISABILITY FACTORS:

Developmental Disabilities: ☐ Yes ☐ No
Non- Ambulatory: ☐ Yes ☐ No
Deaf or Hard-of-Hearing: ☐ Yes ☐ No
English Language Severely Limited: ☐ Yes ☐ No
Physically Impaired: ☐ Yes ☐ No
Visually Impaired: ☐ Yes ☐ No
ADL Functioning: ☐ Yes ☐ No
(Inability to perform independently day-to-day living)

**What auxiliary aids, services, or assistance do you need to help you communicate with us?** ______________

______________

EMERGENCY CONTACT

**Name:** ______________ **Phone: Home:** ______________

**Address:** ______________ **Apt #:** ______ **Work:** ______________

**City/State/Zip:** ______________ **Relation:** ______________

**Legal Guardian:** ☐ Yes ☐ No

**Client Name:** ______________ **Client #:** ______________

## MEDICAL BENEFITS

Medicaid #: ____________________ Medicare#: ____________________

Do you have any other insurance? (Other than Medicaid/Medicare) ☐ Yes ☐ No Name: ____________________

I authorize the release of any medical information necessary to process this or a related claim to:

____________________ Date: ____________________

Insurance Company Name and Address

I authorize payment of benefits to Directions for Living.

____________________ Date: ____________________

Signature

## MEDICAL INFORMATION

Primary Care Physician: ____________________ Phone #: ____________________

Other Treating Physician: ____________________ Phone #: ____________________

Pain Management Specialist: ____________________ Phone #: ____________________

Preferred Pharmacy: ____________________ Phone #: ____________________

Pharmacy Location: ____________________

## SERVICE AUTHORIZATION / CONSENT TO TREAT / CONSENT T0 PARTICIPATE

**My signature below certifies that:**

1) **I give permission to staff of Directions for Living to render mental health/substance abuse treatment and/or prevention services to the person named below.**
2) **I have received a copy of the Client Handbook which includes information regarding:**
   - **Organizational Mission**
   - **Emergency Procedures**
   - **Client Rights and Responsibilities**
   - **Infectious Disease Control**
   - **Notice of Privacy Practices**
   - **Hours of Operation**
   - **Treatment Services**
   - **Grievance Procedures**
   - **HIV/AIDS Education**
   - **Advance Directive**
3) **I have received the HIV/AIDS education information and understand that I may ask for further information regarding testing and other services at any time.**
4) **I understand that I may be contacted about my services at Directions for Living during or after services for quality improvement purposes.**
5) **I understand that Directions may be required to submit statistical and demographic information such as my age, social security number and/or income to certain local, state and/or federal agencies in order to provide my services. I also understand that I may ask for more specific information regarding this at any time.**
6) **I am providing this consent to treatment and/or prevention services voluntarily and understand that I have the right to withdraw my consent at any time.**

____________________
**Print Client Name**

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

____________________ ____________________ ____________________
**Guardian Signature (if applicable)** **Date** **Relation to Client**

____________________ ____________________
**Witness** **Date**

# PERSONAL SAFETY PLAN / MENTAL HEALTH ADVANCE DIRECTIVE

**Client Name: _______________________________________ Today's Date: ___________________**

**It is your right to make decisions about your own health care, and we want to follow your wishes especially if you are in crisis and not be able to tell us what you want. More importantly, your recovery is Directions' top priority and we want to help you prevent a crisis before it starts.**

**A Personal Safety Plan or Mental Health Advance Directive is one way you can let your treatment team know in advance how you would like us to respond if you should begin to feel worse.**

**We hope this form can give us a better sense of how to help you. Please take a minute to answer the following questions. If you have questions about filling this out, please ask any one on your treatment team. If you'd like, you can take this form home and bring it back at your next appointment.**

1. Some of the warning signs that I am not feeling well are when I:
   ☐ Am Sad ☐ Am Angry / Irritable ☐ Have No Energy ☐ Isolate ☐ Drink / Use Drugs
   ☐ Sleep Too Little/Too Much ☐ Don't take care of myself physically ☐ Eat too much / too little
   ☐ Other: ________________________________________________________

2. Some things that may cause me to become very distressed are:
   ☐ Problems with friends or other people ☐ Financial Issues ☐ Getting sick ☐ Family Problems
   ☐ Problems where I live ☐ Problems with my job or school
   ☐ Other: ________________________________________________________

3. Some of the things that help me to cope when I am distressed are:
   ☐ Talking it Out ☐ Quiet Place ☐ Exercise ☐ Being with friends/family members
   ☐ Spiritual Beliefs ☐ Hobbies
   ☐ Other: ________________________________________________________

4. If I have to go to the hospital, I prefer to go to:
   ☐ Suncoast Hospital / Largo Medical Center ☐ PEMHS ☐ St. Anthony's
   ☐ Community Hospital ☐ Windmoor ☐ Morton Plant Hospital
   ☐ Other: ________________________________________________________
   *Please note: We cannot guarantee that you will be sent to your preferred hospital.*

5. If I am in a crisis, what can Directions do to help you?
   ☐ Counseling ☐ Hospitalization ☐ Medication ☐ Contact family / friends
   ☐ Other: ________________________________________________________

| Who is available to help you if you are in a crisis or begin to feel badly, such as a family member, friend, or case manager? (Please include name and phone number.) | May we contact them on your behalf? |
|---|---|
| ____________________________________________ | ☐ Yes ☐ No |
| ____________________________________________ | ☐ Yes ☐ No |
| ____________________________________________ | ☐ Yes ☐ No |

________________________________________ ________________

Client Signature Date

## Finding Your ACE Score

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   **or**
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ________

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   **or**
   **Ever** hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   **or**
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 ________

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   **or**
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ________

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ________

7. Was your mother or stepmother:
   **Often or very often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 ________

10. Did a household member go to prison?
    Yes No If yes enter 1 ________

**Now add up your "Yes" answers: _______ This is your ACE Score.**

092406RA4CR Client Name: Client Number:

Name _____________________________________________ ENGLISH
Date ________________________________

**Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)**
**Self-Administered Form**

**Directions**: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

Filling out this form assists us in identifying your needs and providing you with services. Your answers on this form will not exclude you from services, care or treatment at this program.

During the last 6 months…

| | Yes | No |
|---|---|---|
| 1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)<br>-----------------------------------------------------------------------------------------<br>1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan) | <br>-----------<br> | <br>----------<br> |
| 2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.) | | |
| 3. Have you tried to cut down or quit drinking or using alcohol or other drugs? | | |
| 4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) | | |

5. Have you had any health problems? Please check if you have:
 ___ Had blackouts or other periods of memory loss?
 ___ Injured your head after drinking or using drugs?
 ___ Had convulsions, delirium tremens ("DTs")?
 ___ Had hepatitis or other liver problems?
 ___ Felt sick, shaky, or depressed when you stopped?
 ___ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
 ___ Been injured after drinking or using?
 ___ Used needles to shoot drugs?

**Please continue ⇒**

Name ____________________________________________ ENGLISH
Date ________________________________

Modified Simple Screening Instrument for Substance Abuse (continued)

| | Yes | No |
|---|---|---|
| 6. Has drinking or other drug use caused problems between you and your family or friends? | | |
| 7. Has your drinking or other drug use caused problems at school or at work? | | |

| | | |
|---|---|---|
| 8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) | | |
| 9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs? | | |
| 10. Are you needing to drink or use drugs more and more to get the effect you want? | | |
| 11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? | | |
| 12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone? | | |
| 13. Do you feel bad or guilty about your drinking or drug use? | | |

**The next questions are about your lifetime experiences.**

| | Yes | No |
|---|---|---|
| 14. Have you ever had a drinking or other drug problem? | | |
| 15. Have any of your family members ever had a drinking or drug problem? | | |
| 16. Do you feel that you have a drinking or drug problem now? | | |

**Thank you for filling out this questionnaire.**

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| **Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?** *(Use "✔" to indicate your answer)* | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING ___0___ + _______ + _______ + _______

=Total Score: _______

**If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| **Not difficult at all** | **Somewhat difficult** | **Very difficult** | **Extremely difficult** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

Client Name: Client Number:

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

# Avatar URICA Stage of Change Assessment

**Client Name:** ____________________

**Client ID:** ____________________

**Assessment Date:** ______________ **Practitioner:** ____________________

| | | 1 Strongly Disagree | 2 Disagree | 3 Undecided | 4 Agree | 5 Strongly Agree |
|---|---|---|---|---|---|---|
| 1. | As far as I'm concerned, I don't have any problems that need changing. | | | | | |
| 2. | I think I might be ready for some self-improvement. | | | | | |
| 3. | I am doing something about the problems that had been bothering me. | | | | | |
| 4. | It might be worthwhile to work on my problem. | | | | | |
| 5. | I'm not the problem one. It doesn't make much sense for me to be here. | | | | | |
| 6. | It worries me that I might slip back on a problem I have already changed, so I am here to seek help. | | | | | |
| 7. | I am finally doing some work on my problem. | | | | | |
| 8. | I've been thinking that I might want to change something about myself. | | | | | |
| 9. | I have been successful in working on my problem but I'm not sure I can keep up the effort on my own. | | | | | |
| 10. | At times my problem is difficult, but I'm working on it. | | | | | |
| 11. | Being here is pretty much a waste of time for me because the problem doesn't have to do with me. | | | | | |
| 12. | I'm hoping this place will help me to better understand myself. | | | | | |
| 13. | I guess I have faults, but there's nothing that I really need to change. | | | | | |
| 14. | I am really working hard to change. | | | | | |
| 15. | I have a problem and I really think I should work at it. | | | | | |
| 16. | I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem. | | | | | |
| 17. | Even though I'm not always successful in changing, I am at least working on my problem. | | | | | |
| 18. | I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it. | | | | | |
| 19. | I wish I had more ideas on how to solve the problem. | | | | | |
| 20. | I have started working on my problems but I would like help. | | | | | |
| 21. | Maybe this place will be able to help me. | | | | | |
| 22. | I may need a boost right now to help me maintain the changes I've already made. | | | | | |
| 23. | I may be part of the problem, but I don't really think I am. | | | | | |
| 24. | I hope someone here will have some good advice for me. | | | | | |
| 25. | Anyone can talk about changing; I'm actually doing something about it. | | | | | |
| 26. | All this talk about psychology is boring. Why can't people just forget about their problems? | | | | | |
| 27. | I'm here to prevent myself from having a relapse of my problem. | | | | | |
| 28. | It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved. | | | | | |
| 29. | I have worries but so does the next guy. Why spend time thinking about them? | | | | | |
| 30. | I am actively working on my problem. | | | | | |
| 31. | I would rather cope with my faults than try to change them. | | | | | |
| 32. | After all I had done to try to change my problem, every now and again it comes back to haunt me. | | | | | |