Intake Date: _____

FOLLMAN COUNSELING AGENCY

910 S. ANACORTES ST., BURLINGTON, WA 98233 TEL: 360-755-1125 FAX: 360-757-1125
EMAIL: FRONTDESK@FOLLMANAGENCY.COM

SUBSTANCE ABUSE DISORDER INTAKE PACKET

Office Use Only:
Program: _____ Group: _____ Start Date: _____

Court/Probation(s): _____

Probation Officer: _____ Case #: _____

Attorney: _____ Deferred Prosecution Date: _____

Patient's Name: _____	Patient's Birthdate: _____
Patient's Street Address: _____	Patient's Cell Phone: _____
City: _____ State: _____ Zip: _____	Patient's Home Phone: _____
Patient's Driver's License Number: _____ Patient's Email Address: _____	Patient's Last 4 of Social Security Number: _____
Name of person with whom you live: _____	Relationship (i.e., wife/parents/friend): _____
Name of person to call in an emergency and their address: Name: _____ Address: _____	Emergency Phone/Cell Number: Home Phone: _____ Cell Phone: _____
Patient's Marital Status: _____	Name of person completing this form (if not patient): _____
Patient's Occupation: _____	Work Phone No: _____
Patient's Work Address: _____	State: _____ Zip: _____
Name of referring or responsible Physician/Clinician: _____	Would you like Follman Agency to communicate to your referring Physician/Clinician? Yes ____ No _____ If Yes, please sign Release of Information
Address of referring or responsible Physician/Clinician: _____	Phone: _____

CLAUSE: ENGROSSED SECOND SUBSTITUTE SENATE BILL (E2SSB) 5763/SECTION 508, 70.96a RCW

Are you under **Department of Correction** supervision in addition to a Municipal, District, or Superior Court order to receive mental health or chemical dependency treatment? Yes ____ No _____

Unless you are expressly excluded by a court order, the law requires treatment providers to share information with the Department of Correction(s) and your mental health treatment provider, when applicable. Upon Intake, Follman Agency will request you sign an authorization form to release records to the DOC and to your mental health treatment provider, unless excluded by a court order.

Please initial you have read the above Clause: _____

FOLLMAN COUNSELING AGENCY

SUBSTANCE ABUSE DISORDER INTAKE PACKET

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Patient's Name:_____Date:_____

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing; or
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency; or
4. The disclosure is made to qualified personnel for research, audit, or program evaluation; or
5. The patient commits or threatens to commit a crime either at the program or against any person who works for the program; or
6. The patient talks about hurting oneself, hurting someone else, child abuse, elderly abuse, or pet abuse

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law regulations do not protect any information about suspected child abuse or neglect from being reported under state or local authorities.

See 42 U.S.C 290dd-3, 290ee-3 for Federal laws and 42 C.F.R. Part 2 for Federal regulations.

_____ _____ _____

Patient's Signature Date Counselor's Signature

OPEN DOOR POLICY: Please check which you prefer:

The insurance provider for Follman Agency requires each counselor to leave his or her office door slightly open during individual sessions, unless otherwise permitted by the patient. Please check one of the following:

___ I prefer door to be closed during my session. ___ I prefer door to remain slightly open during my session.

_____ _____

Patient's Signature Date

PHONE APPOINTMENT REMINDER: Please check Yes or No to leave a message: ___ Yes ___ No

_____ _____

Patient's Signature Date

FOLLMAN COUNSELING AGENCY

SUBSTANCE ABUSE DISORDER INTAKE PACKET

OUTPATIENT TREATMENT CONTRACT

Patient's Name:_____Date:_____

I agree to participate in my recommended treatment program. In addition to my attendance, I understand and agree to the following conditions: (Please Initial each line item)

_____1. Total abstinence from all alcohol, non-alcoholic beer, medicines that include alcohol and/or other drugs including marijuana. In the event I do not abstain, or am unable to abstain, I agree to inform my counselor.

_____2. Completing all court ordered and Department of Licensing requirements mandated by law is my responsibility. Only emergencies are reasons for missing any group or individual sessions. I agree to contact this agency in the event I cannot keep my commitment and make special arrangements for make-up time.

_____3. I understand this agency, by law, must report to my probation officer and the Department of Licensing in Olympia the following conditions:

a) Compliance and progress in treatment
b) Lack of significant progress in treatment
c) Relapses including other drug use
d) and a revised treatment plan, if needed

_____4. I understand this agency has the authority to alter or change a diagnosis or treatment recommendations made by any evaluating agency and that treatment itself is an ongoing evaluation process.

_____5. Submit to random urinalysis (UA) tests to determine drug use/alcohol use at my expense.

_____6. I understand this agency holds the philosophy that meeting my financial obligations and responsibilities are a measure of my progress in treatment. Failure to keep financial obligations is not showing significant progress in treatment and could result in termination unless special conditions with the financial department are met.

_____7. In the event of a medical emergency, and my doctor is not available, I may be given emergency medical treatment by qualified medical/hospital personnel when deemed immediately necessary or advisable by a physician to safeguard my health.

Name of Physician: _____Office:_____Phone:_____
(Name or write None)

The concerned court and the Department of Licensing require you to do at least a minimum prescribed treatment program. This program must be completed as required by law to allow us to sign Department of Licensing forms which require your counselor's signature. This includes progress reporting on all deferred prosecution clients and Adult Probation and parole.

PATIENT'S SIGNATURE:_____DATE:_____

COUNSELOR'S SIGNATURE:_____DATE:_____

PARENT'S/GUARDIAN'S SIGNATURE:_____DATE:_____

FOLLMAN COUNSELING AGENCY

SUBSTANCE ABUSE DISORDER INTAKE PACKET

PROGRAM RULES

1. All persons enrolled in groups or other treatment programs at this agency are expected to maintain total abstinence from alcohol or other drugs while in treatment here. **No one will be allowed in group while under the influence of alcohol or other drugs.

2. You must call and cancel appointments you cannot keep within 24 hours, if possible. Missed appointments are billed at $40.00, which is not covered by insurance.

3. Do not come to group or counseling if you have an infectious disease.

4. No alcohol, other drugs, or weapons, including knives, are allowed in any facility of this agency.

5. You must meet your financial obligations according to the arrangements you set up. Any account past due 30 days will result in suspended service.

6. The Follman Agency is not responsible for lost or stolen articles.

7. Abusive language or behavior that threatens human dignity or physical harm to another client or staff member is grounds for dismissal from treatment.

8. You must respect the confidentiality of other clients. Who you see here and what you hear must not be taken outside of this agency.

9. You must wear appropriate attire to any agency function. Shoes and shirts are mandatory. If you arrive dressed indecently, you will be asked to leave.

10. Alcohol or drugs used by court ordered clients, including Deferred Prosecution, must be reported to the appropriate probation officer.

11. All clients showing current intravenous drug use or dependent on barbiturates or benzodiazepines (Valium, etc.) must be examined by a physician and the results of the examination must be in the client's file no later than 21 days following admission, as per WAC 275-19-165.

12. Effective January, 2010, you are required to answer a Tuberculosis questionnaire at the time of your Intake appointment with the results of this test entered in your treatment records, as per WAC 388-805-325.

13. It is your responsibility and obligation to see that the above conditions are met.

****Problem gambling clients are not required to abstain from alcohol/drug use.**

_____	_____	_____
Patient's Signature	Date	Counselor's Signature

FOLLMAN COUNSELING AGENCY

SUBSTANCE ABUSE DISORDER INTAKE PACKET

PATIENT RIGHTS

You have the right to:

Be admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria.

Be reasonably accommodated in the event of sensory or physical disability, limited to communicate, limited English proficiency, and cultural differences.

Be treated in a manner sensitive to individual needs and which promotes dignity and self-respect.

Be protected from invasion of privacy except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.

Have all clinical and personal information treated in accord with state and federal confidentiality regulations.

Have the opportunity to review the patient's own treatment records in the presence of the agency 's administrator or designee.

Have the opportunity to have clinical contact with a same gender counselor, if requested and determined appropriate by the supervisor, either at the agency or by referral.

Be fully informed regarding fees charged, including fees for copying records to verify treatment and methods of payment available.

Be provided reasonable opportunity to practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. You have the right to refuse participation in any religious practice.

Be allowed necessary communication between a minor and custodial parent or legal guardian; with an attorney; and in an emergency situation.

Be protected from abuse by staff at all times, or from other patients who are on agency premises, including:
- Sexual abuse or harassment;
- Sexual or financial exploitation;
- Racism or racial harassment; and
- Physical abuse or punishment.

Be fully informed and receive a copy of counselor disclosure requirements described under RCW 18.19.060.

Receive a copy of patient grievance procedures upon request.

In the event of an agency's closure or treatment service cancellation, you shall be:
- Given 30 days' notice;
- Assisted with relocation;
- Given refunds to which you are entitled; and
- Advised how to access records to which you are entitled.

This agency shall obtain your consent for the release of information to another person or entity. This consent for the release of information shall include:
- Name of the consenting patient;
- Name of the designation of the provider authorized to make the disclosure;
- Name of the person or organization to whom the information is to be released;
- Nature of the information to be released, as limited as possible;
- Purpose of the disclosure, as specific as possible;
- Specification of the date or event on which consent expires;
- Statement that the consent can be revoked at any time, except to the extent that action has been taken in reliance on it;
- Signature of the patient or parent, guardian, or authorized representative, when required, and the date; and
- A statement prohibiting further disclosure unless expressly permitted by the written consent of the person to whom it pertains.

This agency shall notify you that outside persons or organizations which provide services to the agency are required by written agreement to protect your confidentiality.

If an ADATSA recipient, you have these additional rights to:
- Report back to the department's community service office in case of a disciplinary discharge from the program; and
- Request a fair hearing to challenge any departmental action which affects your eligibility for ADATSA treatment or shelter assistance.

Patient's Signature: _____ Date: _____

FOLLMAN COUNSELING AGENCY
SUBSTANCE ABUSE DISORDER INTAKE PACKET
COUNSELOR DISCLOSURE STATEMENT

Counselors practicing counseling for a fee must be registered with the Department of Licensing or certified by the Department of Health for the protection of the public health and safety. Registration of an individual with the Department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. The following information is required to be provided prior to commencing treatment.

TREATMENT PHILOSOPHY ● Follman Agency provides treatment for behavioral health issues including substance abuse disorders (SUD) and mental health (MH) challenges. In the course of treatment, you may be treated for physiological, emotional, psychological, and spiritual effects of SUD and MH challenges. Our programs require abstinence/harm reduction from alcohol and all other mood-altering drugs while in SUD treatment and it is recommended that drugs not be misused while in MH treatment. Evidence Based Practices (EBP) counseling practices are relied upon because they have shown to produce the most effective outcomes. Reality-Based, Solution-Focused and Cognitive Behavioral Therapies as well as mindfulness, emotion regulation, distress tolerance and interpersonal skills are primary techniques. This is augmented with problem solving methods and assignments geared to helping you work through present day issues. Treatment regimens will include, but are not limited to: individual counseling, group therapy, educational sessions, relapse prevention, and discharge planning. The involvement of the significant others in your life may support and strengthen your recovery and therefore is promoted if it is mutually agreed upon by you and your counselor.

Each person's therapy is individually determined according to his or her treatment goals based on your initial assessment and results of evaluation tools. Our clinical orientation emphasizes the importance of using an integrative approach that takes into account the whole person (bio/psycho/social/spiritual) within the context of their culture and relationships. The length of therapy varies according to the nature of your concerns. It usually takes a few sessions to clarify the focus of treatment and develop a treatment approach that will best fit with your needs and goals.

FEES ● Follman Agency treatment fees and policies are outlined and agreed to in your Treatment Contract.

COUNSELOR EDUCATION AND TRAINING ● Follman Agency is approved by the Department of Social and Health Services, Division of Behavioral Health and Recovery to provide behavioral health treatment. Follman Agency staff have met extensive qualifications as set forth in WAC chapter 246-811.

COUNSELOR INFORMATION ● In the course of your treatment at Follman Agency you may receive counseling from any or all of the following counselors. You have the right to choose counselors who best suit your needs and purpose. Counselor registration numbers and a brief description of their qualifications are listed:

The following counselor(s) provide(s) chemical dependency counseling at **THE FOLLMAN AGENCY**.

Counselor Name: James H. Follman CDP, LMHC, NCAC Reg. No. CP00001856/1036/LH00008388
Jim focuses on treating the whole person in a bio/psych/social model within the context of culture and relationship.

Counselor Name: Tim McManus CDP Reg. No. CP00006976
Tim shows that recovery is much more than just not using and that it can lead to a fulfilling life filled with serenity.

CONFIDENTIALITY ● Conversations between you and any Follman Agency staff member will not be disclosed without your written consent unless such disclosure is required or permitted by law. You will be participating in group therapy and Follman Agency requests that you treat information obtained in the course of your group as confidential within the group itself. It is understood that despite such requests, Follman Agency is unable to ensure the confidentiality of information imparted during such group activities.

If you have any questions about this Counselor Disclosure Information sheet, please feel to ask your counselor.

Patient's Signature: _____ Date: _____ Counselor's Signature: _____

PATIENT DISCLOSURE INFORMATION

FOLLMAN COUNSELING AGENCY 910 S. ANACORTES STREET, BURLINGTON, WA 98233

WAC 246-810-030 Requires counselors to inform patients of the counselor disclosure law

PATIENT'S SIGNATURE: _____ DATE: _____ COUNSELOR'S INITIALS: _____

The purpose of the law regulating counselors is:
To provide protection for public health and safety; and
To empower the client/patient by providing a complaint process against counselors who commit acts of unprofessional conduct.
Patients/clients have the right to choose counselors who best suit their needs and purposes.
The extent of confidentiality provided by RCW 18.19.180(1) through (6). Note: Federal confidentiality regulations supersede every item in RCW 18.19, so following the federal regulations for informing the client/patient of the federal confidentiality regulations satisfies this requirement.
Patients are to be provided a list of copy of the act of unprofessional conduct in RCW 18.130.180 and the following address and telephone number:

Department of Health
Health professions Quality Assurance Division
PO Box 47869
Olympia, WA 98504-7869
(360) 236-4903

UNPROFESSIONAL CONDUCT

Counselors are subject to discipline by the Department of Health. Cause for disciplinary action for unprofessional conduct is found in RCW 18.130.180 and includes the following:
The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW.
Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
All advertising which is false, fraudulent, or misleading;
Incompetence, negligence, or malpractice, which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction. The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substance for oneself.
Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.
Failure to cooperate with the disciplining authority by:
Not furnishing any papers or documents
Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority
Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or
Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder
Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority
Hiding or abetting an unlicensed person to practice when a license is required
Violations of rules established by any health agency
Practice beyond the scope of practice as defined by law or rule
Misrepresentation or fraud in any aspect of the conduct of the business or profession
Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk
Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health
Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service
Conviction of any gross misdemeanor or felony relating to the practice of the person's profession
The procuring, or aiding or abetting in procuring, a criminal abortion
The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority
The willful betrayal of a practitioner-patient privilege as recognized by law
Violation of chapter 19.68 RCW
Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding
Current misuse of alcohol, controlled substances, or Legend drugs
Abuse of a client or patient or sexual contact with a client or patient
Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or series intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

NOTICE OF PRIVACY PRACTICES (Page 1)
FOLLMAN COUNSELING AGENCY 910 S. ANACORTES STREET, BURLINGTON, WA 98233

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

As part of our professional practice, we maintain personal information about you and your health. State and federal law protects such information by limiting its uses and disclosures. **Protected Health Information (PHI)** is information about you, including demographic information, that may identify you or be used to identify you. PHI relates to your past, present, and future physical, mental, or health conditions, the provision of health care, services, or the past, present, and future payment for the provision of health care.

Your Rights Regarding Your PHI

The following are your rights regarding PHI we maintain about you:

- **Right to Access to Inspect and Copy**. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy your PHI that we maintain. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend**. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. We are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request a copy of the required accounting of disclosures we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restricting or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication**. You have the right to request that we communicate with you in a certain way or at a certain location. We will accommodate reasonable requests and will not ask why you are making the request.
- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice.
- **Right of Complaint.** You have the right to file a complaint in writing with us or with the Secretary of Health and Human Services if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

Our Use and Disclosures of PHI for Treatment, Payment, and Health Care Operations

- **Treatment.** We may use your PHI for the purpose of providing you with health care treatment. To coordinate and manage your care, we may disclose your PHI to other current providers, and to the extent you have not raised an objection in writing, to your prior providers or other persons, including family members, involved in your care.
- **Payment.** We may use your PHI in connection with billing statements we send you and our system for tracking charges and credits to your account. In addition, but with your authorization, we may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability, as well as to submit claims for payment and to disclose PHI for medical necessity and quality assurance review.
- **Health Care Operations.** We may use and disclose your PHI for the Health Care Operations of our professional practice in support of the functions of treatment and payments. Such disclosures would be to Business Associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist us in our delivery of your health care.

Other Uses and Disclosures that Do Not Require Your Authorization or Opportunity to Object Required by Law

We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are: public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigations of death. We also make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

- **Health Oversight.** We may disclose your PHI to a health oversight agency for activities authorized by law, such as our professional licensure. Oversight agencies also include government agencies and organizations who audit their provision of financial assistance to us (such as third-party payers.)
- **Threat to Health or Safety.** We may disclose your PHI, when necessary, to minimize an imminent danger to health or safety of you or any other individual.
- **Appointment Reminders**. We may disclose your PHI to contact you to remind you of your appointment with us.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

- **Business Associated.** We may disclose your PHI to Business Associates who are contracted by us to perform health care operations or payment activities on our behalf which may involve their collection and use or disclosure of your PHI. Our contact with them must require them to safeguard the privacy of your PHI.

Compulsory Process

We will disclose your PHI if a court of competent jurisdiction issues an appropriate order. We will also disclose your PHI if:

- You and we have each been notified in writing at least 14 days in advance of a subpoena or other legal demand, identifying the PHI sought, and the date by which a protective order must be obtained to avoid our compliance.
- No qualified judicial or administrative proactive order has been obtained.
- We have received satisfactory assurances that you received notice of an opportunity to have limited or quashed the discovery demand, and such time has elapsed.

Use and Disclosures of PHI with Your Written Authorization

We will make other uses and disclosures of your PHI only with your written authorization. You may revoke this authorization in writing at any time, unless we have taken a substantial action in reliance on the authorization such as providing you with health care services for which we must submit subsequent claim(s) for payment.

This Notice

This Notice of Privacy Practices informs you how we may use and disclose your PHI and your rights regarding PHI. We are required by law to maintain the privacy of your PHI and to provide you with notice of your legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of the Notice. We reserve the right to change the terms of our Notice at any time. Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice by providing a copy upon request, or at your next appointment.

CONTACT INFORMATION

If you have questions about this Notice of Privacy Practices, please contact our Privacy Officer.

Kathy Follman

Follman Agency

910 S. Anacortes Street

Burlington, WA 98233

(360-755-1125)

Complaints

If you believe we have violated your privacy rights, you may file a complaint in writing to us, as specified on the first page of this Notice. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

Acknowledgement: I hereby acknowledge reviewing and receiving a copy of this Notice.

_____ _____

Patient's Signature **Date**

Patient's Name: _____ Date: _____

STAGES OF CHANGE READINESS AND TREATMENT EAGERNESS SCALE

(SOCRATES 8A) PAGE 1

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way you might (or might not) feel about your drinking and/or drug use. For each statement, check the box that indicates how much you agree or disagree **with the statement at the present time**. Please check only one number for every statement (item).

Drug of Choice: Alcohol: ___ or Drugs: ___ or Both: ___

	NO. Strongly Disagree	NO Disagree	Undecided or Unsure	YES Agree	YES Strongly Agree
1. I really want to make changes in my drinking/drug use.	1 ___	2 ___	3 ___	4 ___	5 ___
2. Sometimes I wonder if, or I already know, I am addicted to alcohol/drugs.	1 ___	2 ___	3 ___	4 ___	5 ___
3. If I do not change, or if I had not changed, my drinking/drugging, my problems are/were going to get worse.	1 ___	2 ___	3 ___	4 ___	5 ___
4. I have already started making some changes in my drinking/drugging.	1 ___	2 ___	3 ___	4 ___	5 ___
5. I was drinking/drugging too much at one time, but I have managed to change my drinking/drugging.	1 ___	2 ___	3 ___	4 ___	5 ___
6. Sometimes I wonder, or I already know, if my drinking/drugging is hurting other people.	1 ___	2 ___	3 ___	4 ___	5 ___
7. I am, or used to be, a problem drinker/drug user.	1 ___	2 ___	3 ___	4 ___	5 ___
8. I am not just thinking about changing my drinking/drugging, I am already doing something about it.	1 ___	2 ___	3 ___	4 ___	5 ___
9. I have already changed my drinking/drugging, and I am looking for ways to keep from slipping back to my old pattern.	1 ___	2 ___	3 ___	4 ___	5 ___
10. I have, or have had, serious problems with drinking/drugging.	1 ___	2 ___	3 ___	4 ___	5 ___
11. Sometimes I wonder, or have wondered, if I am in control of my drinking/drugging.	1 ___	2 ___	3 ___	4 ___	5 ___
12. My drinking/drugging is causing or has caused a lot of harm.	1 ___	2 ___	3 ___	4 ___	5 ___
13. I am actively doing things now to cut down, stop, or abstain from drinking/drugging.	1 ___	2 ___	3 ___	4 ___	5 ___
14. I want help to keep from going back to drinking/drugging problems that I had before.	1 ___	2 ___	3 ___	4 ___	5 ___
15. I know that I have a drinking/drugging problem.	1 ___	2 ___	3 ___	4 ___	5 ___
16. There are, or have been times, when I wonder if I drink or drug too much.	1 ___	2 ___	3 ___	4 ___	5 ___
17. I am an alcoholic/drug addict.	1 ___	2 ___	3 ___	4 ___	5 ___
18. I am working hard to change, or have changed, my drinking/drugging.	1 ___	2 ___	3 ___	4 ___	5 ___
19. I have made some changes in my drinking/drugging, and I want some help to keep from going back to the way I used to drink/drug.	1 ___	2 ___	3 ___	4 ___	5 ___

STAGES OF CHANGE READINESS AND TREATMENT EAGERNESS SCALE (SOCRATES 8A) CONTINUED – PAGE 2

SOCRATES SCORING FORM:

Transfer the patient's answers from questionnaire:

Recognition	Ambivalence	Taking Steps
1	2	4
3	6	5
7	11	8
10	16	9
12		13
15		14
17		18
		19
TOTALS: ____	**____**	**____**
POSSIBLE RANGE:		
7-35	4-20	8-40

FOLLMAN COUNSELING AGENCY

SUBSTANCE ABUSE DISORDER INTAKE PACKET

CRAVING QUESTIONNAIRE

Patient's Name: _____ Date: _____

Drug of Choice: _____ Program Phase: _____

Please read the sentences carefully. For each one, Rate on a Scale of 0 – 9 (please check one) the answer that best describes how you feel about your AOD (alcohol/other drugs). Your answers will be private and confidential.

1. Rate (check one) how strong is your desire for Alcohol/Drugs right now.
   Scale of: No Desire **to Scale of: Extremely Strong**

   0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___

2. Rate (check one) how strong your desire for Alcohol/Drugs of choice was during the past 24 hours.
   Scale of: No Desire **to Scale of: Extremely Strong**

   0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___

3. Rate (check one) how often did you have the urge to use Alcohol/Drugs during the past 24 hours.
   Scale of: Not Often **to Scale of: Very Often**

   0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___

4. Rate (check one) in the past 24 hours, how strong were your urges for Alcohol/Drugs when something in the environment has reminded you of it (example: seeing a beer ad.)
   Scale of: No Desire **to Scale of: Extremely Strong**

   0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___

5. Imagine yourself in the environment in which you previously used alcohol (a bar, tavern, home, etc.) If you were in this environment right now, what is the likelihood that you would use Alcohol/Drugs (check one.)
   Scale of: Not at all **to Scale of: I am sure I would use**

   0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___

Patient's Name: _____ Date: _____

FOLLMAN COUNSELING AGENCY
SUBSTANCE ABUSE DISORDER INTAKE PACKET

We would like to know what areas or items you wish to work on while you are in our program. After you have completed this checklist, we will meet with you to establish goals and develop your treatment plan.

Do you want to address this in treatment? (Please check one)	YES	NO	MAYBE
Dimension 1			
1. I want to receive detoxification to ease my withdrawal from alcohol or other drugs	___	___	___
2. I am taking prescribed medications and want to see someone about this	___	___	___
3. I am pregnant and want help with this during treatment	___	___	___
Dimension 2			
4. I want help with some health issues (Please check): ___ Dental ___ Eye/Ear ___ Medical			
Dimension 3			
5. I would like to talk about some personal problems	___	___	___
6. I would like help to decrease my stress tension	___	___	___
7. I want help with depression or moodiness	___	___	___
8. I want to work on my spiritual awareness	___	___	___
9. I want to learn how to solve my problems in life	___	___	___
10. I want help with angry feelings and how I express them	___	___	___
11. I would like to discuss some sexual problems	___	___	___
12. I want to learn how to express my feelings in a healthier way	___	___	___
13. I want help with feelings of loneliness	___	___	___
14. I want to discuss having been physically abused	___	___	___
15. I want to discuss having been sexually abused	___	___	___
16. I want to work on having better self-esteem	___	___	___
17. I want help with sleep problems	___	___	___
18. I want help overcoming shyness	___	___	___
19. Someone close to me has died or left me and I would like to talk about it	___	___	___
20. I have thought about suicide and would like to discuss	___	___	___
21. I want help with personal fears and anxieties	___	___	___
22. I feel confused at times and would like help with this	___	___	___
23. I want someone to listen to me	___	___	___
24. I need help in getting motivated to change	___	___	___
25. I would like to talk about my past	___	___	___
Dimension 4			
26. I want to find out for sure whether or not I have a problem with alcohol/drug	___	___	___
27. I do not think I have a problem with alcohol or drugs	___	___	___
28. I might have a problem, but I don't want to quit now	___	___	___
29. I want help to decrease my drinking	___	___	___
30. I want to decrease my use of drugs other than alcohol	___	___	___
31. I want to learn more about alcohol/drug problems	___	___	___

32. I want my treatment to be short	___	___	___
33. I believe my treatment may have to be lengthy	___	___	___
34. I want help to stop drinking alcohol completely	___	___	___
35. I want help to stop using other drugs completely	___	___	___

Patient's Name: _____ Date: _____

FOLLMAN COUNSELING AGENCY
SUBSTANCE ABUSE DISORDER INTAKE PACKET

We would like to know what areas or items you wish to work on while you are in our program. After you have completed this checklist, we will meet with you to establish goals and develop your treatment plan.

Cont'd: Do you want to address this in treatment? (Please check one)	**YES**	**NO**	**MAYBE**
Dimension 5			
36. I want to stop using tobacco	___	___	___
37. I want to decrease my tobacco use	___	___	___
38. I want help with an eating problem	___	___	___
39. I want help with a gambling problem	___	___	___
40. I want to take Antabuse (a drug to help me not drink)	___	___	___
41. I want to take Trexan/Methadone/Suboxone (a medication to help me not use heroin)	___	___	___
42. I want to take Campral (a medication to help me reduce neuronal hyperactivity)	___	___	___
43. I want to learn some skills to keep from returning to alcohol or other drugs	___	___	___
44. I would like to learn more about nutrition and exercise for relapse prevention	___	___	___
Dimension 6			
45. I want help in overcoming boredom	___	___	___
46. I want to learn how to relax	___	___	___
47. I want advice about financial problems	___	___	___
48. I want help in learning to manage my money	___	___	___
49. I want help in setting goals and priorities in my life	___	___	___
50. I would like someone to tell me what to do to solve problems	___	___	___
51. I need to fulfill a requirement for the courts	___	___	___
52. I would like help with problems in my marriage/close relationships	___	___	___
53. I would like help in preventing violence at home	___	___	___
54. I want to have healthier relationships	___	___	___
55. I want help with legal problems	___	___	___
56. I would like help in finding a place to live	___	___	___
57. I would like help in finding a job	___	___	___
58. I want to learn to have fun without alcohol/drugs	___	___	___
59. I would like to learn to manage my time better	___	___	___
60. I want help to receive SSI/disability payments	___	___	___

Patient's Name: _____ Date: _____

FOLLMAN COUNSELING AGENCY
SUBSTANCE ABUSE DISORDER INTAKE PACKET

SUPPORT GROUP ATTENDANCE REQUIREMENTS

Follman Agency patients who have been convicted of **DUI or Negligent Driving** are required to attend **two** sobriety-based support groups **per week** through out the treatment program.

The courts require at least TWO meetings per week to be recorded and submitted to the treatment provider. Less than TWO per week will be reported to the court as non-compliance.

We provide Support Group verification forms on the table in the main hallway across from the front desk. Please turn in the Support Group verification forms before the **fifth day** of each month. There is a $25.00 charge for additional status reports to the courts due to late submission of a Support Group verification form.

Sobriety based support groups include: Alcoholics Anonymous, Al-Anon, Alateen, Cocaine Anonymous, etc.

Patient's Signature _____ Date _____