Green Apple Counseling, LLC
Phone: 406.866.0350
Fax 406.403.0263

Date:_____

Client's name: _____ Date of birth: ___/___ / ___ Gender: F M

Insurance Information: Type:_____ ID#_____

Phone (home): _____ (cell)_____Email:_____

Address: _____City: _____ State: _____Zip:____

Social Security Number_____ Race_____

Emergency contact: _____ Phone: _____ Relation:_____

For Children:

Mom's name_____ Phone:_____

Dad's Name_____ Phone:_____

Relationship Status (more than one answer may apply)

Single Married Widowed Divorced Living Together Dating Separated Partners

Assessment of current relationship (if applicable): Good Fair Poor Abusive

Spiritual/Religious

How important are spiritual matters to you? Not Little Moderate Very

Are you affiliated with a spiritual or religious group? Yes No If Yes, What group: _____

Health Care Information

Name for Primary Care Physician_____ Last Visit:_____

Household Status

Number of people in house_____ Children_____ Relatives_____

Names and ages of Kids_____

Legal

Are you presently on probation or parole? Yes No Officer?_____

Are you involved with Dept of Family Services? Yes No Case Worker?_____

Are you involved in any legal disputes? Yes No Lawyer?_____

Employment/Income

Currently: ____FT _____PT _____Temp ____Laid-off _____Disabled _____Retired

_____Social Security _____Student Other (describe):_____

Place of Employment: _____ Phone:_____

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Date:_____

What made you seek services?

_____

Who Referred you? _____

If an evaluation is needed, who does it get sent to? _____

Past Diagnoses:

What	Who diagnosed?	When?

Current prescribed medications: List all medications, including over the counter.

Name	Dose	How Often

Military experience? Yes No **Combat experience**? Yes No

Current Status:

Anger management Anxiety Coping Depression Eating Disorder Fear/Phobias Mental Confusion
Sexual Concerns Sleeping Problems Gambling Issues Pornography Issues Suicidal Thoughts Alcohol/Drugs
Other:

Acknowledge of receipt of Client Handbook

By signing below, I am acknowledging that I have received a client handbook which I was oriented to and includes the following information:

Initial

☐ CLIENTS RIGHTS: To inform the Clients of Green Apple Counseling of their legal and ethical rights in connection with therapeutic services.

☐ CLIENT CONDUCT: We value the clients that we serve as well as the providers' time and we need cooperation with keeping appointments.

☐ BILLING: Explanation of billing insurance and payments. Please provide your insurance card at the first appointment.

☐ CONSENT TO PSYCHOTHERAPY: Clients give consent to receive services at Green Apple Counseling.

☐ NOTICE OF PRIVATE PRACTICES: This notice describes how health information may be used and disclosed and how you can access to this information.

☐ CFR 42 PART 2: Confidentiality of alcohol and drug abuse patient's records.

☐ COMPLAINTS & GRIEVENCES: To provide clients, visitors, and employees with a means to voice their concerns with the expectation that it will be rectified to their satisfaction.

☐ I authorize Green Apple to bill my insurance on my behalf. I authorize payment directly to Green Apple Counseling, LLC from my insurance company. All charges incurred by me are my financial responsibility and all court fees, attorney fees or other fees necessary to collect this amount are payable by me.

_____ _____

Signature Date

_____

Print Name

Green Apple Staff:

Received By: _____ Appointment with_____ @_____

Verify Insurance_____ Insurance Card_____ Court Documents_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the last *2 weeks,* 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 figety 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	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems,* how *difficult* 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 _____

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Great Falls, MT 59405

BECK Depression Inventory

Please Circle the number next to the statement that best describes how you are feeling.	0 I am no more irritated by things than I ever was. 1 I am slightly more irritated now than usual. 2 I am quite annoyed or irritated a good deal of the time. 3 I feel irritated all the time.
0 I do not feel sad. 1 I feel sad 2 I am sad all the time and I can't snap out of it. 3 I am so sad and unhappy that I can't stand it.	0 I have not lost interest in other people. 1 I am less interested in other people than I used to be. 2 I have lost most of my interest in other people. 3 I have lost all of my interest in other people.
0 I am not particularly discouraged about the future. 1 I feel discouraged about the future. 2 I feel I have nothing to look forward to. 3 I feel the future is hopeless and that things cannot improve.	0 I make decisions about as well as I ever could. 1 I put off making decisions more than I used to. 2 I have greater difficulty in making decisions more than I used to. 3 I can't make decisions at all anymore.
0 I do not feel like a failure. 1 I feel I have failed more than the average person. 2 As I look back on my life, all I can see is a lot of failures. 3 I feel I am a complete failure as a person.	0 I don't feel that I look any worse than I used to. 1 I am worried that I am looking old or unattractive. 2 I feel there are permanent changes in my appearance that make me look unattractive 3 I believe that I look ugly.
0 I get as much satisfaction out of things as I used to. 1 I don't enjoy things the way I used to. 2 I don't get real satisfaction out of anything anymore. 3 I am dissatisfied or bored with everything.	0 I can sleep as well as usual. 1 I don't sleep as well as I used to. 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. 3 I wake up several hours earlier than I used to and cannot get back to sleep.
0 I don't feel particularly guilty 1 I feel guilty a good part of the time. 2 I feel quite guilty most of the time. 3 I feel guilty all of the time.	0 I can work about as well as before. 1 It takes an extra effort to get started at doing something. 2 I have to push myself very hard to do anything. 3 I can't do any work at all.

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0 I don't feel I am being punished. 1 I feel I may be punished. 2 I expect to be punished. 3 I feel I am being punished	0 I don't get more tired than usual. 1 I get tired more easily than I used to. 2 I get tired from doing almost anything. 3 I am too tired to do anything.
0 I don't feel disappointed in myself. 1 I am disappointed in myself. 2 I am disgusted with myself. 3 I hate myself	0 My appetite is no worse than usual. 1 My appetite is not as good as it used to be. 2 My appetite is much worse now. 3 I have no appetite at all anymore.
0 I don't feel I am any worse than anybody else. 1 I am critical of myself for my weaknesses or mistakes. 2 I blame myself all the time for my faults. 3 I blame myself for everything bad that happens.	0 I haven't lost much weight, if any, lately. 1 I have lost more than five pounds. 2 I have lost more than ten pounds. 3 I have lost more than fifteen pounds.
0 I don't have any thoughts of killing myself. 1 I have thoughts of killing myself, but I would not carry them out. 2 I would like to kill myself. 3 I would kill myself if I had the chance.	0 I am no more worried about my health than usual. 1 I am worried about physical problems like aches, pains, upset stomach, or constipation. 2 I am very worried about physical problems and it's hard to think of much else. 3 I am so worried about my physical problems that I cannot think of anything else.
0 I don't cry any more than usual. 1 I cry more now than I used to. 2 I cry all the time now. 3 I used to be able to cry, but now I can't cry even though I want to.	0 I have not noticed any recent change in my interest in sex. 1 I am less interested in sex than I used to be. 2 I have almost no interest in sex. 3 I have lost interest in sex completely.

_____Score Total

Beck Anxiety Inventory (BAI)

Name: _____

Date: _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared/Frozen in place	0	1	2	3
Upset Stomach/Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3

ACES (Adverse Childhood Experiences Scale)

Name: _____ Date: _____

While you were growing up, Before the age of 18 e:	NO	YES
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?	NO	YES
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?	NO	YES
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?	NO	YES
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?	NO	YES
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?	NO	YES
6. Was a biological parent ever lost to you through divorce, abandonment, or other reason?	NO	YES
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 over at least a few minutes or threatened with a gun or knife?	NO	YES
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	NO	YES
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	NO	YES
10. Did a household member go to prison?	NO	YES

Impulsivity Test

		Rarely (1)	Sometime (2)	Often (3)	Very Often (4)	
1.	I don't "pay attention."					
2.	I concentrate easily.*					
3.	I "squirm" at plays or lectures.					
4.	I am a steady thinker.*					
5.	I am restless at the theater or lectures.					
6.	I have "racing" thoughts.					
7.	I change hobbies.					
8.	I often have extraneous thoughts when thinking.					
9.	I do things without thinking.					
10.	I make up my mind quickly.					
11.	I am happy-go-lucky.					
12.	I "act" on impulse.					
13.	I act on the spur of the moment.					
14.	I buy things on impulse.					
15.	I spend or charge more than I earn.					
16.	I change jobs.					
17.	I change residences.					
18.	I can think only about one thing at a time.					
19.	I am future oriented.*					
20.	I plan tasks carefully.*					
21.	I plan trips well ahead of time.*					
22.	I am self-controlled.*					
23.	I am a careful thinker.*					
24.	I plan for job security.*					
25.	I say things without thinking.					
26.	I save regularly.*					
27.	I like to think about complex problems.*					
28.	I am easily bored when solving thought problems.					
29.	I am more interested in the present than in the future.					
30.	I enjoy doing puzzles.					

Attentional Facet I _____ / 20

Attentional Facet II _____ / 12

Motor Facet I _____ / 28

Motor Facet II _____ / 16

Planning Facet I _____ / 24

Planning Facet II _____ / 20

Total _____ / 120

- Total scores of 72 or above = highly impulsive
- Total scores between 52 and 71 = within normal limits for impulsiveness

PCL-5 with LEC-5 and Criterion A

Part 1

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
2. Fire or explosion	☐	☐	☐	☐	☐	☐
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	☐	☐	☐	☐	☐	☐
4. Serious accident at work, home, or during recreational activity	☐	☐	☐	☐	☐	☐
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	☐	☐	☐	☐	☐	☐
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐	☐	☐
9. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
10. Combat or exposure to a war-zone (in the military or as a civilian)	☐	☐	☐	☐	☐	☐
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
12. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
13. Severe human suffering	☐	☐	☐	☐	☐	☐
14. Sudden violent death (for example, homicide, suicide)	☐	☐	☐	☐	☐	☐
15. Sudden accidental death	☐	☐	☐	☐	☐	☐
16. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
17. Any other very stressful event or experience	☐	☐	☐	☐	☐	☐

Part 2

A. If you checked anything for #17 in PART 1, briefly identify the event you were thinking of:

B. If you have experienced more than one of the events in PART 1, think about the event you consider the worst event, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event (check all options that apply):

Briefly describe the worst event (for example, what happened, who was involved, etc.).

How long ago did it happen? _____ (please estimate if you are not sure)

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe

Was someone's life in danger?

_____ Yes, my life

_____ Yes, someone else's life

_____ No

Was someone seriously injured or killed?

_____ Yes, I was seriously injured

_____ Yes, someone else was seriously injured or killed

_____ No

Did it involve sexual violence? _____ Yes _____ No

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____ Accident or violence

_____ Natural causes

_____ Not applicable (The event did not involve the death of a close family member or close friend)

How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?

_____ Just once

_____ More than once (please specify or estimate the total number of times you have had this experience _____)

Part 3

Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4-9	10-13	14+

Name: _____ Date: _____

DAST 10

1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you use more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	Yes	No
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced adverse symptoms (felt sick) when you stopped taking drugs?	Yes	No
10 Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

Name: _____ Date: _____

DSM 5

1. Do you often drink or use larger amounts or over a longer period of time than you originally intended?	Yes	No
2. Have you tried to cut down or control your alcohol or drug use despite a persistent desire to do so?	Yes	No
3. Do you spend a great deal of time attempting to obtain, use and/or recover from the effects of alcohol or drugs?	Yes	No
4. Have you experienced cravings or a strong desire to use alcohol or drugs?	Yes	No
5. Has your alcohol or drug use resulted in failure to fulfill major obligations at work, school or home?	Yes	No
6. Have you continued to use alcohol or drugs despite persistent or recurrent social or personal problems caused your use?	Yes	No
7. Have you given up or reduced important social, occupational or recreational activities because of your alcohol or drug use?	Yes	No
8. Have you continued to use alcohol or drugs in physically hazardous or dangerous situations?	Yes	No
9. Have you continued to use alcohol or drugs despite experiencing physical or psychological problems caused by or exacerbated by your alcohol or drug use?	Yes	No
10. Do you feel you have developed a tolerance to alcohol or drugs, characterized by either a need for increased amounts of a substance to achieve intoxication and/or a diminished effect with the continued use of the same amount of a substance?	Yes	No
11. Have you experienced any withdrawal symptoms (such as shakiness, irritability, sweating, nausea, vomiting, bodily pain, skin sensitivity, etc.) after stopping use of alcohol or drugs? If so, have you ever used alcohol or drugs to relieve or avoid such withdrawal symptoms?	Yes	No

ACES (Adverse Childhood Experiences Scale)

Name: _____ Date: _____

While you were growing up, Before the age of 18 e:	NO	YES
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?	NO	YES
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?	NO	YES
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?	NO	YES
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?	NO	YES
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?	NO	YES
6. Was a biological parent ever lost to you through divorce, abandonment, or other reason?	NO	YES
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 over at least a few minutes or threatened with a gun or knife?	NO	YES
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	NO	YES
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	NO	YES
10. Did a household member go to prison?	NO	YES

SOUTH OAKS GAMBLING SCREEN (SOGS)

1. Indicate which of the following types of gambling you have done in your lifetime. For each type, mark one answer: "not at all," "less than once a week," or "once a week or more."

Not at all	Less than once a week	Once a week or more	
			a. played cards for money
			b. bet on horses, dogs or other animals (in off-track betting, at the track or with a bookie)
			c. bet on sports (parley cards, with a bookie, or at jai alai)
			d. played dice games (including craps, over and under, or other dice games) for money
			e. went to casino (legal or otherwise)
			f. played the numbers or bet on lotteries
			g. played bingo
			h. played the stock and/or commodities market
			i. played slot machines, poker machines or other gambling machines
			j. bowled, shot pool, played golf or played some other game of skill for money

2. What is the largest amount of money you have ever gambled with any one day?

____ never have gambled

____ more than $100 up to $1000

____ $10 or less

____ more than $1000 up to $10,000

____ more than $10 up to $100

____ more than $10,000

3. Do (did) your parents have a gambling problem?

____ both my father and mother gamble (or gambled) too much

____ my father gambles (or gambled) too much

____ my mother gambles (or gambled) too much

____ neither gambles (or gambled) too much

4. When you gamble, how often do you go back another day to win back money you lost?

___ never

___ some of the time (less than half the time) I lost

___ most of the time I lost

___ every time I lost

5. Have you ever claimed to be winning money gambling but weren't really? In fact, you lost?

___ never (or never gamble)

___ yes, less than half the time I lost

___ yes, most of the time

6. Do you feel you have ever had a problem with gambling?

___ no

___ yes, in the past, but not now

___ yes

	Yes	No
7. Did you ever gamble more than you intended?	____	____
8. Have people criticized your gambling?	____	____
9. Have you ever felt guilty about the way you gamble or what happens when you gamble?	____	____
10. Have you ever felt like you would like to stop gambling but didn't think you could?	____	____
11. Have you ever hidden betting slips, lottery tickets, gambling money, or other signs of gambling from your spouse, children, or other important people in you life?	____	____
12. Have you ever argued with people you like over how you handle money?	____	____
13. (If you answered "yes" to question 12)**: Have money arguments ever centered on your gambling?**	____	____
14. Have you ever borrowed from someone and not paid them back as a result of your gambling?	____	____

	Yes	No
15. Have you ever lost time from work (or school) due to gambling?	____	____
16. If you borrowed money to gamble or to pay gambling debts, where did you borrow from? (Check "yes" or "no" for each)	____	____

a. from household money		
b. from your spouse		
c. from other relatives or in-laws		
d. from banks, loan companies or credit unions		
e. from credit cards		
f. from loan sharks (Shylocks)		
g. your cashed in stocks, bonds or other securities		
h. you sold personal or family property		
i. you borrowed on your checking account (passed bad checks)		
j. you have (had) a credit line with a bookie		
k. you have (had) a credit line with a casino		

Developmental History

1. What is your highest level of education?	
2. Were you ever diagnosed with any learning problems such as dyslexia while growing up?	
3. Were you ever suspended or expelled from School?	
4. Did you participate in any extracurricular activities such as band, sports, or school clubs?	
5. Did you have any Special Programming in school?	
6. At what age did you become sexually active?	
7. Prior to the age of 18, was your family ever involved with CPS or DCFS?	
8. How many times have you been arrested? Answer for prior to the age of 18 and since the age of 18?	
9. Did you see a counselor prior to the age of 18, if so, what was the diagnosis?	
10. What is the longest intimate relationship you have maintained?	

Green Apple Counseling, LLC
1500 10th Ave South
Great Falls, MT 59405
Tel. 406.866.0350
Fax. 406.403.0263

AUTHORIZATION/ REQUEST TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I, (client name) _____ (Date of Birth) _____

If a minor, Parent's name: _____Relationship: _____

Hereby authorize: _____

Phone Number: _____ Fax Number: _____

To send and receive information of records for Assessment, Treatment Process, Psychotherapy and/or Discharge Planning, etc. **to GREEN APPLE COUNSELING, LLC.**

The information to be disclosed is marked by a check below:

____Behavior programs	____Case/Progress notes	____Psychological reports
____Mental health Evaluation	____Treatment plans	____Entire record
____ Chemical Dependency Evaluation	_____ Court Documents	____Other _____

This consent will expire (Initial one):

_____1 year from date on which it is signed

_____ Other Date _____

HIV related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: _____do not release. I have had this form explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take cack this consent at any time within 90 days, by giving written notice of revocation to Green Apple Counseling, LLC, except to the extent an action based on this consent has already been taken.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____

Client or Parent/Representative Signature *Date*

_____

Green Apple Counseling, LLC Signature *Date*

Notice: * Protected health information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy law. *Green Apple Counselling, LLC may Not condition treatment, payment, enrollment, or eligibility for benefits contingent on signing this form.

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