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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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 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?	