

Desert View Family Counseling
905 W. Apache
Farmington, NM 87401

ADULT INTAKE SUMMARY

Please PRINT all information in BLUE ink

NAME: _____ AGE: _____ DOB: _____

SS#: _____ GENDER: _____ MARITAL STATUS: _____ PRIMARY LANGUAGE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

IS IT SAFE TO CALL YOUR HOME PHONE? _____ LEAVE A MESSAGE AT YOUR HOME PHONE? _____

IS IT SAFE TO CALL YOUR CELL PHONE? _____ LEAVE A MESSAGE ON YOUR CELL PHONE? _____

PHYSICAL ADDRESS: _____ CITY: _____ ZIP: _____

MAILING ADDRESS: _____ CITY: _____ ZIP: _____

HANDICAPS: _____

EDUCATIONAL LEVEL:

- GRADE SCHOOL TRADE SCHOOL GED
 HIGH SCHOOL COLLEGE: YEARS: _____ DEGREE: _____

REFERRAL SOURCE: How DID YOU FIND OUT ABOUT OUR SERVICES?

- SELF COURT REFERRED: JUDGE: _____ DWI FACILITY
 FAMILY PROBATION: OFFICER: _____ CYFD
 SCHOOL MEDICAL DOCTOR: _____ POLICE DEPT.
 TRIBAL SOCIAL SERVICE OTHER: _____ FRIEND

PRESENTING PROBLEM: DESCRIBE SPECIFICALLY THE PROBLEM THAT BROUGHT YOU TO DESERT VIEW.

PLEASE CHECK OTHER PROBLEM AREAS FOR WHICH YOU ARE SEEKING HELP:

- | | | |
|--|---|--|
| <input type="checkbox"/> Aggression, violence | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Marital Conflicts |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Anger Problems | <input type="checkbox"/> Excessive Stress | <input type="checkbox"/> Problems with Law/Courts |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fighting | <input type="checkbox"/> Codependence |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Grief | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Abused as Child | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Work Problems |
| <input type="checkbox"/> Defiance | <input type="checkbox"/> Homeless | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Impulse Control Problems | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Adult Victim / Witness DV | <input type="checkbox"/> Childhood Issues | <input type="checkbox"/> Suicidal thoughts / actions |

FAMILY ANNUAL INCOME: _____ INSURANCE COMPANY: _____

CHECK ANY OF THE FOLLOWING THAT THE FAMILY IS CURRENTLY RECEIVING OR IS ELIGIBLE TO RECEIVE:

AFDC SSI MEDICAID MEDICARE SSDI FOOD STAMPS

ARE YOU A VETERAN OF THE U.S. ARMED FORCES? DO YOU LIVE WITH A VETERAN OF THE U.S. ARMED FORCES?

EMPLOYMENT STATUS:

WORKING FULL-TIME (35 HOURS OR MORE PER WEEK) WORKING PART-TIME (UNDER 35 HOURS PER WEEK)
 UNEMPLOYED (SOUGHT WORK IN THE PAST 30 DAYS) UNEMPLOYED (NOT SEEKING WORK)
 RETIRED HOMEMAKER
 STUDENT DISABLED
 INMATE OF AN INSTITUTION FULL-TIME MEMBER OF THE ARMED SERVICES
 UNKNOWN OTHER

EMPLOYER: _____ PHONE: _____

SCHOOL: _____

WORK / SCHOOL SCHEDULE: SUN MON Tue WED THUR FRI SAT
HOURS: _____ AM / PM TO _____ AM / PM

DEPENDENTS:

WHERE IS THE CHILD?

NAME OF CHILD	AGE	SEX	HOME	SHELTER	RELATIVE	OTHER
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

ETHNICITY	CLIENT	PARTNER	CHILD	CHILD	CHILD	CHILD	CHILD
ANGLO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HISPANIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIVE AMERICAN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AFRICAN AMERICAN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASIAN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CLIENT'S LIVING ARRANGMENT:

LIVES ALONE LIVES WITH RELATIVE LIVES WITH NON-RELATED PERSON(S)
 PRIVATE RESIDENCE / APARTMENT HOMELESS - STREET
 HOMELESS - SHELTER JAIL OR CORRECTIONAL FACILITY
 TRANSITIONAL LIVING OTHER SHELTERS
 SECTION 8 HOUSING

SPOUSE / PARTNER NAME: _____ AGE: _____

ADDRESS: _____ PHONE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

The New Mexico Crime Victims Reparation Commission was formed in 1981 under the Crime Victims Reparation Act to assist victims of violent crime with expenses incurred as a result of their victimization. Victims who have suffered physical injury or extreme mental distress as a result of one or more of the following crimes may qualify.

HAVE YOU BEEN A VICTIM OF ANY OF THE FOLLOWING IN THE PAST TWO YEARS?

- | | |
|--|---|
| <input type="checkbox"/> AGGRAVATED ASSAULT | <input type="checkbox"/> AGGRAVATED BATTERY |
| <input type="checkbox"/> CRIMINAL SEXUAL CONTACT OF A MINOR | <input type="checkbox"/> CRIMINAL SEXUAL PENETRATION |
| <input type="checkbox"/> MURDER | <input type="checkbox"/> VOLUNTARY MANSLAUGHTER |
| <input type="checkbox"/> INVOLUNTARY MANSLAUGHTER | <input type="checkbox"/> ADANDONMNET OR ABUSE OF A CHILD |
| <input type="checkbox"/> HOMICIDE BY VEHICLE OR GREAT BODILY INJURY BY VEHICLE | <input type="checkbox"/> AGGRAVATED STALKING |
| <input type="checkbox"/> KIDNAPPING | <input type="checkbox"/> ARSON RESULTING IN BODILY INJURY |
| <input type="checkbox"/> AGGRAVATED ARSON | <input type="checkbox"/> AGGRAVATED INDECENT EXPOSURE |
| <input type="checkbox"/> DANGEROUS USE OF EXPLOSIVES | <input type="checkbox"/> NEGLIGENT USE OF A DEADLY WEAPON |

Did the crime occur in New Mexico?

Was the crime reported to Law Enforcement?

CVRC application completed? YES NO

IF CVRC APPLICATION WAS NOT COMPLETED, PLEASE EXPLAIN WHY.

Many victims of crimes are eligible for reparation through the New Mexico Crime Victims Reparation Commission. If you wish to receive more information about eligibility for this program, please ask your Therapist or Case Manager. Desert View will provide any necessary assistance in filling these applications.

AN ADVANCE DIRECTIVE IS A DOCUMENT GIVING ANOTHER PERSON PERMISSION TO MAKE FUTURE MENTAL HEALTH DECISIONS FOR YOU IN THE EVENT THAT YOU ARE UNABLE.

DO YOU HAVE A MENTAL HEALTH ADVANCE DIRECTIVE? YES NO

DO YOU WANT TO ESTABLISH A MENTAL HEALTH ADVANCE DIRECTIVE? YES NO

THE ABOVE INFORMATION IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE.

CLIENT SIGNATURE: _____ DATE: _____

OFFICE USE ONLY:

IS CLIENT APPROPRIATE FOR AGENCY SERVICES? YES NO

WAS CLIENT OFFERED APPOINTMENT? YES NO

If Client is not appropriate, where was Client referred? _____

DATE OF INITIAL CONTACT: _____ DATE OF INTAKE: _____

Desert View Family Counseling Health Summary

Do you have a Primary Care Physician? Name: _____

Do you wish for your PCP to be notified that you are receiving services at Desert View Counseling? Yes No

If you have no PCP, where do you get your health care needs met when necessary? _____

Please list any current health concerns and related treatment. Please include any special health needs. _____

If female are you currently pregnant? Yes No

Please list any current dental concerns and related treatment: _____

Do you suffer from any current or chronic pain (including headaches)? How do you treat this pain? _____

Stages of development (crawling, walking, talking, etc.): _____

Do you have a history of head trauma? Please describe. _____

Do you have a history of seizures? Please describe. _____

Have you ever been unconscious for any reason? Please describe. _____

Please list all past major illnesses, hospitalizations, and / or treatment for significant health concerns.

Date	Location	Health Issue	Treatment

Are you currently receiving mental health treatment or counseling, including substance abuse counseling? Yes No

Name of Therapist, Counselor, Agency: _____

Do you wish that they be notified that you are receiving services at Desert View Counseling? Yes No

Please list all prior mental health treatment or counseling, including substance abuse counseling.

Date	Location	Issue	Treatment

List all medications being taken and dosage and prescribing physician: _____

List all supplements / herbal remedies and non-prescriptions medications currently used: _____

Do you have any known allergies to pharmaceuticals or other substances? _____

Do you smoke cigarettes? Yes No If yes, how many per day? _____

Do you use alcohol? Yes No If yes, how many drinks / how often? _____

Do you use any street drugs? Yes No If yes, which one(s)? How often? _____

Have you ever been treated for drug or alcohol problems, including involvement in a 12 Step Program? Yes No

Have you ever been charged with a DWI or gotten into legal trouble because of drug/alcohol use? Yes No

Has your family, friends, employer, and/or school complained about your drug/alcohol use? Yes No

Have you ever felt that you need to cut down on your drinking or other drug use? Yes No

Is there is history of drug or alcohol abuse in your family? Yes No

**Desert View Family Counseling
Financial Worksheet**

Client: _____

Date: _____

Parent / Guardian (if Client is under 18): _____

How Many in Household? _____

Total Monthly Income (after taxes):

Please List all Expenses:

Rent / House Payment:	<table border="1" style="width: 100%; height: 20px;"></table>
Food and Household Items:	<table border="1" style="width: 100%; height: 20px;"></table>
Utilities (Water, Gas, Electric, etc.):	<table border="1" style="width: 100%; height: 20px;"></table>
Telephone (Cell Phone):	<table border="1" style="width: 100%; height: 20px;"></table>
Car Payment (Insurance and Fuel):	<table border="1" style="width: 100%; height: 20px;"></table>
Credit Card / Loans:	<table border="1" style="width: 100%; height: 20px;"></table>
Other Expenses (Please List):	<table border="1" style="width: 100%; height: 20px;"></table>
Total Expenses:	<table border="1" style="width: 100%; height: 20px;"></table>

Proof of Income Provided? Yes No If NO Explain: _____

Does the above named Client have private insurance? Yes No

Insurance Company Name: _____ Group #: _____ Plan / Policy #: _____

Does the above named Client have Medicaid Insurance? Yes No In the process of getting Medicaid

Salud: Exempt Lovelace Presbyterian Cimarron Eligibility Verified? Yes No

Fees and Co-Payments

**** All clients are responsible for their co-payment at the time of service. Please let us know if you need to make payment arrangements.

Private insurances and Medicaid will be billed if available. If you do not have private insurance or Medicaid, we may have some funding sources to assist you, depending on your criteria. Desert View bills on a sliding scale if you qualify. There is a co-pay for these funding sources, depending on your income.

If you have adjustments that need to be made to your financial sheet, due to income changes please see the Office Manager. **No Call/No Show: If you need to cancel or reschedule you must give 24 hour notice prior to your appointment time or you will be charged a \$20 fee for the missed appointment. (Some exceptions may apply.)** By signing this form you agree that the above information is true and complete to the best of your knowledge, you accept possible no call/no show fees, and that you agree to pay the assigned fees/co-payments.

I have reviewed this worksheet and agree to pay _____ per session and _____ for the Diagnostic Assessment.

Signature of Responsible Party: _____ Date: _____

Witness: _____ Date: _____

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Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist assigned to me. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment if I do not cancel or do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I have read (or had read to me), discussed, understand and agree with all of these statements.

Signature of client (or person acting for client)

Date

Printed Name

Relationship to client
(if necessary)

OFFICE USE

I, the witness, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Witness Signature

Date

Copy accepted by client

Copy refused by client

Copy kept by therapist

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Clients Rights and Responsibilities

Welcome to the Desert View Treatment program. Desert View provides individual, couples, family and group counseling. Your Therapist or Case Manager can also provide you with referrals for other community services.

You have chosen to begin treatment led by professionals who can guide you toward solutions to the problems you are experiencing. Your Therapist will discuss with you the predicted process of your treatment and your goals of treatment. Your Therapist, or Desert View, can not make promises to you about the outcome of your treatment.

A treatment plan will be created by you and your Therapist outlining desired goals. You are free to either consent to, or refuse any recommendations or suggestions of the Therapist without affecting your eligibility for treatment. If you decide not to follow the agreement, either you or your Therapist may cancel the contract and end the services. While you may terminate your counseling at any time, we suggest that you discuss any such decisions ahead of time with your Therapist. There may also be consequences to ending services (for example, if your services have been court ordered).

In a professional relationship between a therapist and a client, sexual intimacy is never appropriate. If sexual intimacy occurs, or has occurred in a previous therapy relationship, it should be reported to the State Grievance Board.

Client's Rights:

- To be treated with respect and consideration.
- Voice any concerns or complaints about Desert View or your treatment without retaliation.
- To know the credentials and experience of your Therapist.
- To know about any changes to your treatment plan and the reasons for the changes.
- To review your treatment records at anytime in accordance with Desert View Policy. (A written request is required.)
- All Desert View Therapists are supervised. Your Therapist may ask you if they can audio tape or videotape your session(s). It is your right to agree to this, refusal will not affect your continued treatment.
- For your mental health information to be protected according to policy at all times.

Confidentiality:

In general, the information you share with Desert View and your Therapist is confidential. In order to provide the best possible services, Therapists at Desert View do consult with each other about cases. There are, in addition, some occasions when confidential information may be released to others. If for some reason there is a need to share information in your record with someone outside of Desert View you will first be consulted and asked to sign an authorization form before the transferring of the information.

Exceptions to Confidentiality:

There are several important instances when confidential information may be released to others without your consent:

- 1) You are mandated by a court to receive services. You can expect the court to request information regarding attendance, attitude, progress, evaluation results, any use of violence or threats, and reasons for termination of services, for example. If your were court ordered for domestic violence, other agencies such as police, probation or parole, and social services may also be included in the exchange of this information.

- 2) You are violating a court order or there is a warrant out for your arrest.
- 3) You are involved in litigation of any kind and inform the court of the services you received from Desert View (making your mental health an issue before the court). You may be waiving your right to keep your records confidential, and you should consult with your attorney before disclosing that you have received treatment.
- 4) If your insurance company or another third party is paying for your treatment services, an agent of this party may be given information about the type(s), cost(s), date(s), and providers of any services or treatment you receive.
- 5) If you threaten to harm yourself or someone else, we must take these threats seriously. We are obligated by law to take whatever actions seem necessary to protect you or others from harm.
- 6) If you have knowledge of or if Desert View Staff have any reason to suspect, the abuse or neglect of a child(ren), a disabled person(s), or an elderly person(s), we are obligated by law to report this information to the appropriate state agency. This law is designed to protect children, the disabled and the elderly from harm and the obligation to report suspected abuse or neglect is clear in this regard.

In addition, there may be other rare instances in which confidential information may be released to others, or that you waive your right to have your records protected.

Our Expectations of You:

- Attend all of your scheduled appointments. If you are unable to keep an appointment, please call to cancel and reschedule at least 24 hours in advance. If you miss appointments without canceling or rescheduling you may be charged for appointments unless it is due to an emergency. In some cases you may be discharged from therapy.
- As a Desert View client you may at some time encounter acquaintances (neighbors, friends, co-workers, teachers, etc.) at the office. As a client you agree not to disclose the identities of any other clients at any time.
- We ask that you refrain from taking nonprescription drugs or alcohol before therapy sessions because they severely impede your treatment. No weapons, firearms, or illegal substances are allowed on the premises at any time.

I acknowledge that I have read (or have had read to me) and understand Desert View's Rights and Responsibilities and/or other information about the therapy I am considering. I have had all my questions answered fully.

Date _____

Client (Client's Guardian) Signature

Witness

Copy accepted by client

Copy refused by client

Desert View Inc.
Documentation of Good Faith Effort to Obtain
Acknowledgement of Receipt of Notice of Privacy Practices

Name of client to whom the Notice was provided: _____

Date Notice was provided: _____ Location: Desert View Inc.

_____ Client received a paper copy at the time of first visit.

_____ Client was asked to sign the Receipt of Notice Acknowledgment Form and was informed that Desert View is required to provide the Notice and obtain a signed acknowledgment.

_____ Client is unwilling or refused to sign.

Describe the reason why the client was unwilling or refused to sign the Notice Acknowledgment Form:

**NOTICE OF PRIVACY PRACTICES
RECEIPT ACKNOWLEDGEMENT FORM**

By signing where indicated below, I acknowledge that I have received the Desert View "Notice of Privacy Practices"

Signature of client (or person acting for client)

Printed name of client

Witness Signature

Date

___ copy accepted by client

___ Copy refused by client

___ Copy kept by Therapist

Desert View Family Counseling
905 W. Apache
Farmington, NM 87401
(505) 326-7878 Fax (505) 326-7879
E-mail: admin@desertviewsas.org

Grievance Policy

A BILL OF CLIENT'S RIGHTS has been provided and signed by you. If you feel your Case Manager or Therapist has violated any of these rights, you have the right to express your grievance, and appropriate action will be taken to remedy the situation.

STEP ONE:

Submit a completed grievance form to the program, in a sealed envelope, marked CONFIDENTIAL. You may obtain the grievance form and envelope from Desert View office staff.

STEP TWO:

The Program Manager will conduct an investigation to determine the facts of the case and complete a report and submit it to the Executive Director of Desert View within 10 days of the receipt of the grievance.

STEP THREE:

The Program Manager will submit the report and copy of the grievance to the Executive Director of Desert View for review and approval. If the Director overturns the decision of the Supervisor, the Director must state the reason and evidence supporting the decision. Within 10 calendar days of the receipt of the report of the Supervisor, the Director will inform the client, in writing, of the decision, and the reason for the decision.

I acknowledge that I have received a copy of Desert View's grievance procedure and that I fully understand the contents of the document.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____