Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

ADULT INTAKE PACKET

Welcome to Provident Behavioral Health! Please complete the attached forms to begin services with our team of behavioral health professionals.

You have been scheduled with: _____
Provider Name & Credentials

Crisis Services

At Provident, you have access to a team of crisis workers 24/7/365. During regular office hours, please call the office where you receive services and ask to speak to your provider if you are in crisis or need immediate assistance. If available, a member of your treatment team will speak with you and assist you. Should your provider be unavailable, another staff will assist you or you will be linked with a Provident Crisis Worker.

After-Hours Crisis Calls: Please call **314-446-5158** for Provident's Crisis Workers for support at any time. Services are available 24 hours a day. In the event that the nature of the emergency is such that you require immediate attention, please call 988 for the National Suicide Prevention Lifeline, call 911, or go to the emergency room nearest you.

Consent to Treatment

- I have chosen to receive behavioral health services from Provident. Services include, but are not limited to, Psychiatric Evaluation, Mental Health Assessment, Medication Management, Case Management, Psychoeducation, and Individual, Family, and Group Therapies.
- I understand that there are both risks and benefits associated with treatment, including side effects from medications that are prescribed.
- I understand that treatment may deal with painful or problematic emotions and experiences. Discussing these experiences may be uncomfortable. However, avoiding the feelings prolongs the discomfort that already exists. During treatment, painful emotions may become more intense, which can be a sign that desired changes are about to occur. I agree to discuss any and all noticeable differences with my treatment team.
- I am aware that treatment is a collaborative process and progress depends on my willingness to actively participate in the change process.
- I understand there is no guarantee that progress will occur.
- I have the right to be informed about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the clinician's qualifications, credentials, and relevant experience; continuation of services if the clinician is unable to continue providing treatment; and other pertinent information.
- I understand that there are fees associated with services and that inability to pay these fees may interrupt the course of treatment.
- I understand that I may stop treatment at any time. I will be responsible for payment of services I have received. I understand that there may be consequences to ending treatment, such as when treatment is court ordered.
- I understand that Provident may terminate treatment if my needs cannot be met by the agency. I understand that agency staff will refer me to an appropriate alternate provider should this occur.
- I understand that I may not be allowed to continue participating in treatment if I: engage in acts of physical violence or verbal abuse; possess a weapon; am under the influence of alcohol or drugs; or engage in illegal behavior on Provident premises.
- I understand that my right to informed consent may be waived in the event that I am at risk of harm to myself or others and professional intervention is necessary.
- I understand that a surrogate decision maker may provide informed consent on my behalf in the event that a physician, psychiatrist, and one other mental health professional have determined that I have lost the capacity to make informed decisions for myself. A surrogate decision maker can only consent to specific mental health services permitted by the Mental Health and Developmental Disabilities Code.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

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Client Rights and Responsibilities

As a Provident client, you are entitled to the following **rights**:

- To be treated with respect, consideration, and dignity, including consideration of social, psychological, spiritual and cultural needs without discrimination including race, color, religion, sex, age, national origin, disability, veteran status, gender identity, gender expression, sexual orientation (real or perceived), or any other characteristic protected by applicable United States federal or state law.
- To be informed about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the clinician's qualifications, credentials, and relevant experience; continuation of services if the clinician is unable to continue providing treatment; and other pertinent information.
- To be treated by professionals who uphold the highest ethical standards and to receive services in a safe, clean environment.
- To participate in decisions involving your treatment and suggest changes to treatment.
- To involve family members and other significant others in your treatment and decision making.
- To be informed about the limits of privacy and confidentiality, and to approve or refuse the release of your treatment records, except when release is required by law.
- To receive information concerning your diagnosis, treatment, and prognosis; and to accept or refuse treatment after full information is given.
- To know what services are available within Provident and the availability of after-hours and emergency coverage.
- To be referred to other professionals when additional services not available through Provident are needed or resources outside of Provident can more appropriately serve my needs.
- To be informed of any change in provider providing my services during treatment.
- To be assisted in obtaining an interpreter in cases of communication barriers (for example, language or hearing impairment)
- To be assisted in obtaining an advocate to represent you when appropriate.
- To have assistance in accessing protective services in instances of abuse or neglect.
- To access a copy of your medical record and request amendments, when appropriate.
- To know the fee for services provided, the policies regarding payment of fees, and to be informed when fees change.
- To discuss dissatisfaction with services provided with your provider by filing a grievance and by participating in the complaint resolution process. Formal grievances are to be submitted in writing to the supervisor at the office at which you receive services or to the Clinical Director. The Clinical Supervisor or Clinical Director will speak with the client and investigate on behalf of the griever, if necessary. A written statement of results will be given to the griever/client within five business days and will include: date grievance received, summary of grievance, overview of investigation process, timetable for completing investigation and notification of resolutions. You can contact the **Clinical Director** at 314-371-6500. Furthermore, you can contact **The Joint Commission** (800-994-6610 or complaint@jointcommission.org) to report any concerns or register complaints about Provident.

As a Provident client, you have the following **responsibilities**:

- To provide, to the best of your knowledge, accurate and complete information about present concerns, past treatment, hospitalizations, medications, and other matters relating to both your physical and mental health.
- To follow the treatment plan developed with your provider and to be responsible for the consequences of refusing treatment or not complying with treatment recommendations.
- To ask questions when you do not understand treatment recommendations or services that are recommended to you or what is expected of you as a client.
- To share your expectations of Provident and to provide feedback on your satisfaction with services received.
- To pay the established fees for services provided at the time services are rendered.
- To attend your appointments and, when unable to do so, to notify the office at least 24 hours in advance.
- To provide current information regarding any insurances you have as well as any changes in insurance coverage that occur during the course of treatment at Provident.
- To follow Provident's Policies and Procedures
- To be considerate and respectful of Provident clients, staff, and property.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

Subpoena Policy

The role of Provident staff is to provide behavioral health treatment and support for our clients and their families. It is not our role to go to court, to be an expert witness, or to make custodial or other legal decisions on behalf of our clients. In the event that a Provident employee is subpoenaed regarding your treatment, you will be responsible for all fees incurred, including but not limited to: time reviewing and compiling your medical records, time spent writing reports or treatment summaries, travel time to and from court, and time spent waiting in court and on the stand. **The fee for services provided in response to subpoenas is $150.00 per hour and must be paid out of pocket by the client, client's parent or guardian, or legal counsel.** As always, we are happy to provide any documentation regarding your treatment in writing once you have signed a Release of Information allowing us to do so.

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Notice of Privacy Practice

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

Introduction: Provident has adopted this Privacy Practice Policy to comply with the Health Insurance Portability and Accountability Act (HIPAA, 1996), the Health Information Technology for Economic and Clinical Health Act (HITECH, 2009), the Omnibus Rule (2013), and the Department of Health and Human Services (DHHS) security and privacy regulations, as well as to fulfill our duty to protect the integrity, confidentiality, and availability of confidential medical information as required by law, professional ethics, and accreditation requirements. All personnel of Provident Behavioral Health (Provident) must comply with this policy. Familiarity with this policy and demonstrated competence in the requirements of the policy are an important part of every employee's responsibilities.

Assumptions: This Notice of Privacy Practice Policy is based on the following assumptions:

- Individually identifiable health information or protected health information (PHI) is sensitive and confidential. Such information is protected by law, professional ethics, and health care accreditation requirements.
- HIPAA requires Provident to protect PHI and to ensure that Provident's Business Associates also protect PHI.
- Provident must enter into Business Associate contracts to protect PHI.
- A Business Associate shall have the meaning specified in the HIPAA Privacy Rule, HIPAA Security Rule, the HITECH Act, and the Omnibus Rule.
- Provident can best perform its duties through the adoption and enforcement of a Privacy Practice Policy.
- Provident workforce members and Business Associates are all bound by this policy, including, but not limited to, any individual who is involved with Provident for the following purposes: employees, volunteers, billing, practicum/internship, and other roles and relationships where access to PHI & ePHI is required.

Provident, its Workforce Members, and Business Associates will:

- Collect, use, and disclose individual medical information only as authorized. Provident's workforce members and Business Associates will not use or supply such information for any purpose other than those expressly authorized by law, professional ethics, and accreditation requirements.
- Implement administrative, physical, and technical safeguards to protect PHI from unauthorized access or disclosures.
- Ensure that medical information must be accurate, timely, complete, and ensure that authorized personnel can access this data when needed.
- Not alter or destroy an entry in a record, but rather designate it as an error while leaving the original entry intact and create and maintain a new entry showing the correct data.
- Implement reasonable measures to protect the integrity of all data.
- Recognize that our clients have a right of privacy and respect clients' individual dignity at all times. Privacy will be respected to the extent that is consistent with performing required services and with the efficient administration of our business.
- Act as responsible information stewards and treat all individual PHI (including medical record data and related financial, demographic, and lifestyle information) as sensitive and confidential.
- Use or disclose only the "minimum necessary" health information to accomplish the particular task for which the information is used or disclosed.
- Disclose information only when there is written authorization for uses or disclosures of psychotherapy notes (if psychotherapy notes are maintained), for uses or disclosures for marketing purpose, and for uses and disclosures that involve the sale of Protected Health Information.
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.
- Not divulge PHI unless the client (or his/her authorized representative) has properly consented to the release or the release is otherwise authorized by law.
- When releasing PHI, take appropriate steps to prevent unauthorized re-disclosures, such as specifying that the recipient may not further disclose the information without client consent or as authorized by law.
- Implement reasonable measures to protect the confidentiality of medical and other information.
- Recognize that some medical information is particularly sensitive, such as HIV/AIDS information, mental health and developmental disability information, alcohol and drug abuse information, and other information about sexually transmitted or communicable diseases and that disclosure of such information could severely harm clients, such as by causing loss of employment opportunities and insurance coverage, as well as the pain of social stigma.
- Treat particularly sensitive information with additional confidentiality protections as required by law.
- Recognize that the client has a right of access to information contained in the medical record owned by Provident.
- Permit clients to access and copy their PHI in accordance with the requirements of the privacy regulation, including their electronic medical record and hard-copy medical record.
- Provide clients an opportunity to request correction of inaccurate data in their medical records in accordance with the requirements of the privacy regulation.
- Allow clients to restrict disclosures of PHI to a health plan when the individual pays out of pocket in full for services received.
- Document and provide clients an accounting of uses and disclosures other than those for treatment, payment, and health care operations in accordance with the requirements of the privacy regulation. Breaches of confidentiality will be documented via Incident Report forms.
- Verify that uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the client.
- Provident will inform you if a breach occurs that may have compromised the privacy or security of your information.

Enforcement: All employees, volunteers, and Business Associates of Provident must adhere to this policy. Provident will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment, professional discipline, and criminal prosecution, in accordance with Provident sanction policy and personnel rules and regulations.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

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Statement of Confidentiality

As a client at Provident, we want you to be informed of your rights and the limits of confidentiality. The confidentiality of personal information shared with your provider(s) is the cornerstone of a therapeutic relationship. In most circumstances, information shared is considered privileged communication and will not be shared with anyone, unless the client first provides signed written consent to do so.

There are, however, some limitations of confidentiality which require the disclosure of information. These include, but are not limited to, the following:

- When there is a serious threat of physical harm to yourself or another person (e.g., suicide or homicide);
- When mandated by state or federal law (e.g., in cases of known or suspected physical or sexual abuse or neglect of children, the elderly, or developmentally disabled);
- When specifically ordered by a court of law;
- For the purpose of professional supervision. Cases at Provident are reviewed regularly with a Clinical Supervisor to ensure quality of the care you are receiving;
- When collaborating with or consulting with your treatment team, including but not limited to: case managers, clinicians, psychiatric mental health nurse practitioners, medical assistants, collaborating psychiatrists, supervisors, practicum students/interns, and others that are Provident clinical and administrative workforce members involved in your treatment program. These individuals are bound by confidentiality requirements. A Release of Information is required to share information with individuals outside of your treatment team at Provident;
- When services are provided out in the community where confidential space is not available or interventions are conducted in public settings, such as in school settings or community based programs. In such circumstances, it may be possible for confidential information to be overheard or clients to be seen by others present in the setting. Please note that Provident staff are to exercise discretion to limit and prevent confidential client information from being disclosed in these settings.
- Information gathered from questionnaires, assessments, and surveys that are used for the purpose of data collection, outcome measurement, or research. Please note that any identifying information will be removed from data used;
- The use of insurance or third-party funding source implies consent by the client that information regarding diagnosis, treatment plan, and clinical information may be disclosed to your insurance company or funding source in order to facilitate insurance claim filing or management of care with your insurance or managed care company.

If it becomes necessary to release information, it will be done in such a way as to protect the confidentiality of clinical information, as much as possible. We want to assure all clients of our commitment to maintain confidentiality and that their case will be handled professionally and with the highest degree of confidentiality possible.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

Client Fee Information

1. Each appointment we have available is an opportunity for our team to help a person or family in need. Appointments missed or cancelled less than 24 hours in advance will result in a fee (**$20 for Counseling & $50 for Psychiatry**). Please notify us well in advance if you cannot attend an appointment so that someone else can be seen during that time.
2. Payment is expected at the time services are provided. If you are unable to pay your sessions fees or copayments at the time of service, your appointment may be rescheduled.
3. All prepaid assessment fees are non-refundable.
4. Insurance and income verification must be submitted prior to or at the first appointment.
5. The client seeking services or parent/guardian seeking services for minor children is responsible for all fees not paid by insurance.
6. By providing Provident with your insurance information, you are consenting to allow information regarding diagnosis, treatment plan, and clinical information to be disclosed to your insurance company for the purposes of claim filing and insurance reimbursement.
7. Insurance deductibles must be met in order for insurance to fund services at Provident. Fees charged to you will equal the standard rate required for all services provided until the deductible is met.
8. The fee for service without insurance will be based on our self-pay scale. The fee for service will be determined by the total household income and household size. Proof of income must be provided in order to be assigned a reduced fee for self-pay services.
9. If a client chooses not to use insurance, the standard out-of-pocket rate is required for all services.
10. Past due balances may interfere with the ability to schedule future appointments.
11. Cash, checks, money orders, and credit cards are acceptable forms of payment.
12. If you have any questions concerning your fees, charges, or payments that cannot be answered at the location where your services are provided, please call our **Relations Coordinator at 314-802-2647**.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

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Consent to Telehealth Services

Provident offers telehealth appointments, which use video conferencing to meet with your provider without being in the office. Telehealth is available to clients with video conferencing capabilities on their smart phone, computer, or tablet with webcam and microphone, as well as strong internet connectivity that supports participating in a video conference with good audio and video quality.

By participating in telehealth services with Provident, you are indicating consent to receive services delivered via video conference. Provident uses a HIPAA compliant account and has a Business Associate Agreement with Zoom, the video conferencing software company. There are advantages, disadvantages, and limitations regarding the security of confidential information when utilizing telehealth, which will be discussed with your provider. Provident's providers work to maintain the same level of care and professionalism that you would receive during an office-based visit. Your consent also indicates that you will, to the best of your ability, participate in your telehealth service in a confidential space in your own home to provide yourself the best atmosphere for your appointments.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

Telehealth Appointment Instructions

To prepare for your telehealth appointment:

1. Download the Zoom app to your device (smart phone, tablet, computer)
2. Allow the Zoom app to access to your camera and microphone to enable audio and video for telehealth.
3. **New Clients:** Complete your Consent Forms, Intake Survey, and any other forms assigned to you in your ClinicTracker Patient Portal. A link to verify your Patient Portal account will be sent from ClinicTracker, our electronic health record software company. Please check your junk mail if you do not see the verification email in your inbox.
4. Locate a quiet, confidential space in your home to participate in your telehealth session. Minimize distractions as much as possible. This time is for you!
5. **To join your appointment:** Access the Zoom meeting link in your Patient Portal Message or email. ***Copy and paste the link in your web browser.***
6. If you have not received your Zoom meeting link for your appointment, please contact the front desk at the site where your provider works:
    - **Counseling: St. Louis City (Olive Street):** 314-371-6500
    - **Counseling: Creve Coeur (Ladue Road):** 314-878-4340
    - **Counseling: South (Tesson Ferry Road):** 314-898-0102
    - **Counseling: Psychiatric Services:** 314-802-2670

Provident Behavioral Health

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Signature Page

Full Name: _____ **Birth Date: ___/___/_____**
First, Middle, & Last

Contact Information:

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email: _____

Provident may contact me and leave a message by (check all that apply): ☐ Voicemail ☐ US Mail ☐ Text Message
☐ **Please do not** contact me in the following ways: _____

In the case of any emergency, please notify:

Name: _____ Relationship: _____ Phone: _____

☐ Address same as client Address: _____ City: _____ State: _____ Zip: _____

Consent to Treatment

I have reviewed the Consent to Treatment policies, they have been explained to me, and I understand them. I request services from Provident.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Rights and Responsibilities

I have reviewed the Client Rights and Responsibilities policies, they has been explained to me, and I understand them.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Notice of Privacy Practice

I have reviewed the Notice of Privacy Practice policies, they have been explained to me, and I understand that Provident follows HIPAA privacy laws and will protect the confidentiality of my protected health information.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Statement of Confidentiality

I have reviewed and understand the Statement of Confidentiality policy and understand the extent to which Provident is permitted to disclose information about me.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Fee Information

I have reviewed the Client Fee Information policy, it has been explained to me, and I understand the fees associated with services and missed appointments.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Consent to Telehealth Services

I have reviewed and understand the Consent to Telehealth Services and consent to participate in telehealth services, when appropriate and available.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Provident Behavioral Health

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Fee Determination Form

Client Name: _____ **Client DOB:** _____

Parent Name/Name of Insured: _____ **Insured DOB:** _____

Home Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell/Other Phone #:** _____

Billing Address (if different than Home): _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Insurance Information: ☐ I have insurance ☐ I do not have insurance

Name of Primary Insurance Company: _____ ID#: _____ Group ID: _____
Insurance Card Holder Name: _____ Copay: $_____ Deductible: $_____

Name of Secondary Insurance Company: _____ ID#: _____ Group ID: _____
Insurance Card Holder Name: _____ Copay: $_____ Deductible: $_____

Employment Information: ☐ I am employed ☐ I am not employed

Household Income Information: Please provide income information for all members in your household

Gross Household Income		
Family Member	**Employer Name**	**Annual Income**
Self:		$
Significant Other (if living together)**:**		$
Other Family Members in Household:		$
Child Support/Alimony Received (annual amount):		$
If you did not file a Tax Return, please note Annual Gross Income (before taxes):		$
Total Annual Gross Household Income:		$
Total # of people living in household (including yourself):		
Fee amount for Self-Pay Services is based on Total Gross Household Income and household size. Household income information is gathered on all clients to better understand the demographic background on all of our clients. Your income will not negatively impact your ability to receive services.	**Counseling** Mental Health Assessment Individual & Family Therapy **Psychiatric Services** Psychiatric Evaluation: Follow Up/Medication Management:	**Max out of pocket fees** $140 $140 $240 $150

I understand that all payments and co-payments are due at time of service. An appointment cancellation notice is required 24 hours in advance to avoid a charge being made to me. I authorize release of any medical or other information necessary for my insurance company/funding source to process claims for services received. I authorize that payment from my insurance company, Medicare, or Medicaid be made on my behalf to Provident for any services provided to me by the agency. I also request payment of government benefits to the party who accepts assignment. This consent remains in my file and can be revoked by me at any time upon written request by me to Provident. If my particular insurance carrier or funding source does random site reviews or audits, I understand that representatives review the contents of my file.

My signature indicates I have read and understand all of the above.

Client/Guardian Signature(s): _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

Please attach copies of:

1. **If insured: Insurance, Medicare, and Medicaid Cards** (front & back)
2. **If self-pay: IRS 1040 Tax Return Form or 2 most recent Paycheck Stubs, Benefit Statement** (for Unemployment or Social Security Disability), or other proof of income.

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Adult Intake Survey

Legal Name: _____ Birth Date: ___/___/_____ Age: ____ Sex at Birth: ☐ Male ☐ Female

Preferred/Chosen Name: _____ Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Other: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email: _____

Race/Ethnicity: ☐ Black or African American ☐ Caucasian ☐ Asian ☐ Hispanic/Latino ☐ Biracial/Multiracial
☐ Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Other/Describe: _____

Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Questioning ☐ Other: _____

Marital Status: ☐ Single ☐ Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Significant Other Name: _____ Age: _____

Who referred you to Provident? _____

HOUSING

I live in an: ☐ Apartment ☐ House ☐ Other: _____ that I ☐ Rent ☐ Own

What is your living situation? ☐ Stable ☐ Unstable ☐ Homeless ☐ Dangerous or Hazardous

Total # of people living in the household (including yourself): _____

Who lives with you?

Name of Household Member	Age	Relationship

EMPLOYMENT HISTORY

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Student ☐ Disabled ☐ Retired

Name of Employer(s): _____ Job Title: _____

Length of Current Employment: ☐ 0-6 months ☐ 7 months-1 year ☐ 1-5 years ☐ 6-10 years ☐ 10+ years

Hours worked weekly: _____ How are you paid? ☐ Hourly ☐ Salaried ☐ Commission ☐ Contract ☐ Self-Employed

Is your income adequate? ☐ Yes ☐ No Is your income stable? ☐ Yes ☐ No

Are there others who assist you financially? ☐ Yes ☐ No If yes, who: _____

What other jobs have you held? _____

What is the longest you have held a job? _____

Do you need a referral for job training? ☐ Yes ☐ No

Are you disabled or receiving workers' compensation? ☐ Yes ☐ No If yes, explain: _____

Are you here for a disability or worker's compensation issue? ☐ Yes ☐ No If yes, explain: _____

Do you use assistance to pay utility bills or other expenses? ☐ Yes ☐ No If yes, explain: _____

Is there enough food and clothing in the household? ☐ Yes ☐ No

Annual Family/Household Income: $_____

Provident Behavioral Health

Client Name: _____
DOB: ___/___/____
Date Completed: ___/___/____

EDUCATION AND LEARNING

Primary Language: ☐ English ☐ Other: _____ Do you need an interpreter? ☐ Yes ☐ No

Years of Education: ☐ GED ☐ High School Diploma ☐ Trade/Technical School ☐ Some College
☐ Associate's ☐ Bachelor's Degree ☐ Master's Degree or Above ☐ Other: _____

MILITARY HISTORY

Have you ever been in the military? ☐ Yes ☐ No
Branch of Service: _____ Dates of Service: _____
Discharge Status: _____ Have you seen combat activity? ☐ Yes ☐ No

FAMILY HISTORY

I was raised by: ☐ Biological Parents ☐ Single Parent ☐ Foster/Adoptive Family ☐ Grandparent(s)
☐ Two-Parent Household ☐ Other: _____

How many brothers and sisters in your family? _____

CHILDHOOD RELATIONSHIPS

Was anyone emotionally, physically, or sexually violent or abusive to you? ☐ Yes ☐ No

Did you witness any emotional, physical, or sexual violence or abuse as you grew up? ☐ Yes ☐ No

ADULT RELATIONSHIPS

Have you ever been afraid of being hurt by your partner or someone else? ☐ Yes ☐ No

Have you ever been hit, kicked, slapped, pushed or shoved by a partner, spouse, or someone else? ☐ Yes ☐ No

Have you ever been forced or pressured to have sex when you did not want to? ☐ Yes ☐ No

LIFESTYLE

What activities do you enjoy in your free time? _____

Who in your life do you depend upon for emotional support? _____

My support system includes: ☐ Many friends and family ☐ few friends or family ☐ no support system

What community or self-help groups do you use? _____

What is your religious background and/or spiritual beliefs? _____

Are you active or still participate in these spiritual practices? ☐ Yes ☐ No

Has your spiritual experience been helpful to you? ☐ Yes ☐ No

LEGAL HISTORY

Have you ever been arrested and/or charged with any crimes? ☐ Yes ☐ No

Explain: _____

Current Court Involvement: ☐ None ☐ DWI/DUI ☐ Probation ☐ Parole ☐ Pending Charges ☐ Diversion ☐ Lawsuit
☐ Restraining Order/Order of Protection ☐ Other: _____
Name of Probation/Parole Officer: _____

Have you or your family been involved with Children's Services (DFS, DCFS, Children's Division)? ☐ Yes ☐ No ☐ Currently Involved

Explain: _____

Provident Behavioral Health

Client Name: _____
DOB: ___/___/____
Date Completed: ___/___/____

MEDICAL HISTORY

Height: _____ Weight: _____ Date of Last Physical Exam: ____/____/_____

Primary Care Provider: _____ Practice Name/Location: _____

Phone Number: _____ ☐ Provident can coordinate care with my primary care provider

If you do not have a doctor, do you know how to access medical care? ☐ Yes ☐ No

Please list any other doctors or specialist you work with and what issues they are treating you for: _____

_____

Indicate which of the following medical conditions ***currently*** affect you:

☐ Acid Reflux	☐ Allergies	☐ Asthma	☐ Autoimmune Disorder	☐ Birth Defects
☐ Cancer	☐ Chest Pain/Pressure	☐ Chronic Pain	☐ Constipation	☐ Cough
☐ Diabetes	☐ Diarrhea	☐ Difficulty Breathing	☐ Difficulty Speaking	☐ Difficulty Swallowing
☐ Dizziness/Vertigo	☐ Ear Pain	☐ Eating Disorder	☐ Epilepsy/Seizures	☐ Fatigue
☐ Fever/Chills/Sweats	☐ Eye Pain	☐ Glaucoma	☐ Headaches/Migraines	☐ Hearing Loss
☐ Heart Disease	☐ Heart Attack	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ Kidney Problems	☐ Kidney Disease/Dialysis	☐ Liver Problems	☐ Loss of Appetite	☐ Menstrual Problems
☐ Nasal Congestion	☐ Pregnancy	☐ Shortness of Breath	☐ Sickle Cell	☐ Sleeping Problems
☐ Stomach Pain/Problems	☐ Stroke	☐ Thyroid Disorder	☐ Traumatic Brain Injury	☐ Urinary Problems
☐ Vision Problems	☐ Vomiting	☐ Weight Change (loss/gain)	☐ Difficulty Walking/Coordinating Movements	

☐ Other: _____

Are you currently being treated for the medical conditions listed above? ☐ Yes ☐ No

Please explain any current or past medical conditions, serious illnesses, injuries, or surgeries: _____

_____

Please list any allergies you have (food, medication, seasonal, etc.): _____

Do you have any difficulty sleeping or problematic dreams? ☐ Yes ☐ No If Yes, describe: _____

Family history of medical issues *(include medical issue and family member relationship):* _____

Have you had any sexually transmitted diseases or infections?

☐ None ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HIV/AIDS ☐ HPV ☐ Syphilis ☐ Other: _____

Current Medications: Please list all prescriptions, over the counter medications, and supplements you are currently taking.*

Medication Name	Dosage/Frequency	Start Date	Prescribing Physician	Side Effects

Do you take your medication as prescribed? ☐ Yes ☐ No

***attach medication list, if needed**

Pain Screen: On a scale of 1 to 10, what is the present level of **physical** pain you are experiencing? *(circle one)*

0 1 2 3 4 5 6 7 8 9 10
No Pain **Extreme Pain**

Location of Pain: ☐ Muscular ☐ Joint ☐ Neck ☐ Back ☐ Other: _____

Does your pain affect your daily activities? ☐ Yes ☐ No

Nutrition Screen: *Please answer the following about your nutritional habits. Please explain any items marked "yes".*

Yes	No	I…	Explanation:
1	0	1. Have had a decreased appetite/has been eating less than normal.	Decreased appetite has lasted for: ____ **(#) days/weeks/months**
1	0	2. Have lost or gained at least 10 pounds in the last **3** months.	_____ pounds ☐ gained ☐ lost
1	0	3. Have an allergy, illness, or condition impacts how they eat.	Explain:
1	0	4. Require a special diet.	Explain why special diet is needed and if you adheres to diet:
1	0	5. Have dental problems that make it hard to eat.*	Describe tooth or mouth pain/problems:
1	0	6. Eat fewer than 2 meals per day.	
1	0	7. Eat too few fruits or vegetables or milk products.	
1	0	8. Do not always have enough money to buy the food I need.**	
1	0	9. Have been binge eating (eating large quantities of food at once).	
1	0	10. Have been forcing myself to vomit after eating.	
1	0	11. Have been excessively active to burn off calories consumed.	
1	0	12. Have been concerned with weight and/or restricting calories.	
Total Score:		**Score Interpretation:** Scores of 4-7 = use clinical judgement to determine referral needs. Scores of 8+ = refer to doctor, nutritionist, or other appropriate resource(s). *Refer to dental care if dental problems are noted. **Refer to resources for food if family needs assistance.	

Provident Behavioral Health

Client Name: _____
DOB: ___/___/____
Date Completed: ___/___/____

SUBSTANCE USE HISTORY

Substance	Age of First Use	How Often?	How Much?	Date of Last Use?
Caffeine				
Tobacco/Nicotine				
Alcohol				
Cannabis				
Cocaine				
Heroin/Opioids				
Amphetamines				
Hallucinogenic				
Prescription				
Other: _____				

Have you ever participated in substance abuse or misuse treatment? ☐ Yes ☐ No

If Yes, Where? _____ When? _____ How Long? _____

I have attended AA (Alcoholics Anonymous) and/or NA (Narcotics Anonymous) meetings: ☐ Yes ☐ No

Would you like information about smoking cessation? ☐ Yes ☐ No

GAMBLING SCREEN

During the past 12 months, have you become restless, irritable, or anxious when trying to cut down on gambling? ☐ Yes ☐ No

During the past 12 months, have you tried to keep your family member or friends from knowing how much you gambled? ☐ Yes ☐ No

During the past 12 months, did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare? ☐ Yes ☐ No

MENTAL HEALTH HISTORY

Have **you** had previous counseling, psychotherapy, or psychiatric care? ☐ Yes ☐ No

If Yes, describe past treatment history, including dates, types of services, medications prescribed, previous diagnoses, and effectiveness of past services:

_____

_____

Do you have any **family history** of mental health or substance abuse problems? ☐ Yes ☐ No

If Yes, explain: _____

Do you have a Psychiatric Advanced Directive? *(If Yes, please provide a copy)* ☐ Yes ☐ No

☐ I would like information about Psychiatric Advanced Directives

What traumatic or difficult events have you experienced in your life? *(include accidents, losses, abuse, neglect, or exploitation)*

_____

_____

CURRENT TREATMENT NEEDS

What problems or concerns bring you to Provident today? *(Include when problem began, how often, triggers, etc.)*

_____

_____

What do you hope to accomplish through treatment?

_____

_____

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Name: _____ **Date:** _____

Brief Mood Survey*

Instructions. Use checks (✓) to indicate how depressed, anxious or angry you've been feeling over the past week, including today. Please answer all the items.

Depression	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
1. Sad or down in the dumps					
2. Discouraged or hopeless					
3. Low self-esteem, inferiority, or worthlessness					
4. Loss of motivation to do things					
5. Loss of pleasure or satisfaction in life					
Total Items 1 to 5 →					

Suicidal Urges					
1. Have you had any suicidal thoughts?					
2. Would you like to end your life?					
Total Items 1 to 2 →					

Anxiety					
1. Anxious					
2. Frightened					
3. Worrying about things					
4. Tense or on edge					
5. Nervous					
Total Items 1 to 5 →					

Anger					
1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					
Total Items 1 to 5 →					

Relationship Satisfaction*

Instructions. Use checks (✓) to show how satisfied or dissatisfied you feel in your closest personal relationship.
Please answer all 5 items.

	Dissatisfied				Satisfied		
	0—Very	1—Moderately	2—Somewhat	3—Neutral	4—Somewhat	5—Moderately	6—Very
1. Communication and openness							
2. Resolving conflicts and arguments							
3. Degree of affection and caring							
4. Intimacy and closeness							
5. Overall satisfaction							
Total Items 1 to 5 →							