HOLLAND ASSESSMENT AND COUNSELING

Client Face Sheet

Name:____
First *Middle* *Last*

Address:____
Street/Route *City* *State* *Zip*

Telephone :(   ) ______________   (   )__________________
Home *Cell*

Email Address:____

Drivers License #:_____________________ County of Arrest:__________________

Employment Status: Full Time Part Time Other_______________

Health Insurance: Private Insurance Blue Cross Medicare Medicaid NC Health Choice

for Children Health Maintenance Organization (HMO) Other ___________ None

Sex:_____ Race:_____ D.O.B. ____________ SSN#_____/_____/_____

Age:_____ Education Completed:______ Marital Status:__________

Date of Offense:_______________ Date of Conviction:_______________

# of Prior Convictions:________ BAC Reading:_____ Docket #_________________

Emergency Contact:___________________________Relationship:_______________

Address:___________________________________Phone#_________________________

Holland Assessment And Counseling
Client Rights / Grievances Document

Client Rights:
I understand my basic rights as a client. These rights include:

1. You have the right to be treated with dignity and respect.
2. You have the right to confidentiality.
3. You have the right to be informed of program rules and cost of treatment at Admission.
4. You have the right to be placed in the appropriate level of treatment and be given notice of any change in your status as a client, such as a transfer or early discharge.
5. You have the right to have access to and be a part in the development of your treatment plan, as well as be informed of the reason for treatment.
6. You have the right to be aware of the expectations of you for completion of your treatment plan and treatment.
7. You have the right to refuse treatment at any time and request your release from Holland Assessment & Treatment Services outpatient program.
8. You have the right not to go under physical restraint unless you are a threat to your safety or the safety of others.
9. You have the right to a full explanation, in terms you can understand, of any risk associated with your treatment.

Grievance Policy:
I understand that if I have a complaint/grievance, I should:

All individuals served or persons potentially seeking services and/or family members, have the right to express an appeal or grievance to the agency against decisions which adversely affect individual right to treatment without fear of staff interference or coercion. All complaints and grievances should be forwarded to the Director who will investigate and meet with the grieving party within five days to resolve the issue.

I understand that I have a right to contact the agencies below at any time to discuss my complaint/grievance:

DWI Services, Justice Systems Innovations
NC Mental Health/Developmental Disabilities/Substance Abuse Services
Donna Brown donna.m.brown@dhhs.nc.gov
3008 Mail Service Center
Raleigh, NC 27699-3008
Ph: 984-236-5250 Fax: 919-508-0963

North Carolina Substance Abuse Professional Practice Board
http://www.ncsappb.org/
http://www.ncsappb.org/wp-content/uploads/2012/11/complaints.pdg
P.O. Box 10126 Raleigh, NC 27605
Katie Gilmore, Associate Executive Director
katie@recanc.com

Disability Rights NC
http://www.disabilityrightsnc.org/
3724 National Drive, Suite 100, Raleigh, NC, 27612
(877) 235-4210 or (919) 856-2195
Email: info@disabilityrightsnc.org.

I certify that I have received a copy of this Client Rights/Grievance **Policy.**

Client's Signature: ______________________ Date: ____________

Counselor's Signature/Credential: ______________________ Date: ____________

Updated 01/01/20

Holland Assessment And Counseling

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION CRIMINAL JUSTICE SYSTEM REFERRAL

42 CFR Part 2 and HIPAA

I, ____, authorize
[Patient's Name]

____ to disclose to one another:
[Name or general designation of individual or entity making the disclosure]

Initial all that apply: ☐ NC Department of Community Corrections (PO): ____________________

☐ NC DMV ☐ NC Division of MH/DD/SAS ☐ ____________________
[Name of the Criminal Defense Attorney]

☐ ____________________ ☐ ____________________ ☐ ____________________
[Name of the appropriate court] *[Name of the prosecuting District Attorney]* *[- Other -]*

the following information:

☐ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and/or

☐ ____
[describe how much/what kind of information may be disclosed, including & explicit description of what substance use disorder information may be disclosed; as limited as possible]

for the purpose of ____.
[describe the purpose of the disclosure; as specific as possible]

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and 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. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

____.
[describe date/event/ condition upon which consent will expire; must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: ____________ ____
Signature of Patient

Dated: ____________ ____
Signature of person signing form if not patient

____
Describe authority to sign on behalf of patient

Dated: ____________ ____
Witness/Staff Signature

Notice Prohibiting re-disclosure of Substance Use Disorder Information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §2.12(c)(5) and §2.65. (updated 01/01/20)

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

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?

   Yes No If yes enter 1 ________

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?

   Yes No If yes enter 1 ________

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?

   Yes No If yes enter 1 ________

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?

   Yes No If yes enter 1 ________

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?

   Yes No If yes enter 1 ________

6. Were your parents ever separated or divorced?

   Yes No If yes enter 1 ________

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 at least a few minutes or threatened with a gun or knife?

   Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

   Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   Yes No If yes enter 1 ________

10. Did a household member go to prison?

    Yes No If yes enter 1 ________

Now add up your "Yes" answers: ________ This is your ACE Score.

Adapted from: http://www.acestudy.org/files/ACE_Score_Calculator.pdf, 092406RA4CR

FFT
9/06

SUICIDAL IDEATION QUESTIONNAIRE

INSTRUCTIONS: Listed below are a number of sentences about thoughts that people sometimes have. Please indicate *which of these thoughts you have had in the* ***past month****.* Fill in the circle below the answer that best describes your own thoughts. Be sure to fill in one response for each sentence. *Remember, there are no right or wrong answers.*

THIS THOUGHT WAS IN MY MIND:	Almost every day	Couple of times a week	About once a week	Couple of times a month	About once a month	I had this thought before but not in the past month	I never had this thought
1. I thought it would be better if I was not alive.	○	○	○	○	○	○	○
2. I thought about killing myself.	○	○	○	○	○	○	○
3. I thought about how I would kill myself.	○	○	○	○	○	○	○
4. I thought about when I would kill myself.	○	○	○	○	○	○	○
5. I thought about people dying.	○	○	○	○	○	○	○
6. I thought about death.	○	○	○	○	○	○	○
7. I thought about what to write in a suicide note.	○	○	○	○	○	○	○
8. I thought about writing a will.	○	○	○	○	○	○	○
9. I thought about telling people I plan to kill myself.	○	○	○	○	○	○	○
10. I thought about how people would feel if I killed myself.	○	○	○	○	○	○	○
11. I wished I were dead.	○	○	○	○	○	○	○
12. I thought that killing myself would solve my problems.	○	○	○	○	○	○	○
13. I thought that others would be happier if I was dead.	○	○	○	○	○	○	○
14. I wished that I had never been born.	○	○	○	○	○	○	○
15. I thought that no one cared if I lived or died.	○	○	○	○	○	○	○

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Visit: ○ **Initial** ○ **3 month** ○ **6 month** ○ **9 month** ○ **12 month** ○ **18 month** ○ **24 month**

SITE ○ **Colorado** ○ **Pittsburgh** ○ **Cincinnati**

52933

ID [ ][ ][ ][ ] **DATE** [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

2024

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Client ID# | Today's Date | Facility ID# | Zip Code | Administration

TCU DRUG SCREEN V

During the last 12 months (before being locked up, if applicable) –

	Question	Yes	No
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	O	O
2.	Did you try to control or cut down on your drug use but were unable to do it?	O	O
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	O	O
4.	Did you have a strong desire or urge to use drugs?	O	O
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	O	O
6.	Did you continue using drugs even when it led to social or interpersonal problems?	O	O
7.	Did you spend less time at work, school, or with friends because of your drug use?	O	O
8.	Did you use drugs that put you or others in physical danger?	O	O
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	O	O
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	O	O
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	O	O
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	O	O
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	O	O

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

- O None
- O Alcohol
- O Cannaboids – Marijuana (weed)
- O Cannaboids – Hashish (hash)
- O Synthetic Marijuana (K2/Spice)
- O Opioids – Heroin (smack)
- O Opioids – Opium (tar)
- O Stimulants – Powder Cocaine (coke)
- O Stimulants – Crack Cocaine (rock)
- O Stimulants – Amphetamines (speed)
- O Stimulants – Methamphetamine (meth)
- O Bath Salts (Synthetic Cathinones)
- O Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)
- O Dissociative Drugs – Ketamine/PCP (Special K)
- O Hallucinogens – LSD/Mushrooms (acid)
- O Inhalants – Solvents (paint thinner)
- O Prescription Medications – Depressants
- O Prescription Medications – Stimulants
- O Prescription Medications – Opioid Pain Relievers
- O Other (specify) ____________

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2024

Time to Reorder! You can reorder where you normally purchase stationery products

NIDA Clinical Trials Network

Drug Abuse Screening Test (DAST-10)

General Instructions

"Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Segment: __

Visit Number: __

Date of Assessment: (mm/dd/yyyy) __/__/____

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. **Have you used drugs other than those required for medical reasons?**
   ☐ No ☐ Yes
2. **Do you use more than one drug at a time?**
   ☐ No ☐ Yes
3. **Are you always able to stop using drugs when you want to?**
   ☐ No ☐ Yes
4. **Have you had "blackouts" or "flashbacks" as a result of drug use?**
   ☐ No ☐ Yes
5. **Do you ever feel bad or guilty about your drug use?**
   ☐ No ☐ Yes
6. **Does your spouse (or parents) ever complain about your involvement with drugs?**
   ☐ No ☐ Yes

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371.
Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. J Subst Abuse Treatment. 32:189-198.

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+

"Lie-Bet:" Two-Question Screening for Problem Gambling

The questions:

1) Have you ever felt the need to bet more and more money?
2) Have you ever had to lie to people important to you about how much you gambled?

Intervene if individual is at risk for suicide

Financial problems
Crime
Alcohol/Drug Issues
Depression
Other Mental Health Issues

Administer Lie-Bet Screening

"No" to both questions: No referral; follow-up as needed.

"Yes" to one or both questions: Further assessment needed. Refer the individual for further assessment or, if available, local gambling treatment center.

The Lie-Bet tool (Johnson et al., 1988) has been deemed valid and reliable for **ruling out** pathological gambling behaviors. The Lie-Bet's two questions consistently differentiate between pathological gambling and nonproblem gambling, and are useful in screening to determine whether a longer tool (e.g., South Oaks Gambling Screen/SOGS, DSM-IV) should be used in diagnostics.

The 24-hour Confidential National Gambling Helpline is 1-800-522-4700

References: Johnson, E.E., Hamer,R., Nora, R.M., Tan, B., Eistenstein, N., & Englehart, C. (1988). The lie/bet questionnaire for screening pathological gamblers. *Psychological Reports, 80*, 83-88.

Götestam, K.G., Johansson, A., Wenzel, H.G., Simonsen, I.E. (2004). Validation of the lie/bet screen for pathological gambling on two normal population data sets. *Psychological Reports, 95*, 1009-13.

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www.preventionlane.org/gambling
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