Mental Health Services
Adult Intake Questionnaire

EMERGENCY RESPONDERS
HEALTH CENTER

Today's Date: _____/_____/_____ ☐ **Female** ☐ **Male**

Legal Name: First: ___________________________ Middle Initial: _______ Last: __________________________

Preferred First Name: ______________________________ **Birth Date:** _____/_____/_____ **Age:** _______

Contact Info: Phone: ( ) ______-__________ ☐ Cell ☐ Landline Email Address: ______________________________

Profession: ☐ Fire ☐ Law Enforcement ☐ EMS ☐ Emergency Dispatch ☐ Other: __________________

How many total years have you served in emergency response? __________

Current Level of Emergency Response Duty: ☐ Responder ☐ Chief/Deputy Chief ☐ Administrator

Current Department: ____ **Since:** _______/_______
MM YY

Current Role(s): ____
(Division, Special Operations Team Assignments, Title, etc.)

Military Service: ☐ Active Duty ☐ Reserve ☐ Veteran ☐ Other: ________________________________
Branch of Service: _________________ Deployments:______________________________

Social History

Relationship Status: ○ Single/Dating ○ Partnered/Married ○ Separated/Divorced ○ Widowed

Name of Spouse/Significant Other: _____________________________ Years in this Relationship: _______

How would you describe this relationship? ____

____

____

Parenting Status: ○ Minor Child(ren) (under 18 years) ○ Stepchildren/Blended Family ○ Adult Child(ren)
(Check all that apply.) ○ Departed Children ○ No Children ○ Other Comments: _____________________

Support Network: Who makes up your support system?
(Check all that apply.) ○ Family ○ Friends Outside of Work ○ Friends at Work ○ Faith Community
○ Other: ______________________

Cultural/Religious Background:

Please describe other considerations related to your faith or culture you would like your therapist to know:

____

____

____

Reason for Seeking Care ____

Which services are you interested in at this time?

☐ Individual Counseling ☐ Couple's Counseling with: ______________________________________
(List partner's full name.)*

☐ Workers' Compensation Evaluation for PTSI ☐ Other Support: ______________________________

**Your partner will also be asked to complete an individual intake form.*

What concerns are you seeking support to help manage? ______________________________________

____

When did these concerns begin to trouble you? ____

Which of the following are you currently experiencing? *(Check all that apply.)*

☐ Low/Depressed Mood
☐ Feeling Isolated/Disconnected
☐ Feeling Worthless/Low Self-Esteem
☐ Social Withdrawal
☐ Loss of Interest in Activities
☐ Poor Appetite
☐ Mood Swings
☐ Irritability/Agitation
☐ Feeling Anger/Rage
☐ Feeling Aggressive/Aggressive Behaviors
☐ Low Sense of Motivation
☐ Fatigue/Low Energy
☐ Unusual Weight Loss/Gain
☐ Binge Eating/Over-Eating
☐ Purging/Forced Vomiting
☐ Avoiding Eating

☐ Poor Body Image
☐ Frequent/Chronic Pain
☐ Memory Lapses/Forgetfulness
☐ Absentmindedness/Misplacing Things
☐ Feeling Disconnected Mentally
☐ Hyperactivity/Restlessness
☐ Inability to Focus/Concentrate
☐ Racing Thoughts
☐ Decreased Need for Sleep/ Manic Behavior
☐ Increased Need for Sleep/ Oversleeping
☐ Insomnia/Other Sleep Issues
☐ High Levels of Chronic Stress
☐ Excessive Worry
☐ Persistent Anxiety
☐ Anxiety in Social Situations

☐ Recurrent Fears/Phobias
☐ Feeling Mistrustful
☐ Feeling Unsafe
☐ Panic Attacks
☐ Easily Startled/Hypervigilant
☐ Reliving Past Traumatic Events
☐ Nightmares/Flashbacks
☐ Unwanted Thoughts
☐ Obsessive Thoughts/Behaviors
☐ Compulsive (uncontrollable) Thoughts/Behaviors
☐ Self-Destructive Behaviors
☐ Difficulty Forming/Keeping Relationships
☐ Fear of Abandonment/Loss
☐ Thoughts of Self-Harm
☐ Thoughts of Suicide
☐ Thoughts of Violence/Homicide

Are you currently managing:

○ Relationship/Family Issues ○ Parenting Issues ○ Grief/Loss
○ Job-Related Issues ○ Financial Issues ○ Legal/Custody Issues
○ Abuse/Victimization/Harassment ○ Survivor of Violence/Assault
○ Sexual Issues ○ Sexuality/LGBT Issues

If you indicated "yes" to any of the items above, please briefly describe: ______________________________

____

Do you have a history of experiences or exposures you would describe as "traumatic"?

☐ Recent Work-Related Trauma (past 3-6 months) ☐ Past Work-Related Trauma (more than 6 months ago)

☐ Childhood/Adolescent Trauma ☐ Other Life Trauma

If yes, please briefly provide any information you are comfortable sharing. You'll have the opportunity to describe your experience to your therapist in more detail, when you are comfortable doing so.

____

____

Have you experienced suicidal thoughts or attempts? ○ Yes, recently ○ Yes, in the past ○ Never

If "yes," please briefly describe: ____

____

Medical & Mental Health History

Do you use alcohol and/or other substances? ○ Routinely ○ Often ○ Rarely ○ Never

If "Routinely" or "Often," please provide more details below.

What types of alcohol or drugs do you use? ____

How much of these substances do you use at one time? ______________________________

How often do you use these substances? ___________ When did you last use these substances? _________

Substance Abuse Support/Treatment: *If you have undergone previous treatment for alcohol or drug abuse, including support group attendance, outpatient programs, or inpatient admissions, please list them below.*

Group/Program/Facility	Dates	Group/Program/Facility	Dates

Are you experiencing any medical issues that are impacting you on a personal or professional level? *(Describe.)*

____

____

Primary Care Provider: Name: ___________________________________ Phone: (   ) ______-__________

Family History

Please note any family history of significant medical, mental health or addiction issues, or suicide attempts.

____

____

____

Personal Goals

What are your personal strengths? ____

What do you do to cope with difficult situations? _______________________________

____

What do you hope to gain from counseling? ______________________________________

____

Is there anything else you would like for your therapist to know? _____________________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________________ DATE: ______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		____ +	____ +	____

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

TOTAL: ______________

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

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Name:________________________ **PCL-5** Date:____________________

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

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

Emergency Responders Health Center (ERHC)

8781 WEST ARDENE STREET | BOISE, ID | 208.229.8433 | er-hc.org
316 WEST BOONE AVENUE | SPOKANE, WA | 509.824.7323 | erhcnorth.org

MENTAL HEALTH SERVICES CLIENT INFORMATION & AGREEMENT

CLIENT RIGHTS & RESPONSIBILITIES

You have the right to receive respectful, compassionate, and confidential services and to participate in your treatment planning. You have the right to be informed about your diagnosis (if applicable), your treatment options, and the possible benefits and risks of selected therapies. You have the right to receive services free from discrimination, including based on your ethnicity, national origin, sex, sexual orientation, gender identity, religious beliefs, age, disability, or protected status.

You will be asked to attend sessions as scheduled and promptly communicate if you need to cancel or reschedule a visit, in accordance with ERHC's Late Cancellation/No Show policy. You will be asked to actively participate in your treatment planning, communicate accurately and honestly with your therapist, and follow agreed-upon goals. You will be asked to treat ERHC staff and other clients with respect.

This agreement applies to all services provided through ERHC's licensed mental health professionals, to include but not limited to individual and couple's therapy, clinical support groups, and department-sponsored Check-In Sessions. Note that ERHC **does not provide formal fit-for-duty or IME evaluations**; a Mental Health Services (MHS) Program Coordinator will provide recommendations for qualified providers who perform these assessments, upon department or client request.

CONFIDENTIALITY

Information that you disclose to your therapist will be kept confidential, in adherence with applicable privacy laws. No information will be shared with unauthorized individuals - to include your partner, family members, your employer, or others - unless you provide express written permission. However, you should be aware of the following **Mandated Reporting Requirements**, based on legal obligations within the mental health profession, as well as billing agreements with third parties.

- **Suicidal Ideation** - If you disclose imminent plans to hurt or kill yourself, your therapist must contact resources to ensure your safety.
- **Homicidal Ideation** - If you disclose plans to hurt or kill someone else, your therapist must contact both law enforcement and the intended victim(s).
- **Abuse/Neglect of a Child, Other Dependent, or Vulnerable Adult** - Mental health professionals must report suspected or confirmed cases of abuse to appropriate state Health & Welfare and/or Children's/Adult Protective Services officials.
- **Legal Subpoena** - If a court of law orders ERHC to share written information from your clinical records, your therapist will notify you of the order, ask the court to clarify the scope of information requested, and disclose only the minimum amount of information necessary to satisfy the court requirements. A service fee may apply if a therapist is court-ordered to provide live testimony during a proceeding. Therapists may decline requests from clients or family members to testify in a live proceeding.
- **Clinical Collaborators** - Your therapist may discuss your case with other members of the ERHC clinical and support team, to provide the highest quality care. Your therapist will share only the level of information necessary to support your treatment.
- **Hospitalization/Guardianship/Conservatorship** - If you can no longer make decisions for yourself due to cognitive or emotional incapacitation, your therapist may disclose information to your spouse and/or adult family members and other legally authorized individuals engaged in your care to help them make informed decisions on your behalf.
- **Billing Agents** - Minimal information will be provided to ERHC's billing team to process third-party payment for your visits.
  - Standard Therapy Services: Information provided to insurance/EAP agencies may include visit dates, issue/diagnosis (if applicable), and treatment plans/progress.
  - Insurance & EAP-Paid Check-In Sessions: Information provided to insurance/EAP agencies will include visit dates. A generic "diagnosis code" may be assigned for billing purposes. You may be responsible to provide attendance verification to your department. No clinical information will be shared with your employer.
  - Department-Paid Check-In Sessions: Information provided to your employer will include visit dates, for billing purposes.* Departments who refer employees to ERHC may be provided with a list of these scheduled Check-In Sessions, upon request. If your department has agreed to pay any session Late Cancellation/No Show fees, ERHC will share missed appointment dates/times, along with the missed visit rationale, with them. No clinical information will be shared with your employer.

*Clients based in Valdez, AK: Your department may be billed for a total number of Check-In visits, in aggregate. ERHC will not confirm your visit date with your employer. You may be responsible to provide attendance confirmation to your department officials.

- Workers' Compensation: Information provided to your <u>adjustor</u> (i.e. State Insurance Fund, Corvel, Intermountain Claims, Washington State Labor & Industries, etc.) will include visit dates and a copy of your treatment notes. Information provided to your <u>employer</u> will be limited to return-to-work clearance status only. Please discuss any specific questions with your therapist.

CLIENT RECORDS

ERHC MHS maintains client records (including client forms, progress notes, billing information, etc.) in a secure, HIPAA-compliant electronic health record system, with safeguards to ensure confidentiality, data integrity, and accessibility, in accordance with federal and state laws and professional ethical standards. Records will be maintained for a minimum 7 years following your last date of service. You have the right to request copies or authorize release of your records to another provider, agency, or legal representative, by completing a written Release of Information form; please allow up to 5 business days for processing. ERHC reserves the right to charge a reimbursement fee for excessive records requests.

TELEHEALTH SERVICES

Therapy may be provided through HIPAA-compliant telehealth sessions in qualifying circumstances. You will receive a copy of protocols upon request. Televisits can be provided only when clients are **<u>physically located</u>** in a state where their therapist holds an active license, during their remote session.

COMMUNICATION

If you need to contact your therapist between sessions for non-emergency concerns, please email them or call **(208) 229-8433 [Boise] or (509) 824-7323 [Spokane]** during regularly scheduled clinic hours. Your therapist may communicate with you between sessions via voice mail, text, or email (i.e., to share resources or confirm scheduling information), if you have consented for them to do so. Please be aware these forms of communication are not encrypted. While ERHC strives to protect client privacy, we cannot guarantee the confidentiality/security of therapist or client messages sent through voice mail, text, or email. These methods **should not be used** to communicate mental health disclosures, suicidal/homicidal thoughts, other urgent symptoms, or life-threatening situations. [Refer to After-Hours Care guidance below.] By consenting to communicate in these ways, you acknowledge the associated privacy risks. If you prefer not to communicate using these methods, please discuss alternatives with your therapist.

AFTER-HOURS CARE

ERHC mental health services are provided on an **outpatient basis during standard business hours**. Your therapist may not be immediately available outside of your scheduled sessions, or during non-business hours. If you, or your therapist, determine that a higher level of care is necessary to ensure your safety, ERHC will help refer you to appropriate crisis resources, and/or coordinate a transition to a provider or facility that offers 24-hour coverage. If you experience a mental health emergency or feel that you are in crisis, you may contact the 988 Suicide & Crisis Lifeline (available 24/7 by phone or text), call 911, or go to a safe location such as a trusted urgent care facility or hospital Emergency Room. An ERHC medical provider may be available after-hours for time-sensitive medical questions at (208) 229-3742 [Boise] or (509) 824-7327 [Spokane]. If you experience a medical emergency, please visit an Emergency Room or call local emergency services for assistance.

CLIENT CONCERNS

You have the right to ask questions about your treatment. If you experience any concerns, please attempt to address them with your therapist, first. If your therapist cannot resolve concerns to your satisfaction, or if you are not comfortable discussing concerns with your therapist, please contact the ERHC MHS Program Coordinator at (208) 229-8433 [Boise] or (509) 824-7323 [Spokane]. If the Program Coordinator cannot resolve concerns to your satisfaction, or if you are not comfortable approaching the Program Coordinator, please contact the ERHC Clinic Director at (208) 229-3742 [Boise] or (509) 824-7308 [Spokane]. You may contact the Idaho Division of Occupational & Professional Licenses [https://dopl.idaho.gov] or the Washington State Department of Health [https://doh.wa.gov/licenses-permits-and-certificates/file-complaint-about-provider-or-facility] regarding professional practice concerns, as a resource of last resort.

SOCIAL MEDIA

To protect client confidentiality and ensure an appropriate therapeutic relationship, ERHC staff cannot accept contact requests from current or former clients on any social or professional networking sites.

WEAPONS

Clients who are on duty at the time of their session and/or are trained to carry a weapon as part of their current job are welcome to carry their *work-related weapon* in session. ERHC requests that all other clients refrain from bringing weapons, including firearms, into the Wellness Center. *Please speak with your therapist to discuss any individual concerns.*

SERVICE DISCONTINUATION OR TERMINATION

ERHC MHS is invested in your well-being and in providing you with the highest quality care. ERHC has the right to discontinue treatment when we believe we cannot collaborate with you in a mutually respectful clinical relationship, including if/when:

- Cancelled or missed appointments become a pattern, and cannot be resolved within the therapeutic relationship;
- Clients fail to make timely payment for services;
- Your therapist, in their judgment, is unable to meet your clinical needs, either because your circumstances exceed their scope of practice or because the severity of your symptoms cannot safely be managed at the current level of care;
- If a client is verbally or physically aggressive toward, or threatens/harasses, their therapist or others within ERHC facilities, ERHC will discontinue treatment immediately.
- If ERHC believes a client is under the influence of drugs or alcohol during a session, their therapist may conclude the session early, and require the client to secure, and pay for, a reliable method of transportation to a safe location.

We recognize that concluding client-provider relationships can result in emotional discomfort. Your therapist will not terminate the therapeutic relationship without first discussing this decision with you, and explaining their rationale. If therapy is terminated for any reason, or if you request another therapist, ERHC will provide you with a list of qualified providers to assist you. You may also choose another provider on your own or from another referral source.

You are welcome to discuss any questions regarding the above policies with your therapist at any time.

CONDITIONS FOR TREATMENT AT EMERGENCY RESPONDERS HEALTH CENTER (ERHC)

In consideration of the care and treatment that I will receive or have received at ERHC, I agree to the following: **1. Payment.** I agree I am responsible for any co-payments, deductibles, or charges for services not covered by insurance, government programs, or other payers, unless restricted by applicable law or my insurance agreement with ERHC. I agree to make such payments according to ERHC's terms and will cooperate in submitting claims to potential payers, including insurance, government programs, or other third parties. I understand that I am responsible for any unpaid amounts and agree to pay interest and fees on my overdue account, including but not limited to reasonable costs of collection, collection agency fees, attorney's fees, and court costs. I agree that any overpayment accrued for treatment on any occasion may be applied to my outstanding balance. **2. Assignment and Authorization.** I assign and authorize direct payment to ERHC of any other payments or benefits to which I may be entitled from any government programs, insurance companies, or other entities liable for costs associated with my care. This assignment remains effective until the account is paid in full. **3. Billing Practices.** I understand and agree that any quotes or charge estimates for services rendered and/or insurance benefits available are based upon the best information available at the time, and may change. ERHC may amend quotes, and I agree to be responsible and pay for actual services provided. Payment for all accounts is due at the time of service unless otherwise arranged. Where insurance is available, ERHC will bill and allow reasonable time for payment. I am responsible for any amounts not covered. If payment is not received, I will be billed for all charges and interest. Payment is due upon receipt of the bill. **4. Late Cancellation/No-Show Policy.** I understand that ERHC requests that mental health appointments be canceled no later than 24 business hours prior to start time; that unconfirmed appointments may be canceled and offered to another client; and that fees may be assessed for late cancellations or missed appointments. I have been notified that an updated copy of ERHC's Appointment Late-Cancellation/No-Show policy is available upon request, and is posted at er-hc.org. [Please Initial] ______

CONSENT FOR TREATMENT

I voluntarily consent to care and treatment by Emergency Responders Health Center (ERHC) and its employed or affiliated licensed therapists. I understand and agree that the practice of clinical therapy is not an exact science and that no guarantees have been made to me regarding the results of my care or treatment at ERHC. [Please Initial] ______

PERSONS FOR WHOM PRACTICE IS NOT LIABLE

I understand that Emergency Responders Health Center (ERHC) is responsible only for the acts of its employees acting within the scope and course of their professional duties. I understand that persons who are not employed by ERHC may also be involved in my care or treatment, including but not limited to evaluators, third-party psychiatrists, inpatient facilities, support group facilitators, etc. I understand that ERHC is not liable for the acts or omissions of non-employees or ERHC employees acting outside the course and scope of their professional duties. [Please Initial] ______

EMERGENCY RESPONDERS HEALTH CENTER (ERHC) NOTICE OF PRIVACY PRACTICES

I have received a copy of ERHC's Notice of Privacy Practices on this or a prior occasion. [Please Initial] ______

-or-

I respectfully decline a copy of ERHC's Notice of Privacy Practices. [Please Initial] ______

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE FULLY READ, UNDERSTAND, AND AGREE TO ALL ITEMS CONTAINED IN THIS DOCUMENT (pages 1-4), including but not limited to Client Information, Conditions of Treatment, and Consent. I certify that I am either the Client or the Client's legally authorized representative, and have authority to execute this Consent and Agreement on behalf of myself/the Client. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

Client's Name: ____ Birth Date: ____________
(please print clearly)

Client's Legally Authorized Representative's Name: ____
(if applicable/please print clearly)

Client's/Representative's Signature: ____ Date: _______________

Please save a copy of this agreement for your records. You may request a copy from the ERHC MHS Front Desk.