NEW PATIENT REGISTRATION

ADULT

Name: _____
First Middle Initial Last

Address:_____
City State Zip

Date of Birth:_____ **Gender**: ☐ Male ☐ Female **SSN**:_____ **Marital Status:** ☐S ☐M ☐D

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Employer Work Number:** _____

Emergency Contact: _____
Name Number Relation

Primary Care Physician: _____
Name Number

FINANCIALLY RESPONSIBLE PARTY (GURANTOR) INFORMATION (IF SAME AS ABOVE, PUT "SELF")

Guarantor Name: _____ **DOB:** _____ **SSN:** _____

Mailing Address:_____
City State Zip

Relationship to patient: ☐**Spouse/Significant Other** ☐**Mother** ☐**Father** ☐**Sibling** ☐ **Court ordered** ☐**Other** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Guarantor Employer and Phone Number: _____

As required by law, all minors under the age of 18 must be accompanied by a parent/legal guardian to see the therapist.

PLEASE TURN THIS FORM OVER AND FINISH FILLING OUT THE INFORMATION ON THE OTHER SIDE

PRIMARY INSURANCE INFORMATION

Name of Major Medical Insurance Company | Name of Insured (If Other Than Patient)

Member/Policy I.D. Number | Group Number

Address of Insured | Insured Employer

Insured Social Security Number | Insured Date of Birth

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

SECONDARY INSURANCE INFORMATION

Name of Major Medical Insurance Company | Name of Insured (If Other Than Patient)

Member/Policy I.D. Number | Group Number

Address of Insured | Insured's Employer

Insured Social Security Number | Insured Date of Birth

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Assignment of Benefits: I hereby authorize and request my insurance to pay directly to Oasis Behavioral Health Services the amount due for services rendered to me or my dependent.

Release of Information: I authorize the release of any medical information necessary to process this claim. This may include, but not be limited to, an outpatient treatment summary describing prognosis, frequency of treatment, and/or medications prescribed. This is a continuing consent for release of psychotherapy and/or substance abuse records for the duration of my treatment or until rescinded in writing.

Guarantor Agreement: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Oasis Behavioral Health Services. I understand Oasis Behavioral Health Services may take legal action to obtain payment if my account is in arrears and I have not made prior arrangements for payment. I will be responsible for any fees involved in the collection of this debt if sent to an outside collection agency or attorney. These fees will be added to my total amount due.

Signature (Patient signature, if patient is guarantor.) Date

Parent/Guardian Signature Witness Signature Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

_____ _____

Patient Name Date

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER *(check all that apply)*:

Home Telephone Number: _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

Written Communication

- ❑ O.K. to mail to my home address
- ❑ O.K. to mail to my work/office address
- ❑ O.K. to fax to this number: _____

Work Telephone Number: _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

Other: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION (FOR OFFICE USE ONLY)

DATE	DISCLOSED TO WHOM ADDRESS OR FAX #	(1)	DESCRIPTION OF DISCLOSURE/ PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T = Treatment Records, P = Payment Information; O = Healthcare Operation
(3) Enter how disclosure was made: F = Fax, P = Phone, E = Email, M = Mall, O = Other

Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, we will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement, if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information of only certain individuals involved in your care of the payment of your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician practice.
4. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the notice at any time.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Shawn R. Cade; PO Box 219; Barboursville, WV 25504. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures: We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

_____	_____
Patient Signature	Parent/Guardian Signature
_____	_____
Witness Signature	Date

POLICIES

Thank you for choosing Oasis Behavioral Health Services. To ensure the privacy, respect, and courtesy to our patients, we enforce the following policies. Please do not hesitate to ask us if you have any questions.

Patient Name **(Print)**:_____ Birth Date:_____ Date:_____

Please initial each box to indicate that you have read and agree with these policies, and provide your full signature in the area indicated below by the (X). Thank you.

	See your doctor: If you have not had a physical examination in the past six months, please get a physical exam from your personal physician as soon as possible. Please ask your doctor to send us a copy of your physical exam results.
	Confidentiality: With a few exceptions, our conversations are confidential. State law, HIPAA regulations, and our codes of ethics specifically guarantee privacy. There are some situations, however, in which confidentiality cannot be guaranteed. They fall within the following categories: a. We must notify appropriate persons if we believe that a patient is an imminent danger to themself or others. b. We must report chid abuse or the abuse, neglect, or exploitation of the elderly. c. We will have to respond to a subpoena accompanied by a court order. d. If you are a participant in an insurance or managed care program, your contract may permit administrative access to your therapy record and require that we consult with your physician.
	Payments: Payment of co-pays, deductibles, or any balances not covered by insurance is **due at the time of service**. Returned checks are subject to a $25 fee. Postponement of services may occur under these conditions: No payment on account in the past 45 days, and/or your account is $150 or more in arrears. There will be a $3.00/month statement fee added to all unpaid balances.
	Appointment Cancellations: If you are unable to make your appointment for any reason, please cancel and reschedule as soon as possible. This allows us time to give your slot to someone on our waiting list. Failure to give 24 hours notice will result in a $50.00 missed or late-cancel charge to your account. This charge is not billable to your insurance company, and will be payable at your next scheduled visit. Missed-visits or cancellations for three consecutive appointments may warrant discharge from this episode of care.
	Incidental Fees: I acknowledge there may be charges my insurance might not cover that are necessary to facilitate care. These charges may include urine drug screens, testing, and/or educational materials. Oasis Behavioral Health Services will make every effort to inform you prior to providing the service, but we may not always know in advance. Your session fee may vary according to the service provided. I agree to be responsible for paying these charges.
	Charges for Telephone Consultations: Telephone consultations are *not* covered under insurance benefits. Any phone consultations are pro-rated by time and will be your responsibility to pay at the time of service or at your next scheduled appointment. You will also be responsible for charges related to case management consultations that your clinician determines is necessary to manage your care.
	Form Fees: There may be a charge for completion of reports or forms including, but not limited to: FMLA forms, disability forms, Workers' Compensation, record copying for legal purposes, etc. Fees will need to be paid in full before reports, copies, or forms are released. Check with your therapist for fee information.
	Emergencies: If you feel you need help and cannot reach your therapist, please contact your closest hospital E.R. or your local community mental health center. If your emergency is medication-related, then please contact the prescribing physician.
	Privacy Policy: I acknowledge being offered OBHS's "Notice of Privacy Policies and Client's Rights" form.
	Informed Consent: Before obtaining any medical or counseling care, it is important to gain sufficient knowledge regarding the types of treatment available, any risks, and potential benefits. This is done to ensure you can make well-reasoned decisions about your treatment. Your clinician will discuss with you the methods of therapy and any risks that may arise, and will be available to assist you in making any changes, and to help you understand their impact on you and others. We will always keep you informed of any changes in therapy we propose and any risks we foresee**.**
	Termination of Services: If you choose to stop treatment, we would appreciate a one week notice so that we might meet to discuss the cessation of services and your future plans. If you prefer, we can assist you in locating another provider. We also have the right to terminate services, and will provide you notice appropriate to termination conditions. Three consecutive failed-visits may result in temporary or permanent cessation of services.
	Electronic Communication and Social Networking: If you choose to communicate with anyone in this office by electronic means; i.e., cell phone, email, Facebook, Twitter, texting, etc., please be aware that confidentiality can ***not*** be guaranteed. Therefore, you are urged ***not*** to disclose any information via digital format that you would also not want made public. ***A special note about Facebook and Twitter:*** Individual clinicians in this office will ***not*** "friend" you on Facebook or "follow" you on Twitter, which could be interpreted as therapeutic boundary crossing. If you choose to "friend" us, please do so through our agency site at: http://www.Facebook.com/oasisbehavioralhealth.

X _____ _____/_____

Patient Signature | Parent/Guardian Signature | Date

_____

Witness Signature

OASIS Behavioral Health Services, L.L.C.

689 Central Avenue
PO Box 219
Barboursville, West Virginia 25504-0219
Office - 304/733-3331 Fax - 304/733-3334
E-Mail: wbwobhs1@aol.com
Website: www-PsychOasis.com

PSYCHOSOCIAL HISTORY

Adult
(Age 18 and up)

Please complete this form as fully as possible. The purpose is to obtain a complete and accurate profile of you to assist us in helping you as quickly as possible. Please complete *all* questions to the best of your ability, and as honestly as you can. If there is a question which does not pertain to you, just write N/A (not applicable) in the space provided. Your therapist will review this with you to assure accuracy and to elaborate where indicated.

If you are uncomfortable with answering any part(s) of this questionnaire, simply leave it blank and speak to your therapist about it.

This information is ***CONFIDENTIAL***. It will not be shared with anyone outside this office without your written permission or a court order.

Again, please complete each question. Thank you.

For Office Use Only:

Reviewed With Client (date): _____Clinician's Initials:_____

1. **Identification Data:**

Name:_____ Home Phone:_____

Address: _____ Work Phone:_____

_____ Cell Phone:_____

Date of Birth:_____

Email Address:_____ _____

Social Security #:_____ Race:_____

Sex: M F Age:_____ Height:_____ Weight:_____ Eye Color: _____ Hair Color:_____

Occupation:_____ Employer:_____

Referral Source: How did you hear about our services?

___ Newspaper or Radio Ad/What paper or station?_____

___ Physician Referral/Name?_____

___ Yellow Pages/What City?_____

___ Friend Referral/Name?_____

___ Relative Referral/Name? _____

___ Attorney Referral/Name?_____

___ EAP (Employee Assistance Program)/Name?_____

___ Other/Please Specify?_____

2. **Problem Description:** Please describe why you came here: _____

_____

_____

What caused you to seek help at this time? Why now? _____

_____

_____

3. **Patient/Client Severity Rating:** (Check one) How severe do you consider your problem(s) to be?
   Scale = ___ 1 mildly upsetting
   ___ 2 moderately severe
   ___ 3 very severe
   ___ 4 extremely severe
   ___ 5 totally incapacitating

4. **Marital History:** Marital status: (Check your current status.)
   __Married __Single __Divorced (# of times ___) __Never Married
   __Engaged __Widowed __Separated __Cohabitating (living together)

   If married: Spouse's Name:_____

   Spouses's Age: _____ Spouse's Occupation: _____

   Date of Marriage: _____ Status of Marriage: ___Satisfactory ___Unsatisfactory

	Date Married	Date Divorced	Reason for Divorce
1.			
2.			
3.			

   Have you had affairs? ____Yes ____No
   Has your spouse had affairs? ____Yes ____No ____Don't Know
   Do you want professional help with anything related to marriage and/or relationship with a significant other? ____Yes ____No ____Not Sure

5. **Problem Checklist:** I am seeking help for: (Check all that apply.)
   ___ emotional/psychological problems
   ___ couples problems
   ___ job problems
   ___ sexual problems
   ___ financial problems
   ___ death of a loved one(s) (grief)
   ___ chemical use in another person
   ___ family problems
   ___ school problems
   ___ alcohol and/or drug problems
   ___ legal problems
   ___ health problems
   ___ behavioral problem in another person
   ___ other (describe)_____

   Symptom Checklist: (Check any symptoms you have recently experienced.)
   ___ depressed mood
   ___ nervousness
   ___ loss of energy
   ___ lack of sexual desire
   ___ sudden weight change
   ___ headaches
   ___ excessive exercising
   ___ upset stomach
   ___ chest pain/tightness
   ___ confusion
   ___ indecisiveness
   ___ fear of people, places, things
   ___ numbness
   ___ temper outbursts
   ___ racing thoughts
   ___ hearing voices others don't
   ___ allergies
   ___ nightmares
   ___ excessive laxative use
   ___ disturbed sleep
   ___ loss of control of behavior
   ___ rapid heartbeat
   ___ suicidal ideas
   ___ homicidal ideas
   ___ pain
   ___ excessive worry
   ___ seeing things others don't
   ___ panicky
   ___ taking too many pills
   ___ using pain killers
   ___ alcohol problems
   ___ binging/purging of food
   ___ bowel disturbance -- (constipation/diarrhea)
   ___ memory problems
   ___ feelings of dread
   ___ shortness of breath
   ___ lump in throat
   ___ shyness
   ___ excessive sweating
   ___ nausea
   ___ vomiting

Symptom Checklist continued: (Check any symptoms you have recently experienced.)

___ apathy ___ crying spells ___ faintness or dizziness
___ poor appetite ___ excessive appetite ___ excessive fears
___ difficulty concentrating

6. Review of Systems: Have you had problems with? (check the appropriate box & describe problem)

YES	NO	SYSTEM	BRIEFLY DESCRIBE PROBLEM
		Head	
		Eyes	
		Ears	
		Throat	
		Chest	
		Lungs	
		Heart	
		Stomach	
		Back	
		Kidneys	
		Muscles	
		Bones	
		Neurological	
		Liver	
		Other (explain)	

Clinical - Medical/Physical

1. Please list any adult illnesses – including present illness, head injuries, and/or seizures:_____

   _____

2. List and describe any medical disorders that you are currently being treated for:_____

   _____

3. Who is your treating physician?_____

May we contact your primary care physician? ___Yes ___No

Primary Care Physician's (PCP) Name:_____

PCP Address: _____

_____

_____

PCP Phone #: _____

4. List any medications you are currently taking. Include dosage: (*Continue on back if needed*.)

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED BY
(Example) *Phenobarbital*	*15 mg.*	*Two times a day*	*Dr. Ross*

5. Date of last physical examination:_____

   Performed by: (physician's name) _____

   Results of exam:_____

6. List any severe allergies to foods, medications, or inhalants:_____

   _____

   _____

   _____

7. List history of any past treatment for mental health and/or substance abuse problems:

WHERE TREATED	PROBLEM TREATED	DATE(s) TREATED

7. Educational Experience:

1. Secondary Education - Name of high school and year graduated:_____

   _____

   Or GED: ___Yes ___No Year received:_____

   Highest grade level completed:_____

2. Vocational School Education – Name(s) of school, degree/certificate and date received:

   _____

   _____

3. College Education – Name(s) of college/university, degree received and year received:

   _____

   _____

4. Post-Graduate Work – Name(s) of institution, degree received and year received:

   _____

   _____

5. What is the highest grade level completed? _____

8. Substance Use Assessment:

1. Alcohol and/or Drug Use:

Do you drink alcohol?	___Yes	___No
Do you use (non-prescribed) drugs?	___Yes	___No
Do you ever use drugs and alcohol together?	___Yes	___No
Do you abuse prescribed drugs?	___Yes	___No

If you answered "yes" to any of the above, what is your favorite (usual) alcoholic beverage and/or drug of choice?_____

How often do you drink/use? *(Check one)*	How many drinks/drugs per occasion? *(Check one)*
___**less** than two times per week	___**less** than four drinks per occasion
___**more** than two times per week	___**more** than four drinks per occasion

When was the last time you consumed: Alcohol_____(date)?

When was the last time you consumed: Drugs_____(date)?

(C) Have you ever felt you should cut down on your drinking/using? ___Yes ___No
(A) Have you ever felt annoyed when people talk about your drinking/using? ___Yes ___No
(G) Do you ever feel guilty about your drinking/using? ___Yes ___No
(E) Do you ever drink/use early in the day, as an "eye opener? (To steady your nerves or make you feel normal.) ___Yes ___No

Has drinking or using drugs caused problems in any of the following areas of your life? (Check all that apply.)

___family	___legal	___social	___marriage
___medical/physical	___psychological	___job	___emotional
___financial	___spiritual	___intellectual	___personal

List any blood relative(s) who have had a history of alcohol and/or drug problems, including the substance:

RELATIVE	**SUBSTANCE**

Do you now, or have you ever used any of the following substances:

___marijuana	___pain killers
___diet pills	___sleeping medications
___tranquilizers	___barbiturates (downers)
___laxatives	___amphetamines (speed)
___diuretics (water pills)	___ecstacy
___cocaine or crack	___anabolic steroids
___heroin	___methamphetamine (ice)
___opium	___hashish
___inhalants (gasoline, freon, glue, etc.	___designer drugs (look-alikes)

Have you ever been arrested for:

___PI (public intoxication)	___DUI (driving under influence)
___DWI (driving while intoxicated)	___vehicular homicide
___drug abuse	___possession of drugs

9. Behavioral Dysfunction/Abuse History:

Please check any of the following which are (or have been a problem):

___compulsive gambling
___compulsive sexual acts
___eating disorder
___dependent relationship(s)
___obsessive/compulsive
___sexual offender
___physically abusive
___victim of physical abuse
___child of alcoholic
___religious abuse/addiction
___compulsive spending
___compulsive overeating
___explosive temper
___tobacco addiction
___caffeine addiction
___dysfunctional family
___victim of sexual abuse
___neglected as a child
___unsatisfactory relationships
___self-mutilating behavioral

10. Legal:

Have you ever been convicted of a crime? ___ Yes ___No If yes, what was the charge?

_____

Are you presently suing anyone? ___Yes ___No If yes, who?_____

Is anyone suing you? ___Yes ___No If yes, who?_____

Why?_____

Do you have any legal concerns? ___Yes ___No If yes, describe:_____

_____

Who is/are your attorney(s)?_____

11. Financial:

My average household income is:
___no income ___$0 - $15,000/year ___$16,000 - $30,000/year
___$31,000 - $49,000/year ___$50,000 - $75,000/year ___over $75,000/year

The source(s) of my household income is/are:
___self-earned ___self-earned and spouse ___self and other relative ___retirement income
___welfare ___Social Security ___Workers Compensation ___private disability

In the past year my income has significantly:
___not changed ___increased ___decreased

I am satisfied with my current financial situation: ___Yes ___No

Have you ever had financial counseling? (Other than from your accountant or financial planner)
___Yes ___No

Have you ever filed or obtained bankruptcy? ___Yes ___No If yes, when: _____

Are you currently receiving financial assistance from any of the following sources? (Check all that apply.)

___Worker's Compensation
___Social Security Disability
___Supplemental Security Income (SSI)
___Department of Human Services (DHS)
___relatives
___non-relatives (other than a salary)
___other work-related activity (besides your primary occupation)

12. <u>Employment History:</u> (List your last three employers.):

1. Employer/Company:_____

   Approximate length of employment:_____

   Reason for leaving:_____

2. Employer/Company: _____

   Approximate length of employment:_____

   Reason for leaving:_____

3. Employer/Company:_____

   Approximate length of employment:_____

   Reason for leaving:_____

Have you ever been fired from a job? ___Yes ___No If yes, please explain:_____

_____

13. <u>Physical Well Being:</u> (Check all that apply.)

___exercise regularly (3-4 times/week)
___eat a well-balanced diet
___drink coffee, tea, chocolate, or colas
___take vitamins
___get enough sleep
___practice relaxation exercise
___play regularly (recreation)
___overwork
___use tobacco
___positive relationships

14. Military History:

Have you served in the military? ___Yes ___No If yes, what branch?_____

Number of years served:_____ Your highest rank:_____

Type and date of discharge:_____

15. Socialization: List hobbies and leisure activities:_____

_____

_____

Do you feel you have adequate social skills? ___Yes ___No If no, explain:_____

_____

What social media do you use? ___Facebook ___Twitter ___Texting _____Other

16. Religion/Spirituality: (Check all that apply.)

1. Religious affiliation: ___Atheist (does not believe in God)
   ___Agnostic (doubts whether God exists)
   ___Christian, specify denomination:_____
   ___Other, please specify:_____

   Do you attend services regularly? ___Yes ___No

   Do you think (or has anyone ever indicated) you are fanatic about religion? ___Yes ___No

2. Spiritual practices: (Check all that currently apply.)

   ___prayer ___meditation ___yoga
   ___participate in a support group (such as a 12 step program)
   ___other, please specify:_____

   _____

17. Sexual History

Sexual preference: ___heterosexual (male + female)
___homosexual (same sex)
___bisexual (either sex)
___celibate (abstain from sex)

Have you have any problems in the following areas? (check all that apply to you.)

Male Only
___primary impotence (not able to have erection) ___premature ejaculation
___secondary impotence (not able to keep erection) ___inability to ejaculate

Female Only
___vaginismus (spasms in vagina) ___inability to lubricate during sexual arousal
___delay or absence of orgasm ___premature climax

Both Sexes
___dyspareunia (painful intercourse) ___low or lack of sexual desire
___avoidance of sexual curiosity ___severe emotional discomfort about sex
___repeated sexual conquests ___numerous affairs
___compulsive masturbation ___feelings of inadequacy about sex

Have you ever been arrested for a sex crime? ___Yes ___No If yes, what crime:_____

_____

18. Family History:

1. Birth Family: (List each member of your *birth* family.)

NAME	RELATIONSHIP TO YOU	THEIR AGE

NOTE: *Use back of this form if you need more space.*

2. Immediate Family: (List each member of your *current* family, if different from above.)

NAME	RELATIONSHIP TO YOU	THEIR AGE

Describe any illnesses, injuries, or diseases that any family member has/had: (Include physical, mental, or chemical.)_____

_____

_____

_____

18. Treatment Goals: What are your goals for treatment?

1. Short Term Goals:

   A. _____

   B. _____

   C. _____

2. Long Term Goals:

   A. _____

   B. _____

   C. _____

Thank you. Please use the back of this sheet to tell us anything else you feel we should know about you.

_____ _____
(Your Signature) (Date)