Southwest Youth & Family Services, Inc. Date: _____

Client Information

Name: _____ Maiden: _____
First Middle Last

Date of Birth: _____ SSN: _____

Age: _____ Race: _____ Gender: *Male* *Female*

Household Information

Phone: _____ Phone: _____

Address: _____

Please provide the following information for each person who lives at this address.

Name	Age	Relationship

Person to Contact In Case of Emergency

Name: _____ Relationship: _____

Address: _____

Phone: _____ Phone: _____

Please explain why you are seeking services:

What are your immediate and urgent needs?

Name of Probation Officer(s): _____

Name of DHS Caseworker(s): _____

Client Name: _____ Date: _____ **Page 2**

Financial Information

Please indicate how much income your household receives from each source on a monthly basis.

	Monthly		Annual
Employment		**Staff will total and calculate annual.**	
Spouse/S.O. Employment			
Child's Employment			
Social Security			
TANF			
Child Support/Alimony			
Gambling/Lottery			
Rental Property			
Unemployment			
Worker's Comp			
Military			
Retirement			
Other			
Total			

Please indicate how income was verified.

Two Recent, Consecutive Pay Check Stubs	☐	☐	Federal Form W-2 (1 year FTE)
Verification of Income from Current Employer	☐	☐	Medicaid Card
Government Document Verifying Income	☐	☐	Federal Income Tax Return
Signed Income Statement If Other Verification Not Available*		☐	

**I, _____, affirm that the income information provided above is true and accurate and that I am unable to provide any other source of income verification other than this statement because _____.*

Client Signature: _____ Staff Signature: _____

Insurance Information

Provider: *SoonerCare* *Medicare* *Private/Other:* _____

MHSAS *Insure Oklahoma* *None*

Member ID: _____

Staff Only HH#: _____

Client is at or below 200% of Federal Poverty Level.	**Yes**	**No**
Client is uninsured/underinsured for needed behavioral health services.	**Yes**	**No**
Client does not meet Medicaid eligibility criteria.	**Yes**	**No**

Mental Health Screening Form III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins - "Have you ever ...."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? YES NO

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? YES NO

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? YES NO

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? YES NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see? YES NO

6. (a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? YES NO

   (b) Did you ever attempt to kill yourself? YES NO

7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? YES NO

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property? YES NO

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES NO

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO

Client Name/ID#: _____ Date:_____

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?
    YES NO

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? YES NO

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES NO

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. YES NO

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES NO

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? YES NO

Print client's name: _____

Date: _____

Reviewer's comments: _____

_____

Total Score: _____
(Each yes = 1 point)

Client Name/ID#: _____ Date: _____

Client Name:_____ Date:_____

TCU Drug Screen V

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

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

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

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

Client Name:_____ Date:_____

13. How often did you use each type of drug **during the last 12 months**?	Never	Only a few Times	1-3 Times per Month	1-5 Times per Week	Daily
a. Alcohol	○	○	○	○	○
b. Cannaboids – Marijuana (weed)	○	○	○	○	○
c. Cannaboids – Hashish (hash)	○	○	○	○	○
d. Synthetic Marijuana (K2/Spice)	○	○	○	○	○
e. Opioids – Heroin (smack)	○	○	○	○	○
f. Opioids – Opium (tar)	○	○	○	○	○
g. Stimulants – Powder cocaine (coke)	○	○	○	○	○
h. Stimulants – Crack Cocaine (rock)	○	○	○	○	○
i. Stimulants – Amphetamines (speed)	○	○	○	○	○
j. Stimulants – Methamphetamine (meth)	○	○	○	○	○
k. Bath Salts (Synthetic Cathinones)	○	○	○	○	○
l. Club Drugs – MDMA/GHB/Rohypnol/Ecstasy)	○	○	○	○	○
m. Dissociative Drugs – Ketamine/PCP (Special K)	○	○	○	○	○
n. Hallucinogens – LSD/Mushrooms (acid)	○	○	○	○	○
o. Inhalants – Solvents (paint thinner)	○	○	○	○	○
p. Prescription Medications – Depressants	○	○	○	○	○
q. Prescription Medications – Stimulants	○	○	○	○	○
r. Prescription Medications – Opioid Pain Relievers	○	○	○	○	○
s. Other (specify) _____	○	○	○	○	○

14. How many times before now have you ever been in a drug treatment program?
[DO NOT INCLUDE AA/NA/CA MEETINGS]

○ *Never* ○ *1 time* ○ *2 times* ○ *3 times* ○ *4 or more times*

15. How serious do you think your drug problems are?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

16. During the last 12 months, how often did you inject drugs with a needle?

○ *Never* ○ *Only a few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

17. How important is it for you to get drug treatment now?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

Client Name:_____ Date:_____

PCL-C

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one 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.**

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?	1	2	3	4	5
2.	Repeated, disturbing *dreams* of a stressful experience from the past?	1	2	3	4	5
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4.	Feeling *very upset* when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
6.	Avoiding *thinking about* or *talking about* a stressful experience from the past or avoiding *having feelings* related to it?	1	2	3	4	5
7.	Avoiding *activities* or *situations* because *they reminded you* of a stressful experience from the past?	1	2	3	4	5
8.	Trouble *remembering important parts* of a stressful experience from the past?	1	2	3	4	5
9.	*Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13.	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14.	Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15.	Having *difficulty concentrating*?	1	2	3	4	5
16.	Being "*super-alert"* or watchful or on guard?	1	2	3	4	5
17.	Feeling *jumpy* or easily startled?	1	2	3	4	5

Total:_____

BBGS – Brief BioSocial Gambling Screen

OHCA Member ID:_____ **Date:**_____

1. During the past 12 months, have you become restless, irritable, or anxious when trying to stop/cut down on gambling?

   Yes No

2. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?

   Yes No

3. 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

Results: Positive Negative

Name:_____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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 ☐

Southwest Youth and Family Services, Inc.

Confidential TB Screening Questionnaire/Acknowledgement

Client Name:_____ ID#:_____ Date:_____

1) Have you been tested for TB within the past year? **YES** **NO**

   If YES, what were the results? **POSITIVE** **NEGATIVE**

2) Have you ever had a TB skin test come back positive? **YES** **NO**

   If YES, when?_____

3) Have you ever been diagnosed as having TB? **YES** **NO**

4) Are you HIV Positive? **YES** **NO**

5) Have you worked in health care or stayed in a homeless shelter, jail, or prison in the past year? **YES** **NO**

6) Have you lived with or had close contact with someone who you knew was sick from TB? **YES** **NO**

7) Where were you born?_____

8) Do you have any of the following symptoms of TB: **YES** **NO**

A bad cough lasting 3 weeks or longer	Pain in the chest	Coughing up blood or sputum
Fatigue or weakness	Rapid weight loss	Chills
Fever	Night Sweats	

It is recommended that anyone who answers YES to questions 3, 4, 5, or 6 be tested annually.

It is also recommended that anyone born outside the US be tested annually.

9) Do you want to take a TB skin test? **YES** **NO**

If YES, please visit the health department checked below as soon as possible.

☐ Grady County Health Department - 2116 Iowa, Chickasha, OK 73018 - Phone: (405) 224-2022
Monday, Tuesday, Wednesday, Friday: 8 a.m. - 4 p.m.

☐ Caddo County Health Department - 216 West Broadway, Anadarko, Oklahoma 73005 - (405) 247-2507
Monday, Tuesday, Wednesday, Friday: 8 – 11 a.m. or 1 - 4 p.m.

If NO, please sign the following acknowledgement:

I, the undersigned, hereby acknowledge that I have been offered the option of having a TB skin test. I further acknowledge that I have declined the same on my own free will, with full understanding of the risk involved.

Client Signature:_____ Date:_____

Witness:_____ Date:_____

"This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."
"The person receiving this information may redisclose and use it only to carry out that person's official duties with regard to the use of client's criminal proceedings with which this consent is given."

REV 8/16