First Step Denton County Outreach Program, LLC
1310 Teasley Lane Denton, TX 76205
Phone: 940-484-7837 Fax: 940-484-7835

Make sure you provide us with accurate information about your attorney, parole or probation officer!!!

This would include correct mailing address, zip code, and current phone numbers.

DRUG & ALCOHOL EVALUATION
IOP/SOP INTAKE PACKET

First Step
Client Information Sheet

Name: _____ Date: _____ Time: _____
Address: _____
City: _____ State: _____ Zip: _____
(Please immediately notify office staff is your address or phone numbers change)

Emergency Contact Information

In the event of an emergency that would prevent you from contacting someone, whom may we contact on your behalf?
Name: _____ Relationship: _____
Phone: _____ Cell: _____
Do you have any urgent medical conditions or any other limitations that we should know about? If yes, please stop here and notify staff for instructions. YES NO

Visit Information

Date of birth: _____ Age: _____ Gender: M F
Referred by: _____ Phone: _____
Agency name: _____ Reference #: _____
Purpose of visit/presenting problem:

Are you on probation or parole? YES NO
If yes, what is your probation/parole officer's name: _____
Where do you report? _____

Are you currently receiving services for substance abuse or mental health from any other provider? YES NO
If yes, please explain: _____

Are you covered by health insurance, Medicaid, or Medicare? YES NO
If yes: Insurance Company Name: _____
Group Number: _____ Policy: _____
Member Number: _____ Subscriber ID: _____
Phone: _____

FIRST STEP
DENTON COUNTY OUTREACH PROGRAM, LLC

INITIAL SCREENING FORM (please print clearly)

Last Name: _____ *First Name:* _____ *Date:* _____

Contact made: (Circle one) *In person* *By phone* *Referred by?* _____

1. **Did you often use larger amounts of alcohol or drug or use them for a longer time than you plan or intended?** *(Circle one)* ***YES*** ***NO***

2. **Did you try to cut down on alcohol or drugs and were unable to do it?** *(Circle one)* ***YES*** ***NO***

3. **Did you spend a lot of time getting alcohol or drugs, using them, or recovering from their use?** *(Circle one)* ***YES*** ***NO***

4. **Did you often get so high or sick from alcohol or drugs that it - - -**
   a. **Kept you from doing work, going to school, or caring for children?** *(Circle one)* ***YES*** ***NO***
   b. **Caused an accident or became a danger to self or others?** *(Circle one)* ***YES*** ***NO***

5. **Did you often spend less time at work, school, or with friends so that you could drink or use drugs?** *(Circle one)* ***YES*** ***NO***

6. **Did your use of alcohol or drugs often cause - - -**
   a. **Emotional or psychological problems?** *(Circle one)* ***YES*** ***NO***
   b. **Problems with family, friends, work, or police?** *(Circle one)* ***YES*** ***NO***
   c. **Physical health or medical problems?** *(Circle one)* ***YES*** ***NO***

7. **Did you increase the amount of alcohol or a drug you were taking so that you could get the same effect as before?** *(Circle one)* ***YES*** ***NO***

8. **Did you ever keep drinking or taking drugs to avoid withdrawal or keep from getting sick?** *(Circle one)* ***YES*** ***NO***

9. **Did you get sick or have withdrawal when you quit or missed drinking or taking a drug?** *(Circle one)* ***YES*** ***NO***

10. **End the number of which substance that caused you the MOST serious problems (see list below).**
    Enter the number answer here: _____
    Number of days used in the last 30 days? _____

1. Alcohol	**2. Marijuana**	**3. Amphetamine/Methamphetamine**
4. Cocaine (powder)	**5. Crack cocaine**	**6. Heroine**
7. Methadone	**8. Inhalants**	**9. Ecstasy, Acid, or LSD**
10. Prescription Drugs (please list): _____		
_____		

(Screening form continued on next page)

FIRST STEP
DENTON COUNTY OUTREACH PROGRAM, LLC

Last Name: _____ *First Name:* _____ *Date:* _____

11. From the same list, which substance caused you the *second most* serious problems?
Enter the number answer here: _____
Number of days used in the last 30 days? _____

12. From the same list, were there any other substances that caused you problems?
Enter the number answer here: _____
Number of days used in the last 30 days? _____

13. How often did you inject drugs with a needle?
(circle one) Never Only a few times 1 to 3 times per month 1 to 5 times per month About every day

14. How serious do you think your alcohol or drug problems are?
(circle one) Not at all Slightly Moderately Considerately Extremely

15. How many times before now, have you been in an alcohol or drug treatment program?
Enter number of times: _____

16. Do you think you need treatment for alcohol or drug use now? *(circle one)* ***YES*** ***NO***
How important to you is it that you get into some type of treatment program now?
(circle one) Not at all Slightly Moderately Considerately Extremely

17. How many times have you received psychiatric or counseling services for reasons other than alcohol or drug problems? (Include hospitalization and outpatient visits) _____

18. Do you currently have any medical or physical conditions? *(circle one)* ***YES*** ***NO***
If "YES" circle the conditions below:

Seizures GI Bleeding Gastritis Severe Anemia Hepatitis HIV
STD TBC Heart disease Hypertension Uncontrollable diabetes Infectious disease
Chronic pain Malnutrition Pregnancy Other:

19. What medications are you currently taking? (List here)

_____
_____

Primary Counselor's Signature: _____

Screening/Intake Staff's Signature: _____

REFERRAL RECOMMENDATIONS AFTER SCREENING:

Formal Assessment **Treatment** **Education** **No services recommended**

BASIS FOR RECOMMENDATION:

_____
_____

IS FOLLOW-UP NECESSARY? YES NO

First Step Denton County Outreach Program
Client Program

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Client's Name Date

Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by this program. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Texas Department of State Health Services
Substance Abuse Compliance Group – Mail Code 1979
Mailing Address
PO Box 149347
Austin, TX 78714

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.)
(Approved by the Office of Management and Budget)

I certify that I have been informed, understand, and have received a copy of required notification of the Confidentiality of Alcohol and Drug Abuse Patient Records as required by Title 41 – Subtitle D – Chapter 1 – Subchapter A – Part 2 – Subpart B Sec. 2.22 Notice to patients of Federal confidentiality requirements.

Client's Signature Date

Staff's Signature Date

First Step Denton County Outreach Program
Client Program

INTAKE AND CONSENT TO TREATMENT

NAME: _____ DATE: _____

I certify that I have had explained to me in simple, non-technical terms in my own language:

- The specific conditions to be treated
- The recommended course of treatment
- The expected benefits of treatment
- The probable health and mental health consequences of not consenting to treatment
- The side effects and risks associated with treatment
- Generally accepted alternatives and whether those alternatives might be appropriate
- The qualifications of staff who will provide the treatment
- The name of the primary counselor
- The Client Grievance Procedure
- The Client Bill of Rights
- The program rules
- Violations that can lead to disciplinary action or discharge
- Any consequences or searches used to enforce program rules
- An explanation of charges and third party billing information, as applicable or indicated
- The facilities, services, and treatment process
- Opportunities for family involvement

I consent to admission to the program by attending practitioner, who is a member of the professional staff and for any counselor, assistant, or designee whom he/she may call to his/her aid for ordinary treatment. Permission is given for me to receive any and all services rendered by First Sept Denton County Outreach Program. By my signature I certify that no coercive or undue influence has been used to obtain my consent. I understand that I can revoke this consent at any time for any reason.

_____

Client's Signature Date

_____

Staff's Signature Date

First Step Denton County Outreach Program, LLC

ATTENTION FIRST STEP CLIENT

The program that you are participating in requires you to participate in individual counseling sessions.

These sessions are 50 to 60 minutes in duration.

If at any time you receive a session that is less than 50 minutes, we request that you immediately notify the Program Director of First Step and your referral or supervision representative.

Client's Signature Date

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*****DISCHARGE POLICY*****

- **ANGER MANAGEMENT**
- **BETTERER'S INTERVENTION PROGRAM**
- **LONG TERM CHEMICAL DEPENDENCY**
- **THEFT INTERVENTION PROGRAM**

ALL PARTICIPANTS ENROLLED IN AN EDUCATIONAL/COUNSELING PROGRAM ARE

ALLOWED THREE ABSENCES WITHIN THE COURSE OF THE PROGRAM. YOU WLL BE

DISCHARGED ON THE THIRD ABSECNE AND REFERRAL SOURCE WILL BE NOTIFIED.

********WARNING: YOU MAY BE RQUIRED TO START THE PROGRAM OVER FROM THE BEGINNING (INCLUDING FEES). PLEASE DO NOT SBATOGE YOURSELF FROM COMPLETING THIS PROGRAM!!!!**

There is a $25.00 reinstatement fee in order to be reinstated into the program once you are discharged.

Your referral source must contact FSOP before you be reinstated into the program.

_____ _____

Signature **Date**

***All clients must attend one class a week (Monday through Saturday)**

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CLIENT BILL OF RIGHTS

(A) The facility shall respect, protect, implement and enforce each client right required to be contained in the facility's Client Bill of Rights. The Client Bill of Rights for all facilities shall include:

1) You have the right to accept or refuse treatment after receiving this information
2) If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
3) You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
4) You have the right to be free from abuse, neglect, and exploitation.
5) You have the right to be treated with dignity and respect.
6) You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
7) You have the right to be told about the program's rules and regulations before you are admitted, including, without limitation, the rules and policies related to restraints and seclusion. Your legally authorized representative, if any, also has the right to be and shall be notified of the rules and policies related to restraints and seclusion.
8) You have the right to be told before admission:
    a) the condition to be treated;
    b) the proposed treatment
    c) the risks, benefits, and side effects of all proposed treatment and medication;
    d) the probably health and mental health consequences of refusing treatment;
    e) other treatments that are available and which ones, if any, might be appropriate for you; and
    f) the expected length of stay
9) You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
10) You have the right to meet with staff to review and update the plan on a regular basis.
11) You have the right to refuse to take part in research without affecting your regular care.
12) You have the right not to receive unnecessary or excessive medication.
13) You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
14) You have the right to be told in advance of all estimated charges and any limitations o the length of services of which the facility is aware.
15) You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.
16) You have the right to make a complaint and receive a fair response from the facility within a reasonable amount of time.
17) You have the right to complain directly to the Texas Commission on Alcohol and Drug Abuse at any reasonable time.
18) You have the right to get a copy of these rights before you are admitted, including the address and phone number of the Texas Commission on Alcohol and Drug Abuse.
19) You have the right to have your rights explained to you in simple terms, in a way you can understand, within 24 hours of being admitted.

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CLIENT BILL OF RIGHTS

(B) For residential sites, the Client Bill of Rights shall also include:

1) You have the right not to be restrained or placed in a locked room by yourself unless you are a danger to yourself or others
2) You have the right to communicate with people outside the facility. This includes the right to have visitors, to make telephone calls, and to send and receive sealed mail. This right may be restricted on an individual basis by your physician or the person in charge of the program it if is necessary for your treatment or for security, but event then you may contact an attorney or the Texas Commission on Alcohol and Drug Abuse at any reasonable time.
3) If you consented to treatment, you have the right to leave the facility within four hours of requesting release unless a physician determines that you pose a threat of harm to yourself or others.

(C) If a client's rights to free communication is restricted under the provisions of subsection (B)(2) of this section, the physician or program director shall document the clinical reasons for the restriction and the duration of the restriction in the client records. The physician or program director shall also inform the client, and if appropriate, the client's consenter of the clinical reasons for the restriction and the duration of the restriction.

Client's Signature

Date

First Step Denton County Outreach Program, LLC

PROGRAM RULES ORIENTATION

TREATMENT ACTIVITIES

I understand that I am responsible for attending all education lectures, individual sessions, and group sessions. I am also responsible for being on time and remaining for the entire session. I understand that the only excused absence from activities must come from a physician, First Step Counselor, or other authorized supervision official.

NUISANCE BEHAVIOR

I understand that clients demonstrating nuisance behavior, becoming argumentative, resistant to treatment, showing poor attitude, or becoming an impediment to the progress of others will be removed from the group. At that time, the client will be made aware of consequences of his/her in appropriate actions or behavior, suggestions for improvement may be made, or dismissal from the program may result.

DRESS

I have been informed that I may dress comfortable, but that appropriate attire is expected. If a staff member asks me to dress in a more appropriate fashion, I am expected to comply.

SMOKING

In order to observe health care and legal standards, the program's policy is to provide a smoke free environment. I understand that smoking is not permitted anywhere, except in outside designated areas.

FOOD & DRINK

I understand that no food or drink is allowed in the building. The only exception is water with a lid.

PAGERS & CELL PHONES

I understand that pagers and cell phones are not allowed in group rooms. Any violation of cell phone or pager policy may result in discharge from the group session and an absence violation. Continued violations may result in discharge from the program.

TARDINESS

Group will promptly begin at the designated time. I understand that at ten (10) minutes after the start of group, no one will be allowed to enter group. Clients who are consistently late, based on the scheduled group time, and may be subject to discharge.

Client's Signature Date

Staff's Signature Date

First Step Denton County Outreach Program, LLC
Client Program

Client Orientation

All clients shall be provided a detailed orientation within 24 hours of admission.

REFERRED BY:_____ DATE:_____

- Client Bill of Rights
- Client Grievance Procedures
- Violations & Behaviors leading to disciplinary action or discharge
- Disciplinary procedures used to enforce program rules
- Program philosophy & treatment objectives
- Opportunities for family involvement
- Program rules

I have read and understand the Client Bill of Rights pertaining to my participation at First Step Denton County Outreach program, and have been offered a copy in the client handbook, which contains all intake and orientation information about the program.

I have read and understand the Client Grievance Procedures as they pertain to my treatment at First Step Denton County Outreach Program.

I have had explained to me all rules and expectations explained in the handbook, including the Client Bill of Rights, Client Grievance Procedures, Violations & Behaviors leading to disciplinary action or discharge, disciplinary procedures used to enforce program rules, program philosophy and treatment objectives, opportunities for family involvement, and program rules.

Client's Signature Date

Staff's Signature Date

First Step Denton County Outreach Program, LLC
Client Program

ABSTINENCE CONTRACT

I _____ understand that I am
(print name)

entering treatment for substance abuse/dependence. In order to gain the maximum therapeutic value of the program, I AGREE TO ABSTAIN from use of any mood altering substances that are not prescribed to me by a physician. This contract is valid until my completion of the program or until I revoke this contract.

MOOD ALTERING SUBSTANCES INCLUDE, BUT ARE NOT LIMITED TO:

ALCOHOL, AMPHETAMINES, BARBITUATES, COCAINE, HALLUCINOGENS, HEROIN, PSP/LSD, MARIJUANA, OPIUM, QUAALUDES, SEDATIVES, TRANQULIZERS, PAIN PILLS (without a prescription).

Client's Signature Date

Staff's Signature Date

First Step Denton County Outreach Program, LLC
Client Program

You have been referred to complete a substance abuse program. We would like to extend our support for you to complete this program SUCCESSFULLY. The consequences of an unsuccessful discharge are too great! The following information is important information pertaining to successful completion of your treatment. Please read the following and initial each line.

_____ Attendance is mandatory and must occur as set forth by your counselor. Minimum attendance is one time per week. You may be dismissed from your program if you have three absences.

_____ Clients presenting to group more than 10 minutes late will NOT be admitted and no credit will be given.

_____ If you have been referred to First Step by probation, standard supportive outpatient treatment consists of 46 hours of group sessions (23 groups) and 6 hours of individual counseling.

_____ Attendance at 12-step meetings in recommended. Documentation of 12-step attendance can be submitted at the time of your individual counseling sessions.

_____ If you have been referred to First Step by probation/parole, we are obligated to inform your supervising officer of missed sessions and/or individual appointments within a period of 24 hours. Please keep this in mind. Do not miss your sessions.

_____ In the event that you are unable to comply with the treatment recommendations or being disruptive to the therapeutic value of the group sessions you will be asked to leave the group and may be terminated from the program.

_____ If your group is being funded by probation, if you are discharged due to attendance or other violations, you may be required to pay for your treatment if readmitted.

_____ If you are a self-pay client, group sessions are to be paid at the beginning of each class.

_____ You are required to attend a minimum of one individual session per month. Your individual session is to be paid prior to the session.

_____ For certification of program, you must attend your scheduled sessions and all must be paid in full.

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FSOP PROGRAM GUIDELINES

You should attend sessions once per week. Failure to attend sessions regularly may result in your being discharged from the program.

1) You asked to pay your fees weekly before each session. These may be paid in cash, money order, or VISA/Master Card. NO CHECKS.

2) You will not be allowed to attend any session if you are more than ten minutes late (10 minutes after the assigned group start time). Cell phones and pagers must be turned off in the group rooms. You will not be allowed to leave the room to attend personal calls.

3) You may not bring your children with you. They are not allowed in the session and we cannot provide child care/supervision for their safety.

4) Progress reports are sent out monthly to all referring sources, usually at the first week of the month.

5) Do not attend group under the influence of alcohol or other drugs. If you do son, you will be asked to leave the group and your referral source may be notified.

6) Your Client Rights are in this packet. Please read them carefully. They are also posted on the bulletin board in the lobby for easy reference.

7) Food and drink are not allowed in the group rooms.

8) Smoking allowed only in the designated smoking areas.

9) You may be dismissed from group without credit if your behavior is disruptive to the group's learning.

10) You must check in at the front desk before entering in order to receive credit.

I HAVE READ AND UNDERSTAND ALL THESE GUIDELINES AND HAVE RECEIVED A COPY OF MY CLIENT RIGHTS.

Signature _____ Date _____

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CANCELLATIONS AND RESCHEDULING APPOINTMENTS

Client, after your initial scheduled appointment by your referring case worker, attorney, probation officer, parole officer or referring TDCH agent; it will become your responsibility to schedule and meet your individual one-on-one sessions.

If you are unable to keep your scheduled appointment, you must reschedule your appointment 24 hours before your cancellation. If you are a NO SHOW or if you do not call in 24 hours before your scheduled appointment, note that it is our policy to charge you as a client a $10.00 rescheduling fee for your missed or cancelled appointment. If is your responsibility to pay this $10.00 rescheduling fee.

_____

Client's Name (Print)

_____ _____

Client's Signature **Date**

_____ _____

Counselor's Signature **Date**

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CLIENT INFORMATION SHEET

Date: _____

Name: _____ Ethnicity: _____

Gender: _____ Age: _____

Marital Status: _____

Highest Level of Education Completed: _____

Occupation: _____

Referral Source:

_____ Court
_____ Probation – Name of officer: _____
_____ Parole – Name of officer: _____
_____ Other agency – Name of agency: _____

To be completed by agency staff:

Program: _____ Orientation Date: _____

Start Date: _____ End Date: _____

_____ CD Evaluation _____ Walk-in

Staff Signature: _____