The Caring Center of Wichita, LLC
MH Acknowledgement Form

Name:	Patient ID:

My initials below Indicate that I have reviewed with the counselor at Caring Center of Wichita, LLC verbally and an explanation was given for each of the identified admission requirements listed below. A copy of each shall be provided to me should I elect to receive such copy once it has been signed.

_____ Notice of Privacy Practices and Consent

_____ Patient Rights

_____ Grievance Policy and Grievance Form

_____ Fee Schedule

_____ Services Agreement

_____ Treatment Contract

_____ I signify by my Initials here that I have elected not to receive a copy of the above Identified forms.

_____/_____ _____/_____

Patient signature Date Counselor signature Date

The Caring Center of Wichita, LLC
MH Concerns Checklist

Name:	Date:

Check any of the following terms that apply to you.

- ☐ Depressed mood
- ☐ Lost interest
- ☐ Lack of energy or fatigue
- ☐ Weight gain or loss
- ☐ Unable to concentrate
- ☐ Excessive sleeping
- ☐ Difficulty sleeping
- ☐ Decreased need for sleep
- ☐ Pressure to keep talking
- ☐ Racing Thoughts
- ☐ Excessive risk-taking behavior
- ☐ Panic attacks
- ☐ Excessive fear of situation or objects
- ☐ Repetitive behaviors to reduce stress
- ☐ Witness/experience events threatening life or serious injury
- ☐ Excessive anxiety or worry
- ☐ Hear/see things others do not
- ☐ Memory problems or Memory loss
- ☐ Suicidal thoughts
- ☐ Significant ongoing physical pain
- ☐ Stomach problems
- ☐ Headaches
- ☐ Bowel problems
- ☐ Balance problems
- ☐ Seizure problems
- ☐ Learning/academic problems
- ☐ Stuttering problems
- ☐ Frequent problems with attention
- ☐ Frequent “on the go” behavior
- ☐ Temper
- ☐ Aggressive behavior towards others
- ☐ Destructive behaviors
- ☐ Frequent lying/deceitfulness
- ☐ Problems following rules
- ☐ Sexual problems
- ☐ Eating problems
- ☐ Nightmares
- ☐ Gambling problems
- ☐ Alcohol usage
- ☐ Drug usage
- ☐ Marital problems
- ☐ Divorce
- ☐ Separation
- ☐ Affair
- ☐ Problems with ex or spouse
- ☐ Relationship problems
- ☐ Parenting problems
- ☐ Problems with friends
- ☐ Problems with children
- ☐ Legal problems
- ☐ Work/job problems
- ☐ Financial problems
- ☐ School problems
- ☐ Shyness
- ☐ Anger
- ☐ Loneliness
- ☐ Insecurity
- ☐ Isolation

Any other concerns or Issues? (If there are no other concerns, please Indicate by "none")

Please look back over the concerns you have checked off and chose the ones that you most want help with.

The Caring Center of Wichita, LLC

Mental Health History

Name:	Date:

Have you ever been in counseling/therapy before? □ Yes □ No

If yes, did you find it helpful □ Yes □ No

Are you currently receiving mental health services? □ Yes □ No

If yes, please provide the following:

Practitioner	Type of Service

Have you ever been hospitalized for mental health concerns? □ Yes □ No

If yes, please explain: _____

Have you ever been diagnosed with a mental illness? □ Yes □ No

If yes, Diagnosis_____ Date Diagnosed: _____

Has anyone in your family ever been diagnosed with a mental illness? □ Yes □ No

If yes, Relationship _____ Date Diagnosed: _____

Have you ever or are you currently engaging in self harm? □ Currently □ Past

Have you ever or are you currently contemplating suicide? □ Currently □ Past

Have you ever attempted suicide? □ Yes □ No

If yes, please provide the following:

Date (MM/DD/YYYY)	Method	Age

Has anyone in your family ever attempted suicide? □ Yes □ No Relationship: _____

Has anyone in your family completed suicide? □ Yes □ No Relationship: _____

The Caring Center of Wichita, LLC

Mental Health History

Substance Use History

Please indicate substances currently used over the past 6-months, how much you use at one time, how many times per day/week you use, age of first use, past usage, and length of time used.

Substance	Current	Amount	Frequency	Age	Past	Length
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						
Other:						

Have you ever believed your substance use was a problem for you? □ Yes □ No

Has anyone ever told you that they believed your substance use was a problem? □ Yes □ No

Have you ever had withdrawal symptoms when trying to stop using any substance? □ Yes □ No

Have you ever had problems with work, relationships, the law, etc. due to substance use? □ Yes □ No

If yes, please explain: _____

_____

Have you ever participated in drug and alcohol treatment? □ Yes □ No

If yes, please provide the following:

Type of Treatment	From (MM/YYYY)	From (MM/YYYY)	Age

Do you currently or have you ever attended alcoholics or Narcotics Anonymous? □ Yes □ No

The Caring Center of Wichita, LLC
Mental Health History

Legal Information

Have you ever been arrested? □ Yes □ No

If yes, please provide the following:

Date (MM/DD/YYYY)	Reason	Age

Are you currently on parole or probation? □ Yes □ No

Have you ever been the victim of a crime? □ Yes □ No

If yes, please list date and briefly describe: _____

_____

_____

Are you currently involved in divorce or child custody proceedings? □ Yes □ No

If yes, please explain: _____

_____

_____

Have you ever been convicted of a misdemeanor or felony? □ Yes □ No

If yes, please explain: _____

_____

_____

The Caring Center of Wichita, LLC
Mental Health Treatment Contract

Name:	Patient ID:

As a patient of The Caring Center of Wichita, I agree to the following expectations and responsibilities as a part of the treatment process:

1. I will attend all required sessions, on time, as scheduled by my therapist. Two absences without notification during treatment will constitute grounds for dismissal from the program.

2. I will pay all fees In accordance with the "Fees and Services Agreement" that I signed. If legally required under a court order to participate in therapy, I understand that the total payment of fees is a direct part of successful completion of this program and a letter of completion will not be sent to the Identified court until those fees are paid In full.

3. While I am in therapy, my family members will be encouraged to attend scheduled family sessions with me should my therapist consider this to be beneficial to my treatment process.

4. I am NOT presently In need of any acute medical care and understand that nursing and medical services are NOT provided by the Caring Center of Wichita, LLC.

5. I understand that the Caring Center of Wichita, LLC reserves the right to refuse service to me after two no call/no show appointments. I further understand that I will be charged a reinstatement fee of $100 and must pay this fee before I can be accepted back into the treatment program.

6. I understand that the Caring Center of Wichita, LLC office location does not have ADA compliant entrances which does limit accessibility. The Caring Center of Wichita, LLC is an English-speaking provider that does not have multi-language speaking staff. Referral will be made to another program that may better meet the needs of those with handicap or language barriers.

_____/_____ _____/_____

Patient signature Date Counselor signature Date