

PLEASE PRINT, COMPLETE AND BRING IN AT THE TIME OF YOUR FIRST APPOINTMENT

Evaluation for Mediation or other Legal Matters

My name is Jon Daily, LCSW, CADC II and I aim to conduct my evaluations with care and respect for the sensitive issues you are dealing with in your life at this time.

A bit about me:

I entered the field of addiction in 1995. I provide expert evaluations and testimony in family, criminal and civil cases that are related to addiction and dual diagnosis in addition to treating patients with addictive disorders daily. For the last 7 years I have been a professor of graduate studies in addiction and addiction treatment for the University of San Francisco. I have also instructed medical residents and post-doctoral students for several years at UC Davis. I present at numerous conferences on this topic throughout the year. In that last year I developed a dual diagnosis treatment program within Sutter Health. I have written two books on the topic and most recently in 2012. Finally, I am the founder and clinical director for Recovery Happens Counseling Services in Fair Oaks & Davis, CA where my staff and I treat 90 patients of all ages each week.

Payment Agreement

I understand that payment for services is due at the start of the evaluation. I understand that it is not acceptable for me to have an outstanding balance.

I take all financial responsibility for evaluation.

Print Name: _____

Signature: _____ Date: _____



Today's Date: _____

Your Name _____ Date of Birth _____

Your Cell# _____

Address _____ City/Zip _____

Occupation _____ Business Phone # _____

Cell# _____, Email: _____

Spouse/Ex _____ Home Phone # _____

Address _____ City/Zip _____

Occupation _____ Business Phone # _____

Cell# _____, Email: _____

Your Mediator or Attorney's info: _____

(I do not contact people without your written consent first)

Please provide us with the name and contact information of the person who referred you to our program.

Name of the person who referred you: _____

Who in your family was the info about our program given to? _____

Do we have your permission to thank them? _____

What is their contact info, ph#, address, email,; _____

Consent to be evaluated

Most people who participate in evaluation benefit from it. Like most kinds of health care, this kind of evaluation requires a very active effort on your part if you are going to get something out of it. In addition, there may be certain kinds of risks involved. For example, the evaluation process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. It is important that you participate in this evaluation/treatment willingly. If you have any questions or concerns about this document or about the services being provided to you please ask.

- Drug or Alcohol testing is a required part of this process. You can bring in a lab result that is dated 24 hrs or less prior than our scheduled evaluation or my agency can do the drug testing .

Acknowledgment

By signing your name in the space below, you are acknowledging that you have read and understood this document and that you voluntarily agree to participate in this evaluation.

Patients Signature (If signature other than patient, List relationship)

Date

Witness' Signature

Date

Authorization to Consult

I understand and authorize the staff at Recovery Happens Counseling Service to consult with each other for the sole purposes of evaluation, assessment, diagnostic, treatment planning, and continuity of care for myself, child and family. Any case consultation with a clinician required outside of Recovery Happens Counseling Services will first require a separate authorization to release information form separate from this one.

Signatures:

Client: _____ Date: _____

Parent, Guardian or Conservator: _____ Date: _____

Counselor: _____ Date: _____

Please keep a signed copy for your records too

COUNSELOR-CLIENT CONFIDENTIALITY, CLIENT SAFETY, AND CLIENT RECORDS

The confidentiality of communications between a client and a counselor is important and, in general, is protected by law. Subject to legal exceptions, information given in therapy will not be shared with anyone without the client's written permission. The following outlines some, but not all, of the circumstances when California or Federal law allows, or requires, a counselor to breach a client's confidentiality.

If a client communicates directly to me that they are a threat of physical harm to an identifiable person, we are required by law to warn the intended victim and notify the police.

If I believe that a client is in such mental or emotional condition that he/she poses a danger to him/herself or others, or the property of another person, I may breach confidentiality or contact others to facilitate the client's safety.

I am allowed by law to take protective action, which may include initiating psychiatric hospitalization of a client for up to 72 hours, even if I must do so without a client's voluntary consent. A counselor has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such a danger exists. If such a situation should arise, it is our policy to fully discuss these matters with a client before taking any action, unless, in my professional opinion, there is a good reason not to do so.

If I have a reasonable suspicion of child abuse or neglect, or abuse of a dependent, or elder adult (age 65 or older), I am required by law to file a report with the designated protective agencies.

In most legal proceedings, a client may assert the Counselor-Patient privilege to protect information about his or her treatment. However, certain legal activities or court actions, such as a client making his/her mental or emotional state an issue in a court proceeding, may limit a therapist's ability to maintain confidentiality. A court may also order a therapist to disclose confidential client information. If you are involved in a legal proceeding, please speak with your attorney about the limits of confidentiality.

At times it may be necessary to consult with other health professionals regarding your case. When I am out of the office (i.e., on vacation, out of town), another professional may be available to cover emergency calls from clients and that professional may be advised of client issues that could arise. In addition, I may occasionally find it helpful to consult with another professional about a client's case. In such consultations, I make every effort to conceal the identities of the client(s). Other mental health professionals who cover emergencies or with whom I consult are also legally bound to maintain confidentiality.

In the event that group therapy services are provided, the counselor or practice of professionals involved in conducting or co-conducting the group therapy cannot be held responsible for a breach of confidentiality on the part of group members.

When a client shares information with me outside of the presence of other persons participating in the therapy (such as a spouse or other family members), I cannot guarantee that the information will be kept in confidence from the other therapy participants. This is commonly referred to as a "no secrets policy". This means that I may use my clinical discretion and choose to share such information with

the other participants in the therapy.

Minor children also hold privilege. I believe that good psychotherapy treatment for minors requires that their confidentiality be respected and protected. Information will generally not be shared with parents or others outside of the therapy unless circumstances meet the mandated or permissible reporting criteria described in this section, or if the minor child discloses information which suggests that they are engaging in serious, at risk behavior. I will however, have family sessions to create the space for the child to share their truth with their family.

Most insurance agreements require you to authorize your counselor to provide clinical information, for example, a diagnosis, a treatment plan or summary, or even a copy of the entire record. Once the insurance company has this information, the counselor has no control over what the insurance company does with it. If you request that I provide information to your insurance company, I will ask you to sign an authorization for that purpose.

If the use of a collection agency becomes necessary, I will furnish them with the required information to collect the fees due.

While this summary of exceptions to client confidentiality should prove helpful in informing you about the potential breaches of confidentiality, you should be aware that the laws governing these issues are often complex and I am not an attorney. I encourage our active discussion of these issues. However, if you would like more specific advice, formal legal consultation may be desirable.

This office maintains confidential client records for 6 years after the termination of therapy. After the 6 year post termination period, the client's records will be destroyed so as to protect client confidentiality.

Signatures:

Client: _____ Date: _____

Parent, Guardian or Conservator: _____ Date: _____

Counselor: _____ Date: _____

Please keep a signed copy for your records too



Ph (916) 276-0626 7996/Fax (916)241-9836

Fair Oaks Location: Old Winding Way, Suite #300, Fair Oaks, CA 95628

Davis Location: 204 F Street, Suite E , Davis, CA 95616

Roseville Location: 3017 Douglas Blvd, 3rd flr, Roseville, CA 95661

Authorization to Release/Receive Information

(Please copy and complete this form for each person I need to contact regarding your evaluation)

Client Name: _____ Date of Birth: _____ PH# _____

Address: _____

I authorize the exchange of information between:

My counselor at Recovery Happens Counseling Services:

(Name, Ph#, Fax#) _____

and

(Name, Ph#, Fax#) _____

Duration:

The authorization is effective immediately and shall remain in effect for one year from the authorization date.

Information to Be Exchanged:

() Mutual exchange of information relevant to assessment, diagnosis and treatment.

() Evaluation or Progress Letter

() Other: _____

Authorizing Signatures:

Client: _____ Date: _____

Parent/Gaurdian/Conservator: _____ Date: _____

Treatment Provider: _____ Date: _____

Your Medical History

Doctor's Information: _____

History of health issues and hospitalizations:

How many blackouts have you experienced _____? How many times have you passed out due to intoxication _____? How many seizures have you had which were related to your substance use _____?

List any medications or supplements you are taking and bring proof of prescriptions:

Please list your mental health and/or substance abuse treatment history (level of care, dates and how long): _____

What other information would be helpful:



Family History

List who currently or in the past who in your family has had a problem with alcohol, other drugs or process addictions, i.e., eating disorders, sex, gambling, workaholic, etc:

List who in your family are in recovery:

List who in your family has had a history of mental health issues, i.e., depression, anxiety, personality disorders, schizophrenia, bipolar, etc:

Any other information you think might helpful:

Check the box below regarding your observations of yourself. Current indicates in the past 90 days.

	Current	Past		Current	Past		Current	Past
Restless and unable to sit still			Hurt animals			Slurred speech		
Act without thinking			Sneak out at night			Eat little or fast to lose weight		
Difficulty paying attention			Hurt people			Vomit food intentionally		
Low motivation			Sexual problems			Gorge food		
Short attention span			Problems with the law			Hearing voices or seeing things that aren't there		
Easily frustrated			Fire-setting			Headache		
Easily distracted			Been arrested, in jail or on probation					
Daydream or fantasize a lot						Sadness, crying &/or depression		
Temper outbursts			Nervous/can't relax			Hard to make decisions		
Uncooperative			Worry more than others			Irritable/angry		
Back Talk			Very anxious			Withdrawn from others		
Hard to admit mistakes			Worry a lot about past behavior			Trouble Concentrating		
Argue a lot			Fearful			Trouble going to sleep		
Enjoy "bugging" people			Worry a lot about the future			Memory problems		
Swear of use obscene language			Unusual fears or phobias			Restless sleep, wake up frequently		
Easily annoyed by others			Panic			Nothing fun anymore		
			Overly concerned about germs, safety, and/or health issues,			Wake up very early and can't go back to sleep		
Use alcohol/drugs			Repeat an act over and over that not necessary to do (e.g. washing, checking locks, counting, lining things up.)			Low self-esteem		
Smoke cigarettes						Sleep to much		
Rebellious attitude or behavior			Seam confused a lot			Feeling tired and fatigued		
Damaged property			Can't control body movement			Nightmares, night fears		
Want to run away from home			Not knowing where you are			Weight gain or weight loss		
Stolen things			Feeling odd or different than other people			Have made suicide attempts in the past		
Have run away from home			Blurred or double vision					

Chemical Use History

Please list each drug you have ever used along with 1. the first time you used it, 2. your frequency of use (in a week, month, year for each year since you first started using the substance) and 3. the last time you used the substance. (I know this can take some time and you can type it up and bring it in or write it out on this for or additional paper).

For Example:

Alcohol: I first used it when I was 30 years old. I used it once a month for 6 months, then I used it twice a month up to age 31. At age 31 I used XXXX. The last time I used was this morning.....

Marijuana: I first used in the 7th grade. I didn't use it again until I was in the 9th grade when I used it on the weekends. In 10th grade I used it 3 times a week. Soon I started using it daily and continued to use it regularly since then. In the last 5 years I use it 5 times a week. I last used yesterday...

Do this for all substances: alcohol, marijuana, tobacco, methamphetamine, cocaine, amphetamines, opiates, heroin, hallucinogens, dissociatives, tranquilizers, synthetic drugs, stimulants, downers, etc..

Negative consequences of use

Please list any small, large and all negative consequences you have experienced related to your substance use.

List the incidents that occurred, when it occurred, what the consequence to you was and how you felt about it at the time. (Incident, consequence, feeling).

Please do this for the following areas of life: **school, family, friendships, romantic attachments, kids, money, work, sports, legal, health, mental health, spirituality**. Please take your time and be clear and all inclusive. Please provide concrete specific examples.

For Example:

Family:

3 years ago I lied to my husband and told him I was going to take a walk to the park, but really I just wanted to get out of the house so I could go get drunk. I went to the park and got drunk. When I got home my husband ask me if I had been drinking but I lied to him and said I wasn't. He knew I was lying and I felt annoyed, shame and sadness....

