Orleans County Department of Mental Health

Contact Information

______/_____/_____
Today's Date

____________________ ____________________ ___ ____/___/____ ☐ M ☐ F ☐ Other
Client's Last Name *First Name* *MI* *DOB* *Gender*

____
Address *City* *State* *Zip Code*

Please enter all and check which are your preferences for being contacted:

☐ (____)______-________ *Home* ☐ (____)______-_______ *Cell* ☐ (____)______-_______ *Other*

☐ ____ *Email Address*

Referred By:______________________________

Emergency Contact:

____________________ ____________________ ________________ (____)______-_______
Last Name First Name Relationship Phone

Preferred Language

☐ English ☐ Spanish ☐ French ☐ Other (Please specify) ______________________________

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White

☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

Ethnicity

☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Smoking Status

☐ Non-Smoker ☐ Smoker

Veteran Status

Are you a Veteran? ☐ Yes ☐ No

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

COUNTY OF ORLEANS

Department of Mental Health

(Mental Health, Developmental Disabilities, Substance Abuse and Alcoholism Services)

14014 Route 31 West
Albion, New York 14411-9373
(585) 589-7066

TELEHEALTH INFORMED CONSENT FORM

Telehealth provides an opportunity when determined clinically appropriate or when need is identified for Telehealth, which benefits the clients treatment, including in the areas of; engagement in treatment, reduction of barriers to access to care, and promotion of therapeutic relationship with your treating providers. Clients will have the option to participate in Telehealth if offered and will not be refused treatment if they do not wish to participate in Telehealth.

I, _______________________________ (Patient) hereby consent to engage in Telehealth with Orleans County Department of Mental Health. I understand that Telehealth is a mode of delivering health care services, including psychotherapy and psychiatric services, via communication technologies and capabilities (by use of internet using computer, tablet, or smartphone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form] I received from my provider also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my provider may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my provider is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my provider believes I would be better served by in-person treatment services, my provider will discuss this with me and make these arrangements.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with my provider and agree to them [or for insurance patients: I have discussed with my provider and agree that my provider will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the Financial Expectations form.

10. I understand that my provider will make reasonable efforts to ascertain and provide me with emergency resources accessible to them within their county of residence, to include the closest designated 939 hospital facility. I further understand that my provider may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or contact the Care & Crisis Helpline (585) 283-5200 proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my provider, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

_______________________________________ _________________
Patient / Patients Parent or Guardian Signature Date

____

Patients Printed Name

____

Email address

Verbal Consent Obtained

Provider reviewed Telehealth Informed Consent Form with Patient and Patients Guardian if Applicable, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychotherapy services from this provider and other agency providers via Telehealth.

_______________________________________ ________________
Provider Signature Date

TODAYS DATE: ___________________

ORLEANS COUNTY DEPARTMENT OF MENTAL HEALTH

MEDICAL INFORMATION

NAME: ____ DOB: ___________________________

How has your health been recently? ☐ Good ☐ Fair ☐ Poor

Are you in pain? ☐ 0 None ☐ 1 Minimal ☐ 2 Mild ☐ 3 Moderate ☐ 4 Severe ☐ 5 Extreme

Where is the pain located? _______________________________________ Is it Chronic / Acute (please circle one)

Do you have a primary care physician or family doctor? ☐ Yes ☐ No

If yes, who? ______________________________________ Date of Last Visit with PCP: _________________________

If No Current PCP, Area Provider List: ☐ Given to Client ☐ Client Declined List ☐ Referred to Oak Orchard on Site

Please list any medications you are taking for medical or psychiatric reasons, including over the counter or herbal supplements:

Medication	Medical/Psychiatric condition	Doctor Prescribing
1.________________________	___________________________	____________________________
2. ________________________	____________________________	____________________________
3.________________________	____________________________	____________________________
4.________________________	____________________________	____________________________
5.________________________	____________________________	____________________________

* If more space is needed, please use the back of this form.

Have you ever had any side effects from medications? ☐ Yes ☐ No

If yes, please describe: ____

Do you have any food, drug, or environmental allergies? ☐ Yes ☐ No

If yes, please describe: ____

Have you ever had any of the following medical problems?

____ Anemia/blood problems	____ Arthritis	____ Asthma
____Cancer	____ Diabetes	____ Epilepsy/seizures
____ Fainting	____ Heart disease	____ Head injury
____ High Blood Pressure	____ Kidney disease	____ HIV
____ Fibromyalgia	____ Headaches	____ Thyroid Disease
____ Sleep Difficulties	____ Stroke	____ Stomach / Bowel Problems
____ Liver Disease	____ Respiratory Disease	____ Weight Loss/Gain

____ Other (Please Explain) ____

How much caffeine do you drink each day? ☐ 0-2 cups ☐ 3-5 cups ☐ 6-8 cups ☐ 9-11 cups

Turn over to complete back of this form →

Do you smoke (   ) or use nicotine products (   )? ☐ Yes ☐ No If Yes, how many per a day _______?

Does anyone in your home smoke? ☐ Yes ☐ No

If you quit smoking, when did you quit (month/year)? ___________________________________

Do you currently use alcohol? ☐ Yes ☐ No Do you currently use drugs? ☐ Yes ☐ No

Specify: ____

Have you ever used alcohol? ☐ Yes ☐ No Have you ever used drugs? ☐ Yes ☐ No

Specify: ____

Does anyone in the home use alcohol? ☐ Yes ☐ No Does anyone in the home use drugs? ☐ Yes ☐ No

Specify: ____

Is there anything else you want us to know about your medical history, please use the space below:

____

____

____

Client Signature: ______________________________________ **Date:** _______________________

Parent Signature (If applicable): ________________________________

FOR OFFICE USE ONLY

Clinical Formulation:

____

____

____

____

____

Registered Nurse Signature: _____________________________ **Date:** _______________________

ORLEANS COUNTY DEPARTMENT OF MENTAL HEALTH
BIOGRAPHICAL INFORMATION FORM -- ADULT

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

General Information

Name:___________________________________Age:_____Gender:___M___F Date of Birth___________

Address:____
Street & Number City State Zip

Race______________ Years of Education ______Occupation_____________Home Phone_______________

Circle One: Single Engaged Married Separated Divorced Widowed Other

If married, are you living with your spouse at present? Yes_____ No_____

If married, years married to present spouse? _______

Are you a veteran? Yes ____ No _____ Combat experience? Yes_____ No_____ Describe_____________
____
____

Current Clinical Data

(a) Describe the main problem(s) that led you to seek therapy at this time, including the duration of the problem (or set of problems):

____
____
____
____
____
____
____
____
____
____

(b) Briefly describe the history of this problem, or set of problems, including a list of stress factors which seem to be triggering and/or intensifying the problem now:

____
____
____
____
____
____
____
____
____

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

1) Life is hopeless. _____Never _____Rarely _____Sometimes _____Frequently
2) I am lonely. _____Never _____Rarely _____Sometimes _____Frequently
3) No one cares about me. _____Never _____Rarely _____Sometimes _____Frequently
4) I am a failure. _____Never _____Rarely _____Sometimes _____Frequently

5) Most people don't like me. _____Never _____Rarely _____Sometimes _____Frequently
6) I want to die. _____Never _____Rarely _____Sometimes _____Frequently
7) I want to hurt someone. _____Never _____Rarely _____Sometimes _____Frequently
8) I am so stupid. _____Never _____Rarely _____Sometimes _____Frequently

9) I am going crazy. _____Never _____Rarely _____Sometimes _____Frequently
10) I can't concentrate. _____Never _____Rarely _____Sometimes _____Frequently
11) I am so depressed. _____Never _____Rarely _____Sometimes _____Frequently
12) God is disappointed in me. _____Never _____Rarely _____Sometimes _____Frequently

13) I can't be forgiven. _____Never _____Rarely _____Sometimes _____Frequently
14) Why am I so different? _____Never _____Rarely _____Sometimes _____Frequently
15) I can't do anything right. _____Never _____Rarely _____Sometimes _____Frequently
16) People hear my thoughts. _____Never _____Rarely _____Sometimes _____Frequently

17) I have no emotions. _____Never _____Rarely _____Sometimes _____Frequently
18) Someone is watching me. _____Never _____Rarely _____Sometimes _____Frequently
19) I hear voices in my head. _____Never _____Rarely _____Sometimes _____Frequently
20) I am out of control. _____Never _____Rarely _____Sometimes _____Frequently

Comments:

____

____

Symptoms

Check the behaviors and symptoms that occur to you more often than you would like them to take place:

_____aggression
_____alcohol dependence
_____anger
_____antisocial behavior
_____anxiety
_____avoiding people
_____chest pain
_____depression
_____disorientation
_____distractibility
_____dizziness
_____drug dependence
_____eating disorder
_____elevated mood
_____fatigue
_____hallucinations
_____heart palpitations
_____high blood pressure
_____hopelessness
_____impulsivity
_____irritability
_____judgment errors
_____loneliness
_____memory impairment
_____mood shifts
_____panic attacks
_____phobias/fears
_____recurring thoughts
_____sexual difficulties
_____sick often
_____sleeping problems
_____speech problems
_____suicidal thoughts
_____thoughts disorganized
_____trembling
_____withdrawing
_____worrying
_____other (specify)
____
____
____
____

Additional Clinical Data

Family Functioning

Briefly describe how the problems you are having have been affecting your relationships with family members (for example, your relationship with your spouse or partner, with your children, and with other significant relatives):____
____
____
____

Social Functioning
Briefly describe how the problems you are having have been affecting your social functioning with non-family members (for example, your relationship with friends) ______________________________
____
____
____
____

Work/School Functioning
Briefly describe how the problems you are having have been affecting your work (for example, performance levels, relationships with co-workers) and, if relevant, at school, has been affected by your current problems. ____
____
____
____

Do you currently drink alcohol and/or use any drugs? Yes_____ No_____

If yes, indicate: **Specifically, which substance(s) you use:** __________________________________

Frequency of use: ____

Situation(s) in which use occurs ____
____

Is your current use of alcohol and/or drugs causing or contributing to problems in any aspect of your functioning (relationships with others, functioning at work or school, etc.)? Yes_____ No______

If yes, describe the nature of the problem(s) stemming from your current use of alcohol and/or drugs:
____
____
____
____

Did you receive professional help for these problems? Yes_____ No_____

If you were seen as an outpatient, indicate when and where you were seen and the name(s) of the professional(s) with whom you were in treatment. ____
____
____

Have you ever used alcohol in the past? Yes_____ No_____

If you have used alcohol:

Have you ever tried to cut down on your drinking? Yes_____ No_____
Have you ever been annoyed at other's complaints about your drinking? Yes_____ No_____
Have you ever felt guilty about your drinking? Yes_____ No_____
Have you ever taken a morning "eye opener" drink? Yes_____ No_____

Have you ever used drugs in the past? Yes_____ No_____
Did your previous alcohol and/or drug use cause or contribute to problems in any aspect of your school functioning (for example, relationships with others, functioning at work, functioning at school, physical health, etc.)? Yes_____ No_____
If yes, state the problem(s) stemming from your substance abuse: ____________________________
____
____
____

If you have received professional help for substance abuse problems, indicate when and where you received treatment, and the name of your primary counselor or therapist: ________________________
____
____
____

Is there any family history of alcohol or drug problems? Yes_____ No_____

If yes, describe the nature of these problems: ____
____
____
____

Have you had any problem(s) of a legal nature (including arrests)? Yes_____ No_____

If yes, describe: ____
____
____
____

Family History

Father: If alive his present age:____
If deceased, your age and his age at the time of his death:_______________________
Cause of death: ____
Occupation:____
How would you describe your father and how did you get along with him?___________
____
____

Mother: If alive her present age:____
If deceased, your age and her age at the time of her death:_______________________
Cause of death:____
Occupation:____
How would you describe your mother and how did you get along with her?___________
____
____

Brothers and Sisters:
Name: Age: How do you get along with him/her?

______________________________ ______ ____
______________________________ ______ ____
______________________________ ______ ____
______________________________ ______ ____

Were you adopted as a child? Yes_____ No_____
Were your parents separated of divorced during your growing years: Yes_____ No_____]
Were either of your parents seriously physically ill and/or absent for long
periods of time during your growing up years? Yes_____ No_____
Briefly describe any experiences you had while growing up in your family of origin that you believe
may have a bearing on your present problem(s) ____
____
____
____
____
____

____ ______________________________
Client Signature Date

____ ______________________________
Clinician Signature Date

OMH - Social Needs Screening Tool

Housing Instability

1. What is your housing situation today?

- ☐ I do not have housing (I am staying with others, in a hotel, in a shelter)
- ☐ I do not have housing (I am living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- ☐ I have housing today, but I am worried about losing housing in the future
- ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (Check all that apply)

- ☐ Bug infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Inadequate heat
- ☐ Oven or stove not working
- ☐ No or not working smoke detectors
- ☐ Water leaks
- ☐ Roommate challenges
- ☐ None of the above

Food Insecurity

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

Transportation Needs

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (Check all that apply)

- ☐ Yes, it has kept me from medical appointments or getting medications

- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
- ☐ No

Utility Needs

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

Financial Strain

7. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is**:**

   - ☐ Very hard
   - ☐ Somewhat hard
   - ☐ Not hard at all

Employment

8. Do you currently have a job?

   - ☐ Yes
   - ☐ No

9. Do you want help finding or keeping work or a job?

   - ☐ Yes, help finding work
   - ☐ Yes, help keeping work
   - ☐ I do not need or want help

Education

10. Do you speak a language other than English at home?

    - ☐ Yes
    - ☐ No

11. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.

    - ☐ Yes
    - ☐ No

Family and Community Support

12. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?

- ☐ I don't need any help
- ☐ I get all the help I need
- ☐ I could use a little more help
- ☐ I need a lot more help

13. How often do you feel lonely or isolated from those around you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Always

Childcare

14. Do you have problems getting childcare when you need it?

- ☐ Yes
- ☐ No

Criminal Justice

15. Have you ever been under any form of community criminal justice supervision (prison, jail, probation, parole, or criminal court-based mandate)?

Current	☐ Yes	☐ No
Past Year	☐ Yes	☐ No

Discrimination

16. In the past year have you experienced discrimination based on your skin color, your accent, where you are from, gender, gender identity, sexual orientation, mental disorder, physical condition, substance use or any other reason?

- ☐ Yes
- ☐ No

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: DOB: Date of Referral:

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or 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	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, 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

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, 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