Housley & Associates, PLLC.
P.O. Box 11064
Fayetteville, AR 72703

ACKNOWLEDGEMENTS:

____ I have been given the client handbook and do acknowledge that I have read and understand the contents of this handbook.

____I have been offered a copy of the HIPAA patients' rights policy.

____I have been offered copies of HIV/AIDS/ STD brochures

____I understand that I am responsible for payment of all fees before records/certificates will be released.

___ I have provided the conditions and needs of the mandated referral source and provided copies of court or parole orders

_____ _____

Signature Date

_____

Printed name

Housley & Associates, PLLC.
P.O. Box 11064
Fayetteville, AR 72703
(479)530-2545; (479) 443-2049(fax)

FEE AGREEMENT

I understand that the following fees apply:

$250.00	Initial Session/Evaluation
$175.00	Therapy Session
$250.00	DWI 1 Individual Sessions (maximum 4 sessions)
$900.00	DWI 2 Individual Sessions (maximum 9 sessions)
$250.00	Minor in Possession Individual Sessions (maximum 4 sessions)
$400.00	Anger Management Education (8 hours)
$400.00	Parenting Education One-on-one (8 hours)
$75.00	Parenting Education Group (8 hours) when available
$50.00	Missed appointments that are not canceled at least 24 hours in advance

I understand that I am responsible for payment of all fees, regardless of insurance payments. I am aware that it is my responsibility to check with my insurance company on deductibles and co-pays.

I understand that any fees due will be paid at the time of the session.

_____ _____

Name of Patient/Responsible Party Date

HOUSLEY & ASSOCIATES, PLLC

P.O. Box 11064; Fayetteville, Arkansas 72703
(479)530-2545

CONFIDENTIALITY POLICY

Name:_____
Date of Birth:_____

The agency is bound by ethical principles to keep information about you confidential; however, there are certain exceptions.

1. The counselor/social worker is a mandated reporter for suspected child abuse and neglect and vulnerable adults. We are required to report this to the appropriate authorities even when this requires breaking confidentiality.

2. If we believe that your life or someone else's life in endangered by the actions you are about to take, we may have to break confidentiality to warn or prevent harm to you or to another person.

3. If you are using a third party payor (private insurance or DHS contract), we may be required to submit reports or information, such as a diagnosis, to obtain reimbursement from your insurer.

4. In some circumstances, such as DHS cases, custody and divorce litigation, case records may be subpoenaed by a Judge.

5. If you sign a release of information in order that we may correspond with other professionals, information about you will be divulged with your consent.

6. If you are a legal minor (under age 18) and you engage in behaviors that are seriously threatening your health and well-being, this information may be given to your parents.

7. I also understand that I may withdraw my consent and discontinue participation in casework and counseling/therapy at any time without prejudice to myself.

If you have any questions regarding this policy, please discuss them with your counselor/social worker. Please sign below as consent for treatment and that you have read the above statement and agree to the above terms.

_____ _____
Client (or parent) Signature Date

_____
Witness

Housley and Associates

Date: _____

Client Name: _____ Age: _____ Date of Birth: _____ Sex: M F

Social Security Number _____ Race: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Housing Arrangements: Rent ___ Own ____ Residing with _____

Phone: □ Home: (___) □ Cell: (___) □ Work: (___)
(Please check the best number to use in contacting you)

May we leave a message: Home: Y N Cell: Y N Work: Y N

Email address for messages: _____

Preferred method of contact: Home phone / Cell phone / Email / Text

Marital Status: Single____ Married_____ Separated_____ Divorced_____ Widowed_____

If married, Spouse's name: _____ Age:_____

Please list children's names, ages who has primary custody:

_____

_____

Highest level of Education Completed and Major/ Degree if Applicable:

_____

Employer: _____

Trained Skills: _____

Do you feel your employment is at your skill level Y N

Sources of Income: _____

Have you ever served in the armed forces? Y N If yes which branch of service _____

What were the dates of service _____ Type of discharge (if applicable) _____

What is was your highest rank or classification _____

Combat experience Y N

Insurance: _____ Relationship to Insured: Self / Spouse / Child / Other

If relationship to insured is other than self:

Name and address of insured _____

Housley and Associates

Birthdate of insured: _____

In case of emergency, contact:_____ Relationship:_____

Contact's Home #: (___)_____ Cell #: (___)_____ Work #: (___)

What would you like to focus on in counseling _____

How were you referred? _____ Is this mandated treatment? Y N

Address of mandated referral source: _____

Primary phone number of referral source: _____

+

Please be prepared to provide any documentation of requirements if treatment is mandated.

_____ _____ _____

Signed Name of Client Printed Name of Client Date

Housley and Associates HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above –

(Check either A or B):

- **A. Disclose** my complete health record (including but not limited to diagnoses, treatment, and billing, for all conditions) OR
- B. **Disclose** my health record, as above, BUT do not disclose the following (check as appropriate):
  - Mental health records
  - Alcohol/drug abuse treatment
  - Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- An electronic record
- Hard copy

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

Informed Consent to Treatment & Insurance Filing

I/WE indicate by signing below that I/WE _____ am authorizing Housley & Associates, PLLC. permission for treatment and to file for insurance claims all sessions rendered previous to this date. This does not represent additional cost to me/us In addition, I/WE give permission to file insurance claims from this point forward and agree to pay all relevant deductibles and co-payments. I/WE certify that the insurance information now provided is accurate to the best of my/our knowledge and that coverage existed at the time of service.

Because an employer or other third party may have contracted for various levels of co-payment, deductible, etc. for different groups of workers we can only make an estimate of your portion of the fees when filing your insurance. Therefore you are responsible to verify coverage with your insurance company. Not all information given to you by your insurance company or our staff will be accurate or reflect the final billing practices of your carrier. Not all services are a covered benefit in all contracts and some insurance companies arbitrarily select certain services they will not cover. You are responsible for the unreimbursed amount unless agreed upon in advance and noted on this form in the space provided below*.

Authorization: I/WE hereby authorize Housley & Associates, Pllc to furnish information to insurance carriers concerning my treatment, and hereby irrevocably assign to Housley & Associates, Pllc, all payments for services rendered when applicable excluding reimbursements to the client for advance payment or overpayment. I/WE understand that on occasion insurance companies may determine that services rendered were not reasonable or necessary despite the fact that they were prescribed by my therapist and performed by professional staff with my well-being in mind. I/WE understand that I/WE are financially responsible for all charges whether or not covered by insurance beyond this date. I/We authorize the release of pertinent information to my referring physician when appropriate.

Finally, current insurance practices require that a bill is submitted in the name of one identified client. This does not permit a bill to be submitted with the name of all parties present at the time services are rendered. However, all parties in therapy must understand that each has the same right to privacy and protection from disclosure of confidential information. By signing below all parties acknowledge reading the information above and agree to not allow personal information disclosed in sessions to be released unless all parties present during a session sign a release of information. Personal information of minor children must be signed for by all relevant adult guardians and limitations of confidentiality have been discussed. Our office requests 24 hrs. Notice to change or cancel an appointment. Insurance companies do not allow billing for missed appointments, therefore the client is responsible for short notice cancellation or missed appointment fees.

I understand that the intake session will be billed at $250 per session and individual follow up appointments are $175 per session. All sessions are 45-50 minutes long and additional charges will be agreed upon in advance. If I do not give 24 hours notice to change or cancel an appointment I understand I will be charged and will be responsible for a fee of $50.

_____ _____

Signature (Client/Parent/Guardian) Date

_____ _____

Signature of spouse when attending sessions Date

_____ _____

Signature of other person attending sessions Date

Therapist Initials _____

Housley and Associates

Name: _____

Date: _____

I voluntarily consent to assessment of my involvement with alcohol or other drugs. I affirm that the information I give is truthful and complete.

Client signature: _____

PATIENT DIRECTIONS: Please answer the following questions as completely as possible. Do not leave blanks.

BIOMEDICAL CONDITIONS AND COMPLICATIONS

Yes N/A FAMILY HISTORY

___ ___ ___ Anemia or blood disorders

___ ___ ___ Rheumatic or scarlet fever

___ ___ ___Chest pain

___ ___ ___Fainting spells

___ ___ ___Kidney disease or bladder infection

___ ___ ___Liver diseas, hepatitis or jaundice

___ ___ ___Diabetes

___ ___ ___Tuberculosis: Last test date:____

___ ___ ___Epilepsy

___ ___ ___Shortness of breath

___ ___ ___High or low blood pressure

___ ___ ___Chronic Pain

___ ___ ___Allergies food or drug)_____

___ ___ ___Physical injury What?_____

___ ___ ___Venereal disease/STD What?_____

___ ___ ___Cancer Type?_____

___ ___ ___High or low blood pressure

___ ___ ___Ulcers or pains in the stomach

___ ___ ___Heart trouble

FOR FEMALES: Pregnancy:___ suspected ___ confirmed ___ month pregnant Referred to prenatal care?_____

Family History of Alcoholism Y N Relation_____ Current Use _____ In Recovery _____

Family History of Drug Addiction Y N Relation_____ Current Use _____ In Recovery _____

Have these or any other medical conditions been impacted by uour use of alcohol or other drugs? _____yes _____no

If yes, in what manner? _____

Have you ever had surgeries or been hospitalized? Were nay of these related to you use of alcohol or other drugs?

___ No ___ Yes If so, how?: _____

Do you have access to medical care? ___ yes ___ NO

Provider Name: _____

Address: _____ City/State:_____

Do you routinely use medical care? _____ Yes _____ No

Are you currently taking prescription medications? _____ Yes _____ No

Name of Medications Dose Duration Prescribed For

_____

_____

_____

_____

_____

Current physical illness, other than withdrawal, that need to be addressed or which may complicate treatment (from checklist): _____

How would you describe your physical health? ___ Poor ___ Average ___ Good ___ Excellent

Are you sexually active? ___ No ___ Yes

Sexual contact with anyone who has ever used I.M/I.V. injections for drug use? ___ No ___ Yes

Have you ever had STD/TB education? ___ No ___ Yes

If STD/TB education, where and who? _____

How do you identify you sexual orientation? ___ Heterosexual ___ Homosexual ___ Bisexual ___ Transgender

___ Other ___ Declined to answer

What is your body weight? _____ Are you comfortable with your weight? ___ No ___ Yes

Have you engaged in binging, purging, laxatives, fasting, diet pills, etc? ___ No ___ Yes

If yes, explain: _____

Have you ever taken drugs to control your weight? ___ No ___ Yes

If yes, explain: _____

DIMENSION EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

Emotional Conditions/Complications\Have you ever bee physically abused? ___ No ___ Yes

If yes, explain: _____

Have you ever been sexually abused? ___ No ___ Yes

If yes, explain:

_____

Have you received or participated in counseling for this issue? ___ No ___ Yes

Is Yes, explain:

_____

Have you ever been emotionally or verbally abused? ___ No ___ Yes

If yes, explain: _____

Have you received or participated in counseling? ___ No ___ Yes

If yes, explain: _____

Are there any other significant life events (losses, deaths, divorce, loss of custody of children, etc)?

___ No ___Yes If yes, describe: _____

Are you currently experiencing any of the following? ___ Feeling hopeless ___ Feeling with drawn

___ Self-destructive ___Preoccupation with death ___Sleeplessness ___ Decreased energy ___ Moodiness

___ Taking unnecessary risks ___ Giving away valued possessions

Is there any history of suicide in your family? ___ No ___ Yes

If yes, explain: _____

Have you ever attempted suicide? ___ No ___ Yes

If yes, when and how: _____

Do yu currently have suicidal thoughts? ___ No ___ Yes

If yes, how recently? _____ What are your thoughts? _____

_____

Do you currently have a plan to harm yourself? ___ No ___ Yes

If yes, describe your plan:_____

Have you ever engaged in self-harm behaviors? ___ No ___ Yes

Is yes, describe: _____

DRUG/ALSOHOL USE HISTORY

Fill out completely. Do not leave ou ANY drug or alcohol use even if it was never a problem.

Substance Used	Age 1st used	Regular use	During heaviest period Amount used per day	Method of us oral, smoke, snort, IV, etc.	Date of last use

When do you usually drink or use drugs? (Circle all that apply)

Weekends After work/evenings occasionally during the day Regularly during the day

Frequent, short benders Long, occasional benders Regularly and frequently

Which of the following apply to you? (Circle)

I'm losing control of my drinking/drug use

I'm an alcoholic/drug addict

I can't stop myself

I am deteriorating rapidly, I know why I drink or use drugs

I hate myself

I have a drinking problem

My tolerance is decreasing

My tolerance is increasing

I need a drink when I wake up

I'm not eating regularly

I'm strictly a "social drinker"

I can quit anytime

I might be an alcoholic or drug addict

I have accidents or fall when drinking and sometimes injure muself

I'm a problem drinker or drug user, but not an addict

I get arrested because of my drinking or drug use

I have been unable to complete a task 9or begin) because I ws drinking

I have a drug problem

Which of these apply to you at this time ? (Circle)

School problems Physical problems Financial problems Family problems Marital problems

Threat to job Loss of job Legal problems Loneliness

Behavioral Conditions/Complications

Do you ever have homicidal thoughts? ___ No ___ Yes

If yes, Explain: _____

Do you have nay history of combative and/or assault behavior? ___ No ___ Yes

If yes, explain: _____

Have you ever deiven a motor vehicle after consuming alcohol or any other mind/mood altering substance?

___ No ___ Yes How many times have you done it? _____

How often do you do it?_____ Does it concern you? _____

Did it ever result in an arrest/charges for DUI? ___ No ___ Yes How many times/ _____

What was your BAL/BAC at the time? _____ How much did you consume before driving? _____

Over how much time? _____ What were the circumstances? _____

_____

Have you ever done anything while under the influence of alcohol or other drugs that you later regret?

___ No ___ Yes If yes, explain: _____

How much time do you spend, on average, in a typical week, in activities necessary to obtain , use or recover from the effects of using alcohol or other drugs? (spending time at bars/crack houses, seeking out dealers, recovering from hangovers, etc.) Describe:_____

_____

Have you ever given up or reduced important social, occupational or recreational activities because of using alcohol or other drugs? ___ No ___ Yes If yes, explain:_____

_____

Legal Issues

Is this assessment prompted or suggested by anyone connected to the legal system? ___ No ___ Yes

If yes, explain: _____

Your attorney name: _____ Judge/court name: _____

Other: _____

Have you ever been arrested or charge with a crime? ___ No ___ Yes

Arrest History

Charges	Alcohol/Drug	Date	Where	Disposition

Have you ever been in jail and/or prison? ___ No ___ Yes How many times?_____Where?_____

Are you currently on probation? ___ No ___ Yes If yes, your probations officers name: _____

Release of Information signed? ___ No ___ Yes

Have o been court ordered to participate in treatment for a Substance Related Disorder or Mental Health Disorder___ No ___ Yes If yes, what court issued the order? _____

Are you currently under the supervision of the Department of Corrections ___ No ___ Yes

\If yes, who is the person assigned to supervise your case?_____

Will you sign a release of information to allow contact with that person? ___ No ___ Yes ROI signed on

Are you a drug court participant? ___ No ___ Yes If yes, where? _____

If yes, are currently in Drug Court Treatment? ___ No ___ Yes If yes, where?_____

Any current charges pending? ___ No ___ Yes Describe : _____

Date: _____ Charge: _____ Which court? _____

Have your parental rights been terminated? ___ No ___ Yes

Date: _____ Reason: _____By whom: _____

Cognitive Condition/Complication

Have you continued to use alcohol or other drugs despite having identified problems that were caused or made worse because of that use? ___ No ___ Yes

If yes, describe _____

Have you ever been diagnosed with any cognitive disorder? ___ No ___ Yes

If yes, when, by whom, and what was it?_____

Do you have any problems with understanding written material? ___ No ___ Yes

If yes, what is the problem? _____

Have you ever received any help with this problem? ___ No ___ Yes If yes, what kind of help? _____

Do you need any help to understand written or verbal information? ___ No ___ Yes

If yes, what kind of help do you need? _____

Mental Health Conditions/Complications

Have you had a significant period (that was not a direct result of drug/alcohol use) in which you experienced any of the following?

Anxiety/nervousness	Depression	Hostility/violence	Inability to comprehend
Sleep disturbance	Loss of appetite	Grief/loss issues	Phobias/paranoia/delusions

Other _____

Eating Disorders: ___ Anorexia ___ Bulimia

Hallucinations: ___ Auditory ___Visual

When did you experience them and what did you do about it? _____

Is there a history of mental illness in your family? ___ No ___ Yes If yes, who and what is the illness?

Relative: _____ Illness _____ Status _____

Have you ever been treated for an alcohol problem before? ___ No ___Yes If yes, circle the following applicable programs:

Detoxification Rehabilitation Outpatient Treatment N/A Other: _____

List treatment locations, dates, and indicate type (detoxification, rehabilitation, etc.)

Location	Date	Type

Did you finish treatment? ___ No ___ Yes If no, explain: _____

Are transferring from another treatment facility? ___ No ___ Yes

Are you readmitting into this program? ___ No ___ Yes

Have you ever been diagnosed with a mental health condition? ___ No ___ Yes

If yes, what was the diagnosis? _____

Who diagnosed? _____When? _____Where? _____

Are you currently a client at a mental health center or seeing a private practitioner? ___ No ___Yes

If yes, where? _____ When? _____ For what? _____

Have you ever received counseling or psychiatric treatment? ___ No ___ Yes

If yes, where? _____ When? _____ For what? _____

Are currently using any prescribed medications for mental health purposes? ___ No ___ Yes

Medication _____ Dose _____ Duration _____

Are you currently using non-prescribed drugs for mental health purposes? ___ No ___ Yes

If yes, drug? _____Dose_____

How would you describe your current mental health? ___ Poor ___ Average ___ Good ___ Excellent

READINESS TO CHANGE

Do you believe you currently have a problem with the use of alcohol/drugs? ___ No ___ Yes

If so, which? _____

Do you believe you have had a problem with the use of alcohol/drugs in the past? ___ No ___ Yes

If so, which? _____

Have you ever felt you should cut down or control your use of alcohol/drugs?

___ No ___ Yes If yes, why? _____

Have you ever tried to cut down or control your use of alcohol/drugs, but been unsuccessful? ___ No ___ Yes

If yes, how many times/ _____

How would you access your overall use of alcohol/drugs? _____

_____

Readiness to Change:

At this moment, how confident are you that you will change your current drinking/drug use?

___I do not think I will change my drinking/drug use.

___I have a 50 percent chance of changing my drinking/drug use altogether.

___I think I will definitely change my drinking/drug use.

Would you like to reduce our quit drinking/drug use if you could do so easily? ___ No ___ Yes

How seriously would you like to reduce or quit drinking/drug use altogether?

___ Not at all ___ Not very ___ Somewhat ___ Probably yes ___ Definitely yes

Do you intend to reduce or quit drinking/using drugs in the next two weeks?

___ Definitely not ___ Probably not ___ Probably will ___ Definitely will

What is the possibility that 12 months from now you will not have a problem with alcohol or other drugs?

___ Definitely not` ___ Probably not ___ Probably will ___ Definitely will

RELAPSE HISTORY

Have you ever attempted to discontinue you use of alcohol? ___ No ___ Yes

If yes, how many times? _____ What is the longest you have abstained? _____ What motivated you to abstain?_____

Have you ever attempted to discontinue your use of drugs? ___ No ___ Yes

If yes, how many times? _____ What is the longest you have abstained? _____ What motivated you to abstain?_____

Did you resume using? ___ No ___ Yes

If yes, what led you to resume? _____

How did it make you feel to resume using? _____

Have you ever experienced cravings to use alcohol or drugs? ___ No ___ Yes

What are the thoughts or events that evoke cravings? _____

RECOVERY ENVIRONMENT

Which of the following employment problems have you ever experienced due to alcohol and/or drug use?

___ N/A ___Fired ___Used at Work ___Quit

___ Late for Work ___ Diminished Productivity ___ Absenteeism

Do you currently identify with any organized religion? ___ No ___ Yes If yes, which one? _____

Were you raised in an organized religion? ___ No ___ Yes If yes, which one? _____

Do you consider yourself to be a spiritual person? ___ No ___ Yes If yes, in what way? _____

Do you identify yourself with any cultural, ethnic background or community? ___ No ___ Yes

If yes, describe: _____

Are there any barriers to accessing treatment? ___ No ___ Yes If yes, explain: _____

Have you ever been involved with any self-help support groups? ___ No ___ Yes

If yes, ___ Past ___ Current Which one? _____When? _____ Why? _____

How do you feel about your involvement? _____

Are you will to attend self-help support groups now? ___ No ___ Yes If yes, which one? _____

Du you need a sponsor? ___ No ___ Yes

What kind of activities do you participate in? _____

What do you do in your leisure time? _____

What involves drinking/drugs?_____

What kinds of activities do you participate in that do not involve drinking/drugs? _____

Peer Group:

How many friends do you have? _____

How many of your friends use alcohol/drugs? _____

How many close friends do you have? _____

How many of your close friends use alcohol/drugs? _____

Are there barriers to accessing treatment? ___ No ___ Yes If yes, Explain: _____

ALCOHOL/DRUG USE QUESTIONS

1. Do you get drunk or high at school/work?
2. Do you miss work/school because you are using or crashing?
3. Have you given up sports or other activities since you have been using or drinking?
4. Has your alcohol/drug use caused legal, school, or family problems?
5. Do you have to use or drink more to get high now than when you started?
6. Have you ever had withdrawal problems when you stopped using?
7. Do you ever use or drink to stop feeling bad rather than to get high?
8. Have you lost control of your drinking? ___ No ___ Yes If yes, at what age did you first lose control of your drinking?
9. Have you ever had a blackout? ___ No ___ Yes If yes, at what age?_____

Have they increases? ___ No ___Yes

10. What is the average amount of hard liquor/beer/wine you consume? (Type, amount, frequency?)
11. Do you ever go on "binges" or periods of uncontrolled drinking? ___ No ___ Yes If so, how ofter?
12. Do you drink daily ___ No ___ Yes Amount?
13. How long have you been drinking daily?
14. Have you ever had the "shakes" when you stop drinking? ___ No ___ Yes If yes, please describe:
15. Have you ever seen or heard things that were not actually there/ ___ No ___ Yes
16. Have you ever had delirium tremens (DTs)? ___ No ___ Yes If yes, please describe:
17. Has a physician ever told you to stop drinking? ___ No ___ Yes If yes, why?
18. With whom do you usually drink? (Circle all that apply)

Spouse Other relative Neighbors By myself

Strangers Co-workers Friends at a bar Classmates

19. When drinking, how do you act and feel? (circle all that apply)

Angry Mean and pick fights Get into arguments Happy Have fun

Get into physical fights Rarely get angry Violent Other: _____

20. How do your parents, wife/girlfriend, or husband/boyfriend feel about your drinking?

Don't seem to mind Don't say much about it Nag me about it Have threatened to leave

N/a Other: _____

21. Would you say that your girlfriend/wife, boyfriend/husband has a drinking problem? ___ No ___ Yes
22. Would you say that your girlfriend/wife, boyfriend/husband has a drug problem? ___ No ___ Yes
23. Have any family activities changed because of your drinking? ___ No ___ Yes
24. Has your sexual life changed because of your drinking? ___ No ___ Yes
25. Have you ever quit drinking ___ No ___ Yes If yes, when ? _____

How long did you stay sober? _____

Did this "dry" period follow any form of treatment? ___ No ___ Yes If yes, what type?_____

Where? _____

What thigs did you do to stay sober instead of drinking?_____

Did you have any symptoms when you stopped drinking? _____

26. In your own words what is alcoholism or drug dependence? _____

_____

_____

27. Please describe yourself and specifically list your strengths and weaknesses:

_____

_____

_____

_____

_____

_____

_____

_____

Minor in Possession Issues (answer this section if you have been charges with Minor in Possession)

1. Has your drinking or drug use ever caused problems in school? ___ No ___ yes
2. Have you ever been sent home from school because of drinking or drug use? ___ No ___ Yes
3. Have you ever been suspended from school? ___ No ___ Yes
4. Have you ever been expelled from school? ___ No ___ Yes

If yes, why were you expelled? _____

5. Are you having any other school problems? ___ No ___ Yes If yes, explain:

_____

6. Do you have enough credits to graduate? ___ No ___ Yes If no, please explain:

_____

Staff Signature

_____

Date

_____

For office use only: Summary of Client's problem, needs, strengths and weaknesses:

_____

_____

_____

_____

_____