

Appointment:		Cancellation Reason <No Selection>
Canceled: <input type="checkbox"/> Yes <input type="checkbox"/> No		
No Show: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was the client rescheduled <Select>		New Appt Date/Time:
Cancel/No Show Notes:		
Hospital Department:		
Consumer name:		
Consumer DOB:		Age:
Gender:	Marital Status:	
Employer/School:		
Insurance: -Select- Type:		
Person(s) Living in Current Home:		
Supportive?		
PCP:		
Presenting Problem:		
Previous Psych Tx/Hx:		
Current Suicidal/Homicidal Ideations/Hx of SI:		
Medical History:		
Notable Labs:		
Vital Signs:		
BAL:		
Tox Screen:		
Height:	Weight:	
Allergies:		
Current Medication (include name, dose, route):		

Chemical Dependency (including last use, first use, duration, pattern of use and consequences):

Which of the following statements best describes how you feel about your current substance use?

☐ N/A

☐ I don't feel I have a problem with my current alcohol and drug use, AND I don't feel I need any help or treatment for it at this time.

☐ I do feel I have a problem with my current alcohol and drug use, BUT I don't feel I need any help or treatment for it at this time.

☐ I do feel I have a problem with my current alcohol and drug use AND I do feel I need some help or treatment for it at this time.

Legal History:

Assessment:

Assessment Recommendations:

Confidentiality and scope of services explained to client and/or family? -Select-

Client rights explained to client and/or family? -Select-

Therapist's credentials explained to client and/or family? -Select-

Diagnosis:

Provider's Signature

&STFCONSENTX&

Administrative Information

Reference No.	Date of Service &EVEFMM&/&EVEFDD&/&EVEFYR &	Service Code &EVESRV& - &SRVDSC&	Program &EVETRT& &EVEPRG& - &EVEPRGDSC&
Confirmation &EVECNFDSC&	Start Time - Stop Time &EVETIM& - &EVEEND&	Sub-facility Code &EVESFC& - &EVESFCDSC&	Place of Service &EVEPLC& - &EVEPOS&