Rural Nevada Counseling – Supportive Housing
Confidential Client Intake Form

Phone – (775) 575-6191

Fax – (775) 980-8042

www.ruralnevadacounseling.org

General Information

Name____Date_______________

County of Residence_______________

Address____

City____State_____________Zip_________

Years at Address____________________

Phone #'s: Home____________Work________________Cell ______________________

Please **DO NOT** contact me at: Home Work Cell

E-mail____

Sex: M * F * Trans Date of Birth____________________Age_________

SSN#_____________Race__________Ethnicity__________

Mother's Maiden Name______________________

Birth City______________________US Citizen______________

Veteran____________

Referred By___________________________________

How did you hear about our services?____

Emergency Contact__________________________Phone # ______________________

Have you been in a controlled environment in the past 30 days? Y / N

If so, where? __________________ How many days?__________________

Do you have an ID card? Y/N

Do you have a Social Security card? Y/N

Do you have your Birth Certificate? Y/N

Medical

How many times have you been hospitalized?_______In the past 12 months?_________

Health Insurance? Y/N Name of Provider_____________Card #___________________

Do you have any chronic Medical Problems? Y / N Doctor_______________________

If so, please list:

____

____

Date of last physical exam

____

Date of last TB Test ____________________________________

Results ______________________________

*If accepted, it is your responsibility to provide a copy of current TB results prior to arrival into RNC supportive housing unit. Rural Nevada Counseling is prohibited, by law, to accept you into our supportive housing program without this documentation.

Medications Currently Taking (This information is mandatory to enter treatment)

____
____
____
____

Are you on Disability: Y / N
Medicare: Y / N
If yes to disability, for what?____________________
If female, are you pregnant? Y / N / NA
Medical problems in the last 30 days? Y / N If so, how many days?___________

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How troubled are you about medical problems?__________
How important is treatment for your medical problems? _____________

Education

Grades completed___________Technical Training?_________________months
Medicaid: Y / N Card #____________________
Driver's License or ID #________________Applied for Medicaid: Y / N
Over the past three years have you been more employed or unemployed?________
Days worked in the past 30?______Dependents_________

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How troubled or bothered have you been by employment problems in the past 30 days? _________________________
How important to you now is treatment for these employment problems? _______

SUBSTANCE USE

Drug Use and Patterns	Use Past 12 months	Use Past 30 days	Highest use Frequency and Amount	Age First use	Date of Last Use	Route	1st, 2nd, 3rd choice
Alcohol							
Heroin Street Methadone							
Barbiturates (Opium/Demerol/ Morphine/Talwin)							
Benzodiazepines (Hypnotics/Sedatives /Anxiolytics							
Cocaine/Crack							
Methamphetamines or other Amphetamines (Speed/Ice/other uppers) (exclude MDMA							
Cannabis (Marijuana/Hashish							
Hallucinogens/ Psychedelics (LSD/PCP/ Mushrooms/Peyote)							
Inhalants							
Other Opiates/Analgesics							
Spice							
Over the counter							

Do you, or have you, ever used intravenous drugs? Y / N
Have you taken the substance in larger amounts or over a longer period than was intended? Y / N
Is there a persistent desire or unsuccessful efforts to cut down or control substance use? Y / N
Did you spend a great deal of time in activities necessary to obtain substances? Y / N
Do or did you have a craving, strong desire or urge to use substance? Y / N
Did you use substance recurrently and the results were a failure to fulfill major role obligations at work, school or home? Y / N
Have you ever been engaged in treatment before? Y / N
If yes, how many times in your life have you been treated for substance use? _________
For what?________ Facility______________________Date_______________________
Did you successfully complete this treatment? Y / N
Have you ever had DT? Y / N Have you ever attended Detox? Y / N
In the past 30 days did you spend money on drugs and or alcohol? Y / N
If yes, how much?________________
Did others give you drugs or give you money? Y / N How much? ________________
What is your longest period going without the use of alcohol and/or other drugs:

____
Have you been bothered by substance use issues in the past 30 days? Y / N
If yes, how many days? ________

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How important is treatment to you at this time? ______________
How serious do you feel your drug and/or alcohol problems are? __________
Have you been involved in prior treatment including residential care? Y/N
If so, where and when and did you successfully complete:

____
____
____

Legal

Was this visit prompted by the criminal justice system? Y / N
If so, which one? ____
Are you on Probation or Parole? Y / N Officer?__________________
Are you under court supervision? Y / N Which one? __________________
Have you ever been convicted of a violent offense? Y/N
If yes, explain
____
Have you ever been convicted of a sexual offense? Y/N
If yes, explain
____
Past charges?
____
____
Current charges?____

# of DUI's? ____________________
How many months have you been incarcerated in your life? ______________________

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How serious do you feel your legal problems are? ______________________
How important do you feel treatment is for these issues? _________________

Relational Information
Marital Status __________________
Children? Y / N
If yes, ages and location: ____
Are any of your children living with someone else due to a protective order? Y / N
How many children do you have?___________Do you owe child support? Y / N
Did you live with someone who drinks or uses substances? Y / N Who? ____________
Have you had problems getting along with anyone in the past 30 days? _____________
Lifetime? _______
Have you ever been sexually, physically, or psychologically abused? Y / N
If so, please explain
____
____
If so, how old were you? ___________________

If so, how old were you and who abused you?
____
____

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How troubled have you been by social or family issues in the past 30 days?
____
How important to you is treatment or counseling for these issues?
____

Mental/Emotional Health
How many times have you been treated for a psychological or emotional problem?
____
In hospital?_______Outpatient?____________
Do you have a psychiatric disability? ________________

Have you experienced:	Past 30 days	In lifetime
-Serious Depression	Y / N	Y / N
-Anxiety or Tension	Y / N	Y / N
-Hallucinations	Y / N	Y / N
-Trouble Controlling Violence	Y / N	Y / N
-Behavior	Y / N	Y / N
-Thoughts of Suicide	Y / N	Y / N
-Attempted Suicide	Y / N	Y / N

Been Prescribed Medications for Mental Health Reasons? Y / N
If so, please list: ____

____

In the last 30 days have you experienced psychological issues? Y / N
How many days? __________

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How troubled have you been in the past 30 days by psychological issues?

____
How important now is treatment for these psychological problems?

____

Personal Scales
On a scale from 1-10, 1 being poor and 10 being high, how would you rate the following?

Your self-esteem? __________
Your support system? __________
Your family stability? __________
Employment Skills? __________
Academic Stability? __________
Motivation to change? __________
Self-Care? __________
Self-Control? __________

Have you recently lost somebody close to you? Y / N

Please list any other information you would like us to know?

____

RNC Supportive Housing Rules

As a functional and balanced household, it is important that you treat each other with respect and care regardless of personality or belief. Making this house a HOME will depend on cooperation from everyone. We are not here to govern or rule, we are here to support you in your personal growth and recovery. By applying to Rural Nevada Counseling's supportive housing program, you are agreeing to a minimum of a 6-month process of alcohol and drug treatment, life skills training, medical and mental health, educational and job skills development and various other interventions before we begin the process of assisting you in finding full-time sustainable employment and long-term housing. All services are provided at one of our offices and we will assist you with transportation to and from your appointments. However, in order to maintain our environment for everyone, some ground rules are listed here. Some of these are State Health and Fire Code Requirements and others are to maintain an environment focused on recovery living. The following supportive housing agreement has been set forth to assure safety for you and your roommates.

1. Alcohol, gambling or the use of any mind or mood altering chemicals (legal or not) is forbidden at any time during residency, on or off the premises.
2. Violence, including verbal abuse will not be tolerated and you may be asked to leave the house should this occur.
3. Weekly and daily chores list will be assigned by House Dad/Mom. Chores will be done on a daily basis.
4. Sign-out sheets will be signed each time you leave and return to the house. We need to know where you are and when you are plan on returning at all times.
5. When it is determined by your Case Manager/Counselor you are ready to seek employment, you will be up and ready for job searching by 8am Monday through Friday.
6. Wake up time is 7am for those who are not involved in job searching Monday through Friday.
7. Beds must be made, Rooms neat and orderly, and clothes put away by 8am Monday through Friday.
8. It is unacceptable to quit your job without advising your Case Manager/Counselor first who can assist you with various issues that may surround this choice.
9. Dinner is a community meal and requires all house members (who are not employed or who do not have work schedules which could prevent them) to eat together as house mates. Dinner is prepared by all house members depending on your assigned day of the week.
10. Attendance at all groups and individual counseling sessions is mandatory to maintain residency in our supportive housing unit. Additionally, your Case Manager/Counselor may require your attendance at other meetings including; self-help support, educational, and other sessions depending on your individualized treatment plan. If required, your attendance becomes mandatory and failure to follow through may result in termination from RNC Supportive Housing Program.
11. Helping to give back in the community through weekly Community Service is a requirement for all house mates who are not engaged in full-time employment.
12. Fees will be incurred based on the following general schedule:
    a) Counseling fees may be charged beginning on the day you arrive
    b) Room/Board fees may be charged on the day you arrive
    c) Speak with your Case Manager/Counselor regarding your fees, as it is not our goal to set you up to fail based on fees. Generally speaking, we start charging fees only after you have

acquired employment and we will never 'discharge' you for not paying your fees as a single issue.

13. Visitors/Passes are allowed only when house dad/mom is present and upon prior approval from your treatment team and not to be scheduled during appointment/treatment times.
14. Curfew times are 5pm Monday through Sunday unless engaged in verifiable employment or prior approval by your treatment team.
15. House phone is provided for your convenience. No cell phones unless approved by your treatment team.
16. Smoking is allowed only in approved area and no less than 500 ft from the house. This is a privilege not a right and can be taken away at any time it is abused.
17. There is no dating or sexual intimacy between clients of the agency regardless of which program location they attend/reside. Pornography is forbidden.
18. TV hours are determined by treatment team and house dad. Mon-Fri – no later than 10pm on non-holidays.
19. All residents are subject to random drug screens.
20. Food Stamps are overseen by your house dad/mom and are released to you when you leave your stay.
21. Food supplies are managed by your house dad/mom and are prepared in accordance with the posted 4-week menu.

This is now your home temporarily and we make every attempt to make it comfortable and for your time here to be positive. It is our goal to help you find the path to a healthy and fulfilling lifestyle.

By signing below, I acknowledge that I have been oriented to my house's general rules and I agree to abide by the above guidelines. In so doing, I am making a commitment to recovery and a new life.

____
Client Signature

____
Date Signed

Visitor's Rules

All visitors must agree to adhere to the following rules:

1. All visitors must read and sign the confidentiality form when visiting. No visitor may disclose any information regarding a client's attendance or any other information that will identify a client as a house member in one of Rural Nevada Counseling's supportive housingunits.
2. A staff member must be present whenever guests are in the house. Clients must arrange for visits in advance.
3. All visits must take place in the common areas. There are the living, dining and kitchen areas. No visitors are allowed in the bedrooms at anytime.
4. Visitors should dress appropriately. Please avoid provocative clothing or any logos that would promote the use of alcohol, drugs, or a lifestyle incongruent with the agency's mission.
5. Please avoid excessive 'public display of affection.'
6. This is a non-smoking facility. Please do not smoke on the property.
7. Anyone entering onto a Rural Nevada Counseling property in possession of, or under the influence of an intoxicating substance will be asked to leave immediately.
8. Children must be supervised at all times.
9. Please respect all Rural Nevada Counseling properties. If you need something, please ask a staff member.
10. Rural Nevada Counseling staff reserves the right to ask guests to leave at any time for any behavior they deem inappropriate.

____
Guest Signature

____
Date Signed

Request for RNC Supportive Housing

I,____, hereby request residency at one of Rural Nevada Counseling Supportive Housing Units for as long as clinically beneficial to me as deemed necessary by my treatment team. I have read the rules and procedures pertaining to supportive housing requirements, and give my word to abide by them and to participate fully in my recovery process and my individualized service plan. I agree to work with my Counselor to develop a personal plan for my growth and to continue to review and develop that plan on a regular basis as I meet the goals I set for myself. I realize that failure to work within the guidelines set forth by RNC's Supportive Housing Unit(s) could result in my dismissal from the house, which will be reported to any entity requiring said notifications. I also understand that if I reported to Rural Nevada Counseling admission staff any information that was falsified in order to gain admission, and said admission was dependent on that self-report, that I may be transferred to a more appropriate level of care or discharged. I understand that if I require a more intensive level of care such as residential treatment due to increase of symptoms, I will work with RNC staff in whatever way is required of me.

____
Client Signature

____
Date Signed

Rural Nevada Counseling
720 South Main Street, Suite C
Yerington, NV 89447
1-866-831-2774
Phone: 775-463-6597
Fax: 775-463-6598

Dayton
775-246-6214
Fernley
775-575-6191
Silver Springs
775-577-4633
Virginia City
775-847-9311

CONSENT TO TREATMENT

As a client of the Rural Nevada Counseling I understand that:

1. I am entitled to treatment and rehabilitation care to include referral to appropriate medical, psychological and training services as part of my treatment plan.

2. I have the right to refuse any or all parts of the treatment plan, with the exception of emergency medical treatment.

3. Consent to any or all parts of the treatment plan may be withdrawn at any time.

4. I will be informed of the nature, consequences and purposes of the treatment plan, and any alternative plans and resources available.

5. Participation in an AA or NA is encouraged. I will respect member's right to confidentiality, and authorize AA or NA involvement in my treatment.

Treatment conditions and program expectations:

1. To achieve/ maintain abstinence from all mood altering chemicals

2. To learn about the disease concept of addiction

3. To improve self-esteem

4. To reduce defense mechanism

5. To accept responsibility and develop a plan for recovery

6. To achieve/ maintain economic self sufficiency

I have been fully informed of the above, understand the process, and agree to accept such treatment and to cooperate in its implementation.

______________________________ _______________
Client signature Date

______________________________ _______________
Witness Date

______________________________ _______________
Signature of parent, guardian or authorized representative Date

Supported by: State of Nevada Mental Health & Developmental Service, Substance Abuse Prevention & Treatment Agency/
Lyon County/City of Fernley/City of Yerington/Healthy Communities Coalition of Lyon & Storey Counties/Yerington Youth Task Force
OFFICES IN: Yerington – Fernley – Silver Springs – Dayton – Virginia City

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, ____, authorize

_______ Rural Nevada Counseling _______
(Name or general designation of program making disclosure)

to disclose to: ____
(Name of person, treating provider, entity or organization to which disclosure is to be made)

the following information:
(Select the nature of the information that you want released to this party)

___ Drug & Alcohol Assessment report ___ Comprehensive Evaluation ___ Diagnosis	___ Progress Notes ___ Treatment Plans ___ Discharge Summary	___ All of my substance use disorder records ___ General Summary Letter only
	___ Other (Specify):______________________	
The purpose of the disclosure authorized herein is to:		

(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

____
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Date: ____________________ ______________________________
Client Signature

Date: ____________________ ______________________________
Signature of parent, guardian or authorized representative if needed

Supported by: BHPT - Behavioral Health Prevention & Treatment
Lyon County/City of Fernley/City of Yerington
PROVIDING SERVICES IN: Yerington – Fernley – Silver Springs – Dayton

Updated:05-2017

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