



A NoN-PROFIT COUNSELING AGENCY

1802 California Street, Eureka, CA 95501 (707) 443-7358 FAX (707) 443-1092

PC1000 DRUG AND ALCOHOL DIVERSION CONFIDENTIAL INTAKE FORM

Date: _____

INTAKE # _____

Client Name: _____
Home Phone: () _____
Address: _____ City: _____ Zip: _____
Age: _____ Birth Date: ____/____/____
Soc. Sec. #: _____ - _____ - _____ Drivers License #: _____

CASE # _____
County: _____
Probation Officer/ Attorney: _____ Phone # _____

Occupation: _____
Employer: _____ Work Phone: _____
Employer Address: _____ City: _____ Zip: _____

Significant Other (S.O.) Name: _____
S.O. Age: _____ Birth Date: ____/____/____
S.O. Employer/Occupation: _____
S.O. Work Phone: _____
Emergency Contact: _____ Phone: _____
Please list others in household and relationship to applicant:
Name: _____ Rel: _____ Age: _____
Name: _____ Rel: _____ Age: _____
Name: _____ Rel: _____ Age: _____

FOR INTERVIEWER'S USE ONLY.

OFFICE USE ONLY: Paid Date: Needs Appointment: Date: Time:

SOCIAL HISTORY

0-none 1-daily 2-weekly 3-monthly 4-quarterly 5-yearly

Circle

How often did you experience drug use by parents at home as a child? 0 1 2 3 4 5

Family background _____

Family involvement in drugs/alcohol _____

COUNSELING HISTORY

1 - Never 2 - once or twice 3 - sometimes 4 - a lot

Do you have any special physical or mental condition? 1)Yes 2) No 1 2
What? _____

Have you ever received counseling or mental health services? 0 1 2 3 4 5 6
1) No 2) For relationship problems other than substance abuse
3) For violence 4) For psychiatric problems
5) For substance abuse 6) Other, please specify; _____

Have you ever attempted suicide? 1) Yes 2) No 1 2
How many times? _____

CRIMINAL HISTORY

Were you convicted of a crime other than drugs? 1) Yes 2) No 1 2

If "Yes", what? _____

Were you under the influence? (specify what) _____

Were you ever incarcerated? 1) Yes 2) No 1 2
Why? _____

***** GO ON TO NEXT PAGE *****

Ever been arrested for DUI? _____ If yes, describe: _____

Drug arrests/convictions _____

Probation/parole _____ Civil suits _____

Drug/alcohol history: Age first use _____ Substance _____

Pattern of use (i.e. daily, weekly) _____

Previous treatment: _____ Problems identified: _____

Chemical Dependency _____ 1. _____

12-Step _____ 2. _____

Psychiatric _____ 3. _____

Other _____ 4. _____

**VIOLATION OF THE FOLLOWING MAY RESULT IN IMMEDIATE
DISMISSAL FROM THE DRUG DIVERSION PROJECT.**

- 1) Please contact your group leader at least 24 hours in advance if you are unable to attend group. Group members are expected to actually make the call. When canceling an appointment, you yourself must call, not anyone else. **Absences cannot be excused if a partner, relative or friend call.** All illnesses will require a note from your physician, otherwise absence will be unexcused.
- 2) We have an answering service available to you **24-hours a day**. If for any reason you need to cancel, call 24 hours in advance to avoid being non-compliant.
- 3) Failure to attend **clean and sober** (that means no use of chemicals 48 hours before meeting) will result in dismissal from the group and you will be considered as absent for that reason.
- 4) Failure to **respect complete confidentiality** will constitute an explanation by that person who breached confidentiality. Explanation will be offered to the entire group and the group will make recommendations to the Group Counselor. Decision of the Group Counselor relevant to future participation is final.
- 5) If you have questions regarding these policies, please contact the Humboldt Family Service Center at 443-7358.

Client's Signature

Date

PC1000 DRUG DIVERSION PROGRAM OFFICE POLICIES

COST: The class is \$300.00, unless you have been issued a fee waiver from the Superior Courts in the past six months. The balance of \$300.00 must be paid in order to register for the next workshop.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or cancelling an appointment. There is a \$20.00 late cancellation fee and a \$50.00 "No-Show" fee (meaning that it is past the time of your intake or exit interview and you have not yet called or shown up). The Saturday Workshops only have room for twelve people; if you have confirmed your attendance and not shown up to the first workshop, you will be charged \$100.00 for the space that was reserved for you. You are responsible for these fees. No other appointments will be scheduled until these fees have been paid. These fees will not be billed to Medi-Cal, private insurance, or to any other agency.

EMERGENCY PROCEDURE: If you need to contact your instructor between sessions, please leave a message with the office or answering service at 443-7358. Your call will be returned. If an emergency situation arises, inform the service that your call is an emergency. Please do this for true emergencies only. Each client's situation is unique and it is **possible you will be billed for a phone consultation**. This service is available to you 24 hours a day.

IF FOR ANY REASON A CHECK IS RETURNED TO US BY THE BANK: We do not re-deposit. You must replace the amount of the check and the bank service fees with either cash, cashiers check or money order. A personal check is not acceptable at this point. **RETURNED CHECK FEE IS \$15.00.**

I have read and understand these office policies.

Client's Name Printed

Client's Signature

Date

GROUP AGREEMENT

My goals in participating in the PC1000 Drug Diversion Project counseling program are:

- 1) To have an open mind, learn something about drugs and how they relate to my situation.
- 2) To actively explore myself, my attitudes and my conditioning in order to assess my behavior.

In pursuing these goals, I make these commitments to myself and to the other members of the group:

- To attend meetings regularly and on time.
- To attend clean and sober.
- To respect complete confidentiality.
- To participate actively.
- To disclose the full extent of my drug use.
- To be honest and straightforward.
- That however I got here, I am here because I want to learn.

Date

Signature

DRUG DIVERSION PROJECT

CONFIDENTIALITY RELEASE FORM

Ordinary Patient – Psychotherapy privilege is limited for participants of the above treatment program at Humboldt Family Service Center. Since you have been referred for treatment through a community based treatment program, many agencies, court and other therapists may be involved. A staff of counselors from Humboldt Family Service Center and other agencies meets weekly to coordinate service, assess progress and make recommendations.

The California Evidence Code (1012) states that confidentiality means that confidential information is not disclosed to the third party other than those “who are present to further the interest of the patient in the consultation, or those whom disclosure is reasonably necessary for the purpose for which the psychotherapist is consulted.”

As part of the program, we may consult with other therapists, probation officers, child welfare services, attorneys, District Attorney, Public Defender, other appropriate agencies/individuals when this is considered necessary to further your interests or to accomplish the purpose for which you consulted with us. The agencies shall include but **are not limited to:**

- 1) Humboldt County Probation Department (or any other county probation department)
- 2) State Parole Board Office
- 3) Public Defender
- 4) District Attorney
- 5) Private Attorney _____

I, _____, understand the limits to the patient-psychotherapist privileged communication, and agree that this release covers those agencies identified as necessary to the therapeutic process.

Signed _____

Date _____

