THE CARTER TREATMENT CENTER

380 Dahlonega Street, Suite 100, Cumming, GA 30040 (678) 771-8468
1325 Satellite Blvd, Suite 1004, Suwanee, Georgia 30024 (678)545-2136

New Client Registration Form

Date: _____

Name (Please print): _____ Gender Identification _____

DOB: _____ SSN: _____ Marital Status: _____

Address: _____ City: _____ State/zip: _____

Cell Phone: _____ Do we have permission to call/text or leave messages? Yes No Y

Email: _____ Permission to send information? Yes No Y

Vehicle Make and Model: _____ Vehicle Year: _____ Vehicle Color:_____ Veh Tag #: _____

Primary Care Physician: _____ Phone No.: _____

List any medical conditions and/or diagnosis': _____

_____

Please list any medications you are taking; the dosage and the condition being treated.

Medication/Dose	Condition	Medication/Dose	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who Prescribes your medications?_____

Family / Friends Contact: _____ Relationship: _____ Phone: _____

Email: _____ Permission to send information? Yes No Y

We often send out information regarding local meetings, support groups and community education events as well as alumni functions and activities. Are there any other friends or family members you would like us to email with this information? Please include their email:

_____

_____

_____

**Please present Insurance card and Picture ID to staff.*

_____ _____

Client Signature Date

AUTHORIZATION TO PAY BENEFITS TO THE CARTER TREATMENT CENTER, CONSENT FOR TREATMENT, AND PRIVACY NOTICE

VOLUNTARY CONSENT TO TREATMENT/ASSESSMENT

I voluntarily consent to participate in a mental health and/or substance use disorders assessment that may result in receiving treatment administered by staff from **THE CARTER TREATMENT CENTER, Inc.** I understand that following the assessment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment
b. Alternative treatment modes and services
c. The manner in which treatment will be administered
d. Probable consequences of not receiving treatment

The evaluation will be conducted by a licensed therapist or a certified addiction counselor, or by an individual supervised by any of the professionals listed. Treatment services will be conducted as outlined in the regulations set forth by the Official Code of Georgia; Drug Abuse Treatment and Education Programs.

Expected Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment, psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimated prognosis, and education and rehabilitation planning. Possible benefits to treatment include abstinence from alcohol and/or drug use, improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

HIPPA NOTICE OF PRIVACY PRACTICES

This notice has been furnished to you. It describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully. The privacy of your health is important to us.

FINANCIAL AGREEMENT

I hereby assign payment directly to **THE CARTER TREATMENT CENTER, Inc** for any treatment performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to **THE CARTER TREATMENT CENTER, Inc** for all charges in the event that I have no insurance, or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if **THE CARTER TREATMENT CENTER, Inc.** files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out-of-pocket costs" are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment accepted include check, cash, and credit card.

I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account, until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Georgia.

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY **TO THE CARTER TREATMENT CENTER, Inc**, THE AMOUNT ALLOWED FOR SERVICES RENDERED UNDER MY BENEFIT ALLOWANCE FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I FURTHER AGREE TO PAY ALL COPAYS AND DEDUCTIBLES FOR SERVICES.

_____ _____

CLIENT'S SIGNATURE DATE

_____ _____

POLICYHOLDER'S SIGNATURE DATE

_____ _____

STAFF SIGNATURE DATE

THE CARTER TREATMENT CENTER
380 Dahlonega Street, Suite 100, Cumming, GA 30040 (678) 771-8468 / fax (678) 845-8415

Credit Card Authorization & Appointment Cancellation Policy

It is the policy of The Carter Treatment Center to not double book appointments. Each Individual or Family appointment is a block of our clinicians' time reserved exclusively for a single Client/Family Member. When a Client misses an appointment or fails to provide at least 24 hours' notice for cancellation, the Client has occupied the reserved block regardless of any service rendered. **Therefore, the Client, not the insurance company, will be charged the full session rate of $100 per appointment missed or cancelled with less than 24 hours' notice.**

I, X_____, have read, understand and agree to The Carter Treatment Center's appointment cancellation policy. I understand that I am responsible for full payment of any appointments missed or cancelled with less than 24 hours' notice.

Client Signature: X_____Date: X_____

Credit Card Authorization and Guaranty of Payment

Client Name_____

Name on Credit Card: _____

Credit Card Number: _____

Credit Card Type: _____ CVV No.: _____ Exp. Date: _____

Zip Code: _____ Contact Phone Number: _____

I authorize The Carter Treatment Center to charge this credit card for any of the following circumstances:

Charges for missed appointments, as incurred, at the full session rate. This is regardless of what you typically pay per session.

This authorization remains in effect until a cancellation notice is received in writing or all charges incurred are satisfied.

Client Signature X_____ Date: X_____

Cardholder Signature: (**if different**) X_____ Date: X_____

SBQ-R Suicide Behaviors Questionnaire – Revised

Name: _____ **Date:** _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself?
   - ☐ 1. Never
   - ☐ 2. It was just a brief passing thought
   - ☐ 3a. I have had a plan at least once to myself but did not try to do it
   - ☐ 3b. I have had a plan at least once to myself and really wanted to die
   - ☐ 4a. I have attempted to kill myself, but did not want to die
   - ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year?
   - ☐ 1. Never
   - ☐ 2. Rarely (1 time)
   - ☐ 3. Sometimes (2 times)
   - ☐ 4. Often (3-4 times)
   - ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it?
   - ☐ 1. No
   - ☐ 2a. Yes, at one time, but did not really want to die
   - ☐ 2b. Yes, at one time, and really wanted to die
   - ☐ 3a. Yes, more than once, but did not want to do it
   - ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday?
   - ☐ 0. Never
   - ☐ 1. No chance at all
   - ☐ 2. Rather unlikely
   - ☐ 3. Unlikely
   - ☐ 4. Likely
   - ☐ 5. Rather likely
   - ☐ 6. Very likely

Permission for use granted by A. Osman, MD

Name:_____ Date: _____

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months…		**Circle**		
1.	Have you used drugs other than those required for medical reasons?	Yes	No	Y
2.	Do you abuse more than one drug at a time?	Yes	No	Y
3.	Are you unable to stop abusing drugs when you want to?	Yes	No	Y
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No	Y
5.	Do you ever feel bad or guilty about your drug use?	Yes	No	Y
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No	Y
7.	Have you neglected your family because of your use of drugs?	Yes	No	Y
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No	Y
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No	Y
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No	Y

Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation.)

AUDIT

Name:_____ **Date:** _____

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol) =

8-9 oz. of malt liquor (about 7% alcohol) =

5 oz. of wine (about 12% alcohol) =

1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at ***www.who.org***.

Name:_____ Date: _____

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

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A2663B 10-04-2005

Name: Date:

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Name: _____ Date: _____

PCL-C

The next questions are about problems and complaints that people sometimes have in response to stressful life experiences. Please indicate how much you have been bothered by each problem in the past month. For these questions, the response options are: "not at all", "a little bit", "moderately", "quite a bit", or "extremely".

		Not at all	A little bit	Moderately	Quite A Bit	Extremely
PCL1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	1	2	3	4	5
PCL2	Repeated, disturbing dreams of a stressful experience from the past?	1	2	3	4	5
PCL3	Suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)?	1	2	3	4	5
PCL4	Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	5
PCL5	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5
PCL6	Avoiding thinking or talking about a stressful experience from the past or avoiding having feelings related to it?	1	2	3	4	5
PCL7	Avoided activities or situations because they reminded you of a stressful experience from the past?	1	2	3	4	5
PCL8	Having trouble remembering important parts of a stressful experience from the past?	1	2	3	4	5
PCL9	Loss of interest in activities that you used to enjoy?	1	2	3	4	5
PCL10	Feeling distant or cut off from other people?	1	2	3	4	5
PCL11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
PCL12	Feeling as if your future somehow will be cut short?	1	2	3	4	5
PCL13	Having trouble falling or staying asleep?	1	2	3	4	5
PCL14	Feeling irritable or having angry outbursts?	1	2	3	4	5
PCL15	Difficulty concentrating?	1	2	3	4	5
PCL16	Being "superalert" or watchful or on guard?	1	2	3	4	5
PCL17	Feeling jumpy or easily startled?	1	2	3	4	5

Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

Name: _____ Date: _____

LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
2. Fire or explosion	☐	☐	☐	☐	☐	☐
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	☐	☐	☐	☐	☐	☐
4. Serious accident at work, home, or during recreational activity	☐	☐	☐	☐	☐	☐
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	☐	☐	☐	☐	☐	☐
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐	☐	☐
9. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
10. Combat or exposure to a war-zone (in the military or as a civilian)	☐	☐	☐	☐	☐	☐
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
12. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
13. Severe human suffering	☐	☐	☐	☐	☐	☐
14. Sudden violent death (for example, homicide, suicide)	☐	☐	☐	☐	☐	☐
15. Sudden accidental death	☐	☐	☐	☐	☐	☐
16. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
17. Any other very stressful event or experience	☐	☐	☐	☐	☐	☐

USE HISTORY

History of Alcohol and Drug(s) Abused (Either Not Prescribed, or an Abused Prescription)

Substance	**Type**	**Age 1st use**	**Highest Amount of Use Was __ Between Ages of ___ and __**	**Pattern of Use over last 30 Days**	**Pattern of Use over last 12 months**	**Date and Amt of last use**	**Method (oral, IV, snort, etc.)**
Alcohol							
Amphetamines							
Methamphetamines							
Benzodiazepines							
Cannabis							
Synthetic Marijuana "Spice"							
Cocaine							
Crack							
Heroin							
Opioids (other than Heroin, specify)							
Inhalants							
MDMA							
PCP							
Kratom							
LSD							
Mushrooms (Psilocybin)							
Other Drug, Specify							

Dimension 1 *(Acute Intoxication and/or Withdrawal Potential)*

Have you ever been prescribed Methadone?_____ Abused? Y N

Have you ever been prescribed Buprenorphine/Suboxone? _____ Abused? Y N

(If alcohol user): How many drinks does it take to feel it? _____

(If alcohol user): How many drinks does it take to get a good buzz? _____

(If alcohol user): How many drinks does it take to get drunk? _____

What is your longest period of abstinence? _____

How did you maintain abstinence? _____

Current Withdrawal Symptoms: (circle)

Nausea Anxiety Abdominal Cramps Sweating Tremors Chills Dizziness Muscle Aches Agitation Hyperactivity Diarrhea Difficulty Breathing Nervousness Runny Nose Depression Headache Clouded Thinking Fatigue Shakiness Goosebumps Vomiting Sneezing Enlarged Pupils Hallucinations Clammy Skin Hot/Cold flashes Pale Nightmares Slurred Speech Fever Difficulty concentrating

Client Denies Withdrawal Symptoms

Post-Acute Withdrawal Symptoms (PAWS): (circle)

Fatigue Depression Anxiety Sleep Disturbances Cognitive Impairment Anhedonia Cravings

Cravings: (1 to 10) _____ **Breathalyzer Reading**:_____**Drug Screen Results**: _____

Prior Substance Abuse Treatment:

Name of Facility	Date Admitted	Date Discharged	Treated for which drug(s) or alcohol?	D/C Type (Planned, AMA)

<u>Dimension 2</u> *(Biomedical Conditions and Complications)*

Medical History

Height: _____Weight: _____ Do you have any concerns about your weight? _____

Have you ever dieted? _____Are you currently unhappy with your weight? Y N

Do you have any current medical problems? Yes / No If so, be specific_____

__Hypertension __Heart problems/disease _____Diabetes ____Lung Problems ____ Obesity

___Liver abnormalities (elevated enzymes) ____Neurological Issues _____Chronic pain (back, neck)

Have you ever had any other serious injury or chronic medical condition? No_____ Yes _____
If so, please be specific: _____

_____

Have you ever experienced any type of brain injury, concussion or any other neurological issue? Y N
If so, please be specific: _____

_____

Current Medications	**Dosage**	**What is the medication for?**	**Compliant?**
Past Medications	**Dosage**	**What was the medication for?**	**Compliant?**

Any over the counter medication? Yes / No **(If yes, please list amount and frequency)**

Sleep
How many hours of sleep per night?

Difficulty staying asleep? Yes / No

Difficulty Falling asleep? Yes / No

Recent sleep changes? Yes / No

Appetite
How many meals do you eat per day?

Appetite changes recently? Yes / No

Recent weight changes? Yes / No

Difficulty with daily living activities? Yes / No
(hygiene, paying bills, social interaction, getting out of bed, etc.)

Allergies
Do you have any drug allergies? Yes / No

Do you have any other allergies? (Food, bee stings, materials, etc.)

History of seizures: Yes / No

What kind?

When was the first one?

Date of last seizure:

Alcohol/Drug related: Yes / No

History of overdose: Yes / No

History of blackouts: Yes / No

History of DTs: Yes / No