L·S·L·C
Life Skills Learning Center

CLIENT INFORMATION

Name of Client (please print) _____

Address _____
City State Zip

D.O.B._____ Birth Sex: M or F (circle one) Marital Status _____ (single, married, divorced, widowed)

Gender Identity:_____

Race: *(circle most predominate)* Hispanic or Latino, American Indian or Alaskan Native, Black or African American, Asian, Native Hawaiian or other Pacific Islander, White

Email Address:_____

Primary Language: _____

Employment: *(where and what do you do)*_____

_____

Home Phone:_____ May we leave a message? ☐ Yes ☐ No

Cell Phone:_____ May we leave a message? ☐ Yes ☐ No
(Cell number may be used for Telehealth/Zoom so please write legibly)

Work Phone:_____ May we leave a message? ☐ Yes ☐ No

What is your religious affiliation? _____

What is your highest level of schooling? _____

Are you currently on probation/parole? Y___N____

CONVICTION(S)	DATE ARREST OCCURRED	WAS PROBATION/ PAROLE SUCCESSFULLY COMPLETED	DATES INCARCERATED (IF APPLICABLE)

Who is your parole/probation officer:_____

Please describe the most recent legal issues you have had (even if you are not on probation):_____

_____

Why are you here today? *(circle all that apply)*

Counseling with Licensed Clinician *(length to be determined)*

Assessment *(one appt. with counselor for recommendations)*

Anger Management Class *(8 weeks to complete)*

Domestic Violence Offender Treatment Intervention Class *(52 weeks to complete)*

Parenting Class *(9 weeks to complete)*

****

EMERGENCY CONTACT INFORMATION

Name _____ Phone # _____

Relationship to you _____

Choose # 1 or # 2

1. **I give consent for LSLC to contact this person only in case of a *medical emergency*_____.**
   (initial)

OR

2. **I give consent for LSLC to speak to this person about any information in regards to my care or services _____.**
   (initial)

*The consent to contact this person is valid for **one year** or until I notify LSLC to revoke it*_____.
(initial)

I acknowledge that the above information is correct and that my confidentiality is protected.

_____ _____
Client Signature Date

_____ _____
Life Skills Staff Date

****

Client revoked consent on: _____ LSLC Staff: _____

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CLIENT RIGHTS FOR SERVICES

As a client, you have the right to appropriate care and protections. State and Federal laws and regulations guard your confidentiality. You may also have other rights, which are listed below. Read carefully and be sure to ask your facilitator if you have any questions about them.

1. Confidentiality and Release of Information: I understand that information concerning my contact with this agency will be held confidential among the LSLC staff to protect my right to privacy. I further understand that such information will not be disclosed without my written permission, or that of my legal guardian, except under special circumstances such as:

   a. If I threaten to injure myself or someone else
   b. When such information is required by law to be reported such as information regarding abuse, neglect, molestation, or exploitation of minor, incapacitated adult, elder person 65 or older, or in case of court order
   c. For medical emergency

2. I understand and have the right to:
   a. Privacy
   b. Considerate care that respects my privacy and individual needs
   c. Information about my services and any correspondence related to me
   d. Know the names and functions of everyone who works with me
   e. Refuse a recommended plan of care
   f. Expect staff to treat all communications and records about my care confidentially
   g. Expect continuity of care and be told about choices
   h. Appropriate recognition and consideration of my spiritual and cultural values

3. I understand I have the right to file a complaint about the services I receive if necessary. Misunderstandings or conflicts may arise and it is my right to have these issues resolved. LSLC has established a Grievance Policy that will investigate my complaint and form a plan for corrective action.

A written copy of the *Privacy Notice to Patients* and *Grievance Policy* will be provided to me upon request.

Having been informed of my rights and obligations as a client, I hereby give my consent for services:

_____ _____
Client Signature or Guardian Date

_____ _____
LSLC Staff Date

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Answer ALL of the questions.

ANGER QUESTIONNAIRE

Episode:

Please describe in detail the anger episode that brought you here: _____

_____

_____

When did the anger episode occur?_____

Where did the anger episode occur?_____

With whom?_____

What happened?_____

_____

What actions did you demonstrate during the angry episode? ☐ Physical ☐ Verbal

☐ Threats ☐ Property destruction ☐ Other: Explain:_____

_____

Main types of angry words and thoughts during the angry episode:_____

_____

Explain how did you feel physically while you were angry? ☐ Tense ☐ Rush

☐ Strong ☐ Other Explain:_____

How did the angry episode end?_____

Were there any use of alcohol and/or drugs by anyone involved? ☐ Yes ☐ No

If yes, by whom?_____

Duration:

When you become angry, how long to you remain angry?_____

Intensity:

On a scale of 1 to 10, with one representing no anger and 10 representing explosive anger, rate the intensity of your anger during the angry episode:_____

Frequency:

How often have you had trouble with your anger:_____

☐ This time only ☐ This month only ☐ Last six months ☐ Since childhood

☐ Adolescent ☐ Only as an adult

CONNECTION BETWEEN YOUR USE OF ALCOHOL/DRUGS AND ANGER/AGGRESSION

☐ Anger/aggression gets worse when using.
☐ I only get in trouble with my anger/aggression while using.
☐ I'm less angry/aggressive when I drink or use drugs.
☐ Others tell me there is a connection but I have trouble believing it.
☐ There seems to be no connections at all.
☐ Other alcohol/drug connections with anger/aggression (Explain):_____

_____

_____ _____

Client Signature or Guardian Date

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1200 N. Thornton St., Suite H Clovis, NM 88101
Ph. 575-935-4411/Fax 575-935-0400

RELEASE OF INFORMATION

Client Name (Print) _____ DOB_____

Address_____
Street City State Zip

I hereby authorize (Agency Name)_____

Attention (Name & Title)_____

Phone Number_____ Fax Number_____

To release the following information for the purpose of coordination of care & treatment planning:

- o Intake Information
- o Discharge Summary or Certificate of Completion
- o Psychiatric/Psychological Evaluation
- o Treatment Plan(s)
- o Recommendation Letter
- o School Records (report cards, discipline, teacher observations, IEP)
- o Diagnosis, Functional status, Prognosis
- o Medical Records from _____to_____
- o Legal Records (excludes attorney/client privilege)
- o Psychosocial Assessment
- o Domestic Violence/Anger Assessment
- o Placement History
- o Substance Abuse/Alcohol Assessment (protected under 42 CFR Part 2)
- o Chronological Offense Records
- o Probation/Parole Agreement
- o Court Orders
- o Consultation/Dialogue (phone, in-person, secure email, fax)
- o Referral Information/Service Plan
- o Fees/Balance Owed
- o Educational Tests/Evaluations
- o Attendance/Progress Reports
- o Other_____

******MH/BH Psychotherapy Notes (actual notes excluded as defined in 45 CFR 164.501)

The information shall be released to (Agency Name)_____

Attention (Name & Title)_____

Phone Number_____ Fax Number_____

****

PROHIBITION ON REDISCLOSURE: Federal Law & State Regulations prohibit further disclosure of this information to any Persons or Agency without securing another proper written authorization for that purpose.

This is valid for one (1) year after the date of this signature or until either party terminates in writing. I expressly understand and agree that no legal responsibility or liability of any nature shall be to the respondent, the agency or its employees in acting upon this authorization and request.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Legal Guardian (if applicable) Date

_____ _____
Signature of Life Skills Staff (Witness) Date

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ATTENDANCE AGREEMENT
(PLEASE READ)

++++ *IMPORTANT* ++++

The Anger Management class is comprised of EIGHT classes that uses cognitive behavioral therapy to address the anger cycle, conflict resolution, assertiveness skills and anger-control plans. The curriculum is based on the Life Skills Program and the U.S. Department of Health and Human Services workbook*: Anger Management for Substance Abuse and Mental Health Clients.* You will need to complete ALL eight classes and pay in full before we can issue a completion certificate.

Each week a different lesson is completed in the workbook. If you miss a particular lesson (i.e. Lesson 3), you will have to wait until that lesson rotates around again. Excessive absences will cause the 8-week program to last much longer so it is important to attend. If you experience an emergency and provide proof, LSLC will excuse you. The facilitator or office staff will work with you to schedule a make-up. This is the ONLY *approved absence. If you cannot provide proof, you will have to wait until the scheduled date of the lesson(s) you missed to complete the course.

***An approved absence is at the discretion of LSLC.**

IF YOU MISS TWO CONSECUTIVE MONTHS, YOU WILL BE DROPPED FROM THE ROSTER AND ALL FEES PAID ARE FORFEITED. IF YOU RETURN TO CLASS, YOU WILL BE REQUIRED TO START OVER.

By signing below, I agree to the terms listed above. I declare that I have read the information and understand what I have read. I enter into this agreement voluntarily.

_____ _____
Client Signature **Date**

_____ _____
Life Skills Staff **Date**

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PAYMENT CONTRACT

_____ I understand that I have been mandated to attend the eight-week Anger Management class.

_____ I am voluntarily enrolling in the eight-week Anger Management class.

ENROLLMENT FEE: $160.00 ($20.00 per class). We accept checks, cash or money orders.

The entire amount ($160.00) is due the first week of attendance unless I have made prior arrangements with LSLC.

I cannot pay the full balance _____ so I agree to pay $_____ per session.
(Initial)

I am responsible for paying the balance of my account and **no refunds** will be given if I quit coming to class. I will not receive my completion certificate until I have paid in full.

_____ _____
Client Signature Date

_____ _____
Life Skills Staff Date

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ANGER MANAGEMENT CLASS

Date:	Every Thursday except major holidays
Time:	5:00 PM
Place:	1st floor Antioch classroom – (subject to change)
Facilitator:	James Padilla, MS, LADAC
Cost:	$160 ($20 x 8 sessions) – clients can pay in class (cash or money order). Clients can also call the business office during open hours and pay over the phone with credit or debit card. Business office open M-F 8:30-5:00

Thank you,
Life Skills Learning Center

CLIENT KEEP

575-935-4411 (Phone)
575-935-0400 (Fax)

1200 N. Thornton, Suite H
Clovis, NM 88101

(NEW!) www.lifeskillsclovis.com
www.matt25clovis.com