Cashman Center
Therapies for Mind & Body

Cashman Center Client Registration and Treatment Contract

Client Information

Client Name: _____ Gender: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Type: Cell/Home/Work Alt Phone: _____ Type: Cell/Home/Work

Email Address: _____ Opt In for Cashman Center Emails: ☐

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Insurance

Insurance Company: _____ Phone: _____

ID# _____ Policy# _____ Group# _____

Co-pay amount per visit Individual therapy: _____ Effective Date: _____

Policy Holder Information

Insured Person: _____

Date of Birth: _____ Relation to Client: _____ Employer: _____

Secondary Insurance

Insurance Company: _____ Phone: _____

ID# _____ Policy# _____ Group# _____

I assign all benefits from insurance or other third-party coverage to the provider of service. I understand that by signing this form, I acknowledge that if my insurance carrier or HMO/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by provider or its independent contractors. A photocopy of this authorization may be honored.

_____

Client Signature Date

Health Data

How did you hear about Cashman Center? _____

If referred, who referred you here? _____

Please briefly describe your presenting problem: _____

_____

Current Physician: _____

Physician's Clinic: _____

Address: _____

Phone Number: _____ **Fax:** _____

Date of most recent physical: _____

Please list your current medications and dosages: _____

_____

_____

Please list any vitamins, herbs, or supplements that you currently use: _____

_____

Please list any allergies or drug sensitivities: _____

_____

Are you currently or have you in the past been diagnosed and/or treated for? (Please check all that apply)

__stroke	__seizures	__migraines	__liver damage	__thyroid problems
__anemia	__chronic fatigue	__diabetes	__chronic pain	__urinary tract infection
__asthma	__hepatitis	__tuberculosis	__eating disorder	__persistent flu-like symptoms
__cancer	__hypertension	__menopause	__perimenopause	__poly-cystic ovarian syndrome
__cardiac problems		__communicable diseases		__mental illness

__Other: _____

Provider Contract/Release of Information

Given our strong commitment to your holistic health, it is important to have a close working relationship with your physician, psychiatrist, and/or other health care providers. Please complete the attached release to enable us to communicate with your other caregivers. If you have more than one provider, we will provide you with additional forms. We will be happy to answer any of your questions or respond to your concerns regarding this matter.

Please choose one of the following options:

1. **___Yes, please communicate information about my care with my primary care physician and other health care providers. I will complete releases of information with my Cashman Center provider.**

   *I understand that I may sign a release of information at any time for a specific provider and Cashman Center will initiate communication with that provider.

   *I understand that Cashman Center is unable to guarantee protection of information by the HIPAA Privacy Rule upon disclosure to third parties authorized by a signed release of information.

2. **___ No, I do not want Cashman Center to communicate with other providers (see disclaimer below).**

   *Please note that by selecting this option, your provider will be unable to provide documentation to support third party requests (e.g. legal provider, disability services, academic services, insurance claims). Should you require documentation but are unwilling to sign a release for the applicable third party, your provider reserves the right to discuss whether continued services at Cashman Center are appropriate.

Signature of Client_____**Date**_____

Signature of Parent/Guardian_____**Date** _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Client Receipt of Information

I have read, understood, and agree to abide by the policies given to me in the Client Registration and Treatment Contract handbook. I understand all center information provided to me within these documents; should I have concerns about any policies, I will discuss with my treatment provider. The information I received includes:

- **Client registration**
- **Crisis Coverage**
- **Notice of Health Information and Privacy Practices**
- **Responsibilities of Cashman Center**
- **Bill of Rights**
- **Client Responsibilities**
- **Cashman Center is an integrative care clinic, which means consultation occurs across providers on the same case to facilitate care. Providers will disclose the minimal necessary information to protect client privacy.**

Client Signature Date

Parent Signature Date

The CAGE and *CAGE-AID* Questions

The original CAGE questions appear in plain type. The CAGE questions "Adapted to Include Drugs" (CAGE-AID) are the original CAGE questions modified by the ***italicized and bold text.***

The CAGE or CAGE-AID should be preceded by these two questions:

1. Do you drink alcohol?
2. Have you ever experimented with drugs?

If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, ask the CAGE questions.

CAGE and *CAGE-AID Questions*

1. In the last three months, have you felt you should cut down or stop drinking ***or using drugs****?*
   Yes No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking **or *using drugs****?*
   Yes No
3. In the last three months, have you felt guilty or bad about how much you drink ***or use drugs***?
   Yes No
4. In the last three months, have you been waking up wanting to have an alcoholic drink **or *use drugs*?**
   Yes No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

Print Client Name and #_____
Date Of Birth _____

PHQ-9	*Over the **last 2 weeks** (or other agreed time period) how often have you been bothered by any of the following problems?*	*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 fidgety 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 in some way	*0*	*1*	*2*	*3*
	PHQ-9 total score =				

GAD-7	*Over the **last 2 weeks** (or other agreed time period) how often have you been bothered by any of the following problems?*	*not at all*	*several days*	*more than 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 is 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*
	GAD-7 total score =				

Print Client Name and #_____
Date Of Birth _____

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page...

In the past 30 days, how much difficulty did you have in:						
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ____

This completes the questionnaire. Thank you.