

REQUEST FOR SERVICES

Date: _____

What brings you to seek mental health services at this time? (Select all that apply)

- Feeling overwhelmed Relationship issues Anxiety or panic attacks
 Depression Grief or loss Trauma Substance use
 Other mental health concerns Other

Other Services

Do you have a diagnosed mental condition? (Select all that apply)

- Anxiety Depression Bipolar
 Psychotic symptoms (e.g., schizophrenia, schizoaffective, psychosis)
 Eating concerns Trauma-related issues (e.g., PTSD) Substance use
 No diagnosed condition Prefer not to say Other (please specify)

Other Diagnosed

What type of mental health services are you looking for? (Select all that apply)

- Therapy Family therapy Psychiatry/Medication management
 Case management Rehab Employment support Peer support
Housing support Other (please specify)

Other

Type _____

Do you have any preference with clinician/provider?

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What days and times are you generally available for appointments? (Select all that apply)

- Weekday mornings Weekday afternoons Weekday evenings
 Weekends (may not be available)

Do you have a preference for the setting of your sessions? (Select all that apply)

- In-person services Virtual services (e.g., video call)
 A mix of in-person and virtual services

What are your goals for treatment? (Select all that apply)

- Improve mental health Manage anxiety or stress Address depression
 Improve relationships Overcome trauma Substance use recovery
 Develop coping strategies Hearing, seeing, believe, feeling things, that others might not
 Child behavioral issues Other (please specify)

Other Goals

Do you have any specific concerns or areas you would like to focus on? (Select all that apply)

- Personal growth Job/Academic concerns Family issues
 Social issues Identity issues (e.g., gender, sexuality)
 Life transitions (e.g., moving, new job) Health concerns
 Basic needs (e.g., housing, food, budgeting, etc.) Other (please specify)

Other Concerns

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We value your preferences and will do our best to accommodate them in your treatment plan. Please understand that while we strive to match your treatment team to your preferences, availability and the appropriateness of certain services may vary. Regardless of the specific options available, we are committed to working with you to identify the best possible approaches to support your mental health journey. Every preference you've indicated will be carefully considered, and we will discuss all available options with you.

Who referred you here today

- 01 Self 02 Significant other 03 School 04 Church/Clergy
- 05 Group Home 06 Employer/Union 08 Non-Psychiatric hospital
- 09 VA system 10 Indian health services 12 Department of Corrections
- 14 Department of Human Services 21 Private psychiatrist/MH prof
- 22 Social Security 23 Attorney/Legal aid 25 Law enforcement
- 30 Shelter for homeless 32 Court 33 Probation 34 Parole
- 35 Department of Public Safety 37 Private physician
- 40 Referral from another CCBHC 41 Referral from private psychiatric hospital
- 48 Office of Juvenile Affairs 49 TANF/Child welfare 51 Self help group
- 52 Parent/Guardian

Military Status

- Customer: Currently Active Customer: National Guard/Reserve
- Customer: Previously Active Family Member: Currently Active
- Family Member: National Guard/Reserve Family Member: Previously Active
- None

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I CONSENT TO RECEIVE TREATMENT AT RED ROCK BEHAVIORAL HEALTH SERVICES (RR). I AUTHORIZE RR TO USE/DISCLOSE MY HEALTH INFORMATION TO OBTAIN PAYMENT FOR THE SERVICES RECEIVED. I UNDERSTAND A BILL MAY BE SENT TO ME AND/OR A THIRD-PARTY PAYOR. I ASSIGN ALL INSURANCE BENEFITS TO WHICH I AM ENTITLED TO RR. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING OR WHEN ALL THIRD-PARTY CLAIMS ARE SATISFIED. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.**

I HAVE READ, OR HAD THIS INFORMATION READ TO ME, AND UNDERSTAND IT.

 X _____ Date: _____

Do you need any special help or equipment to access services?

Yes

No

Please describe special services or equipment

Do you have health insurance?

Yes

No

If Yes, with whom and include your ID Number

Are you HIV Positive?

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Yes No Prefer not to answer

Have you ever had a TB skin test come back positive?

Yes

No

If Yes, when?

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