Mental Health Counseling & Prevention Program Services

Professional counseling services are designed to improve each person's and family's psychological, emotional, and social needs. Our licensed and experienced counselors use a dual-diagnosis approach to assess and treat mental health, substance use, and problem gambling.

Counseling Services

Counselors may help each client address concerns of conduct, identity, trauma, addiction, or other behavioral concerns. They may also assess mental and/or emotional conditions and help ease adjustments to transitions in family life.

Types of Treatment

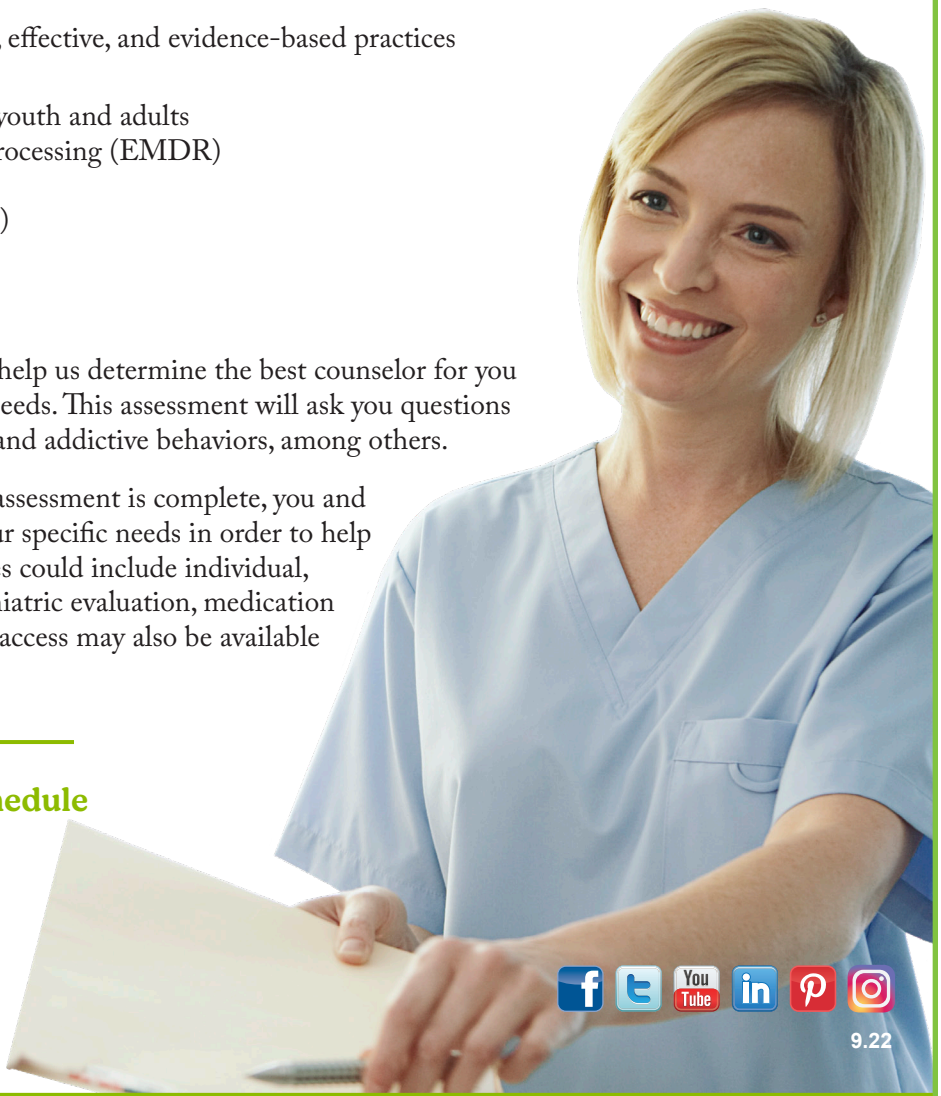
Heartland Family Service incorporates proven, effective, and evidence-based practices in a number of treatments, including:

- Dialectical Behavior Therapy (DBT) for youth and adults
- Eye Movement Desensitization and Reprocessing (EMDR)
- Cognitive Behavioral Therapy (CBT)
- Parent-Child Interaction Therapy (PCIT)
- Child-Parent Psychotherapy (CPP)

How It Works

Each client will fill out an assessment form to help us determine the best counselor for you and the proper treatment that will meet your needs. This assessment will ask you questions about your medical history, history of trauma, and addictive behaviors, among others.

If you decide to enroll in treatment after your assessment is complete, you and your therapist will develop goals to address your specific needs in order to help you achieve your desired outcome. Your services could include individual, family, group, and/or couples counseling. Psychiatric evaluation, medication management, and 24-hour, on-call emergency access may also be available to you.



Walk-in Open Access Evaluation Schedule

Tuesday and Thursday | 8 - 11 a.m.

Heartland Family Service Mental Health Counseling program is part of the Iowa Department of Public Health (IDPH) Integrated Provider Network, with services funded by the IDPH and the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration.

9.22

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info@HeartlandFamilyService.org
HeartlandFamilyService.org

Let's help others overcome challenges.

So everyone can. Heartland Family Service

Heartland Family Service accepts the following insurance:

Aetna
Cigna
Medicare
Midlands Choice
Optum – United Health Care
Tricare
United Healthcare
Wellmark BCBS of Iowa

Iowa Medicaid:

Amerigroup
Iowa Medicaid (IME)
Iowa Total Care

Please be prepared to present your insurance card prior to any services you receive.

Co-pays are due at the time services are rendered.

Sliding fee clients:

Your two most recent pay stubs will be required as well as payment at the time of service.

Full evaluation costs:

The cost of an evaluation in both Iowa and Nebraska is $300. Payment is due at the time of service.

Operating While Intoxicated (OWI) evaluation costs:

The cost of an OWI evaluation is $125.
OWI evaluations are not covered by private insurance.

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So everyone can.

HEARTLAND FAMILY SERVICE

9.22

Mental Health Counseling Program

Confidential Adult Health History

Heartland Family Service has a holistic and integrated philosophy of care. Mental health conditions, addictions, and trauma can be very stressful to the body as well as the mind. We ask for your health history in order to fully assess your needs at the time of the initial evaluation, and to make the best and most comprehensive recommendations for your treatment and services. All information is confidential.

Date:		**Name:**		**D.O.B.:**	

Health History: Please indicate if you have now, or have had in the past, any of these conditions. If you need to add more information about a conditions please use the comment box below

	Current	*Past*		*Current*	*Past*
Head Injury			*High Blood Pressure*		
Blackouts			*Diabetes*		
Migraines			*Asthma*		
Headaches			*Skin Diseases*		
Seizures			*Kidney Problems*		
Lupus			*Liver Problems*		
Fibromyalgia			*Heart Problems*		
Stroke or TIA			*Respiratory Problems*		
Dizziness			*Vision Problems*		
Sleep Difficulties			*Hearing Problems*		
Paralysis			*Back or Neck Pain*		
Stomach or GI problems			*Thyroid Problems*		
Gynecological Problems			*Cancer*		
Sexually Transmitted Disease			*Females: Pregnancy*		
Please list any other medical problems not included above			*Additional Information/Comments:*		

When life improves for one of us, life improves for all of us. We all matter.

Current Medications: Please include prescription and non-prescription medications and check if you are regularly taking these medications

Name of Medication	***Dosage/Frequency***	***Prescribed by***	***Reason Taken***	***Check if taking***
				☐
				☐
				☐
				☐
				☐
				☐

Tuberculosis: Indicate if you have any of the following symptoms at present:

☐ Feeling Weak	☐ Weight Loss	☐ Fever	☐ Night Sweats
☐ Persistent Cough	☐ Chest Pain	☐ Coughing up Blood	☐ Frequently feeling sick
Have you ever had a TB Test? ☐ Yes ☐ No		Results: ☐ Positive ☐ Negative	
Did you have a chest x ray or other tests to confirm or rule out TB? ☐ Yes ☐ No			
Have you lived in the same environment with someone else who had TB or who was at high risk for TB ? ☐ Yes ☐ No			
If your history has placed you at risk for having TB it will be necessary for you to have a TB test, and you will need to provide documentation of the results of the TB test			

HIV/AIDS

Have you ever been tested for HIV? ☐ Yes ☐ No	Results: ☐ Positive ☐ Negative
Have you lived in the same environment with someone else who had HIV or AIDS? ☐ Yes ☐ No	

Hepatitis

Have you ever had a test for hepatitis? ☐ Yes ☐ No	If positive, have you/do you get treatment? ☐ Yes ☐ No
Have you lived in the same environment with someone else who had TB or who was at high risk for hepatitis? ☐ Yes ☐ No	
For therapist use: Was a TB test required? ☐ Yes ☐ No	Was a Health Referral Made? ☐ Yes ☐ No
If a TB Test was recommended please have client sign here:	

Your Current Health Care

Your Primary Care Physician/Name, Address and Phone:	
If you do not have a personal physician do you want a referral? ☐ Yes ☐ No	
Date of last Physical Exam:	Date of last Dental Exam:
Client Signature:	Therapist Signature:

Use this space for any additional information

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 _____

A2663B 10-04-2005

GAIN-Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS 2.0.3

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) ____/____/_____

The following questions are about common psychological, behavioral, and personal problems. These problems are considered <u>significant</u> when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0

IDScr

1. <u>When was the last time</u> that you had <u>significant</u> problems…
   a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? 3 2 1 0
   b. with sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? 3 2 1 0
   c. with feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? 3 2 1 0
   d. with becoming very distressed and upset when something reminded you of the past? 3 2 1 0
   e. with thinking about ending your life or committing suicide? 3 2 1 0

EDScr

2. <u>When was the last time</u> that you did the following things <u>two or more times</u>?
   a. Lied or conned to get things you wanted or to avoid having to do something? 3 2 1 0
   b. Had a hard time paying attention at school, work, or home? 3 2 1 0
   c. Had a hard time listening to instructions at school, work, or home? 3 2 1 0
   d. Were a bully or threatened other people? 3 2 1 0
   e. Started physical fights with other people? 3 2 1 0

SDScr

3. <u>When was the last time</u> that…
   a. you used alcohol or other drugs weekly or more often? 3 2 1 0
   b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs? 3 2 1 0
   c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? 3 2 1 0
   d. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events? 3 2 1 0
   e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? 3 2 1 0

(Continued) After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0

CVScr 4. When was the last time that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	3	2	1	0
b. took something from a store without paying for it?	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	3	2	1	0

5. Do you have other significant psychological, behavioral, or personal problems that you want treatment for or help with? (If yes, please describe below) ..... Yes 1 No 0

v1. _____

v2. _____

v3. _____

6. What is your gender? (If other, please describe below) ……1-Male 2-Female 99-Other

v1. _____

7. How old are you today? |__|__| years

For Staff Use Only

8. Site ID: _____ Site Name v. _____
9. Staff ID: _____ Staff Name v. _____
10. Client ID: _____ Comment v. _____
11. Mode: 1) Administered by staff 2) Administered by other 3) Self-administered
12. Number of 2s and 3s: IDSscr: ____ EDScr: ____ SDScr: ____ CVScr: ____ TDScr: ____
13. Referral: MH____ SA ____ ANG ____ Other ____ 14. Referral Code: _____
15. Referral comments:

v1. _____

v2. _____

v3.