l. pattison counseling

Confidential Client Information

General Information

Date:_____ Referred By:_____

Full Name_____

Name You Prefer:_____ Age:_____ Date of Birth:_____

Race: ___Caucasian ___ Black ___ Hispanic ___ Asian ___ Other:_____ Sex:_____

Contact Information

Street Address:_____ Suite/Apt #:_____

City:_____ State:_____ Zip Code:_____ May We Send Mail Here:_____

Home Phone: (_____)_____ May We Leave a Message Here:_____

Cell Phone: (_____)_____ May We Leave a Message Here:_____

Work Phone: (_____)_____ May We Leave a Message Here:_____

Email Address:_____ May We Send Email Here:_____

Emergency Contact

Name:_____ Relationship:_____

Home Phone:(_____)_____ Cell Phone:(_____)_____

Employment Information

Employer:_____ Length of Employment:_____

Occupation:_____ Average Hours Worked per Week:_____

Average Salary: ___ $0-10,000 ___ $20,001-$40,000 ___ $50,001-$60,000 ___ $80,001-$100,000
___ $10,001-$20,000 ___ $40,001-50,000 ___ 60,001-$80,000 ___ $100,000+

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(407) 501-6102

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Education Information

Last Year of School Completed: ___ 9th ___10th ___11h ___12th ___GED College: ___1 ___2 ___3 ___4

Are You Currently in School: ___ Yes ___No If Yes, What Level:_____ Degree Pursuing:_____

Relational Information

Current Relational Status: ___ Single ___ Dating ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widowed

Are you Content with Your Current Status: ___ Yes ___ No If No, Explain_____

_____

If Married, How Long:_____ Number of Previous Marriages:_____ For Your Partner:_____

If Separated or Divorced, How Long:_____ If Widowed, How Long:_____

Partner's Name:_____ Age:_____ Preferred Name:_____

Partner's Race:_____ Partner's Sex:_____

Partner's Occupation:_____ Average Hours Worked per Week:_____

What Words Would You Use to Describe Your Partner:_____

Is Your Partner Supportive of You Seeking Counseling: ___ Yes ___ No ___ Unsure ___ Partner Doesn't Know

With Whom Do you Currently Live *(Check All That Apply):* ___ Alone ___ Spouse ___ Children ___ Parent

___ Sibling ___ Boyfriend ___ Girlfriend ___ Roommate ___Other:_____

Presenting Problem

Briefly describe why you are wanting to attend counseling _____

_____

_____

_____

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Children

Name	Sex	Current Age Or Year of Death	Relationship To You (Natural, Adopted, Step)	Living with You?	Describe Him/Her

Have You Ever Been Adopted: ___ Yes ___ No If Yes, When:_____

Have You Ever Had a Miscarriage or Medical Abortion: ___ Yes ___ No

Family of Origin

List Mother, Father, Brother, Sister, Step Family or Any other Member who Affect you Negatively

Name	Sex	Current Age	Relationship	Describe Him/Her

Medical Information

Primary Physician: _____Phone: (_____)_____

Address:_____ City:_____ Zip:_____

Are You Currently Receiving Medical Treatment: ___ Yes ___ No

List Any Conditions, Illness, Surgeries, Hospitalizations, Trauma or Related Trauma:_____

_____

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Medications

List All Current Medications You Are Taking, Including those You Seldom Use or Take as Needed

Medication:_____ Dosage:_____ ___Improves ___ Prevents ___ Controls:_____

Medication:_____ Dosage:_____ ___Improves ___ Prevents ___ Controls:_____

Medication:_____ Dosage:_____ ___Improves ___ Prevents ___ Controls:_____

Medication:_____ Dosage:_____ ___Improves ___ Prevents ___ Controls:_____

Are You Taking these Medications According to Your Doctor's Recommendation: ___ Yes ___No

If No, Explain:_____

Physiological Symptoms

Please Check All That Apply

Condition	Past	Present	**Condition**	Past	Present	**Condition**	Past	Present
Headaches			Dizziness			Stomach Trouble		
Visual Trouble			Sleep Trouble			Trouble Relaxing		
Weakness			Tension			Rapid Heart Rate		
Difficulty Breathing			Intestinal Trouble			Hearing Noises		
Change in Appetite			Tiredness			Pain		
Hearing Voices			Seeing Things			Other:_____		

Your Height:_____ Your Weight:_____ How has your Weight Changed:_____

Current Status

Please Check All That Apply

Condition	Past	Present	**Condition**	Past	Present	**Condition**	Past	Present
Stress			Nervousness			Anxiety		
Panic			UnHappiness			Depression		
Guilt			Apathy			Terminal Illness		
Recent Death			Greif			Hopelessness		
Inferiority Feelings			Defective Feelings			Loneliness		

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Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
Shyness			Fears			Friends		
Marriage			Communication			Physical Abuse		
Emotional Abuse			Verbal Abuse			Sexual Abuse		
Temper			Anger			Aggressiveness		
Bad Dreams			Concentration			Racing Thoughts		
Unwanted Thoughts			Memory			Loss of Control		
Impulsive Behavior			Self-Control			Compulsivity		
Sexual Problem			Pregnancy			Abortion		
Legal Matters			Trauma			Eating Problems		
Drug Use			Alcohol Use			Trouble with Job		
Career Choices			Ambition			Making Decisions		
Children			Being a Parent			Finances		
Recent Loss			Natural Disaster			Other:_____		

Level of Distress:

Indicate How Distressed You Are By Placing an "X" on the Scale Below *(1=very little distress; 10= Extreme Distress)*

_____

1 2 3 4 5 6 7 8 9 10

Are you Currently Experiencing Any Suicidal Thoughts: ___ Yes ___ No

Have You Experienced Them In the Past: ___ Yes _No

Have you Ever Attempted Suicide: ___ Yes _No If Yes, When & How:_____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: ___ Yes ___No

If Yes, When and Who:_____

Previous Mental Care

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received

Therapist:_____ Location:_____ Dates:_____ Reason:_____

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Religious Background

Are you currently attending church or a spiritual place? If, Yes, Where and How Often?

_____

What Words You Use to Describe Yourself:_____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up:_____

_____

Complete the Following Thought: God is _____

What is the Name of Your Pastor or Spiritual Leader: _____

Do you have a Personal Support System: ___ Yes ___ No If Yes, Who _____

Sleep Habits

Bed Time: _____Nap:_____ Difficulties Sleeping: ___ Yes ___ No

Sleeping Arrangement: ___ Sleeps in Bed _____ Sleeps in Crib _____ Sleeps with Bed Rails

___ Sleep in Hospital Bed ___ Other:_____

Routine Schedule of Activities:_____

Preferred Hobbies:_____

Food/Activities Needed to Avoid:_____

Fears/Phobias (Dogs, Loud Noises, Dark, Etc.) _____

Signed:_____ Date:_____

Print:_____

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Emergency Contact List

Date:_____

Client's Name:_____

Date Initial Services:_____

Name	Relationship	Home	Cell

Client Signature or Legal Guardian/Parent:

_____

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Informed Consent & Release of Liability Registered Associate

L.Pattison Counseling provides counseling to the local community. The counselor you are working with is working towards a Marriage and Family Therapist license, and has been approved to counsel by the State of Texas as a Marriage and Family Registered Associate.

The completion of an intake questionnaire, informed consent and a release of liability are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent.

In order to initiate counseling, please read the following agreement; your signature attests that you and the counselor understand and agree to the terms contained herein:

- I, _____ understand that my counselor is a registered associate working under the supervision of a qualified supervisor, as specified by Texas Law.

I will allow my counselor to review my counseling sessions with his/her supervisor for continuing internship education. I understand that all my information pertaining to these sessions is considered confidential.

- I understand that my counseling records are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession.

  Such As:
  1. If you report any child, elderly or disabled abuse or neglect.
  2. If you report planning to hurt yourself or someone else with malicious intent.
  3. If you or the counselor are subpoenaed by the court for any legal matters.

- In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release and forever discharge and covenant not to sue or hold legally liable the associate, supervisor or staff at L. Pattison Counseling from any and all claims, demands, damages, actions or causes whatsoever related to the counseling process.

- I also understand that my counselor is under the supervision of _____. If you have any concerns please contact her at, _____.

I have read and understand the preceding information and agree to the policies as stated. I understand that this agreement is a prerequisite to my receiving counseling through L. Pattison Counseling.

Signature:_____ Date:_____

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HIPPA POLICIES & PROCEDURES

NOTICE OF HEALTHCARE PRIVACY PRACTICES AT PASSPORT HEALTH, LLC
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We Have A Legal Duty To Safeguard Your Protected Health Information (PHI)
We are legally required to protect the privacy of health information that may reveal your identity. This information is commonly referred to as "protected health information," or "PHI" for short. It includes information that can be used to identify you that we have created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when and why we use and disclose your PHI.

With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice. You can also request a copy of this notice at any time from the contact person listed in Section VI below, by calling our office.

How We May Use And Disclose Your Protected Health Information
We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below we describe the different categories of our uses and disclosures and give you some examples of each category.

During your intake, prior to receiving any health care services, you will be asked to sign a statement permitting PASSPORT HEALTH and its medical staff to release your health information for purposes of Treatment, Payment and Health Care Operations. A description of each of these uses is described as follows.

Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.
We may use and disclose your PHI for the following reasons:

For treatment. We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care.

To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims or provide services on our behalf, or provide services directly to you.

For health care operations. We may disclose your PHI in order to operate our health care delivery system. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants and other in order to make sure we're complying with the laws that affect us.

To the extent we are required to disclose your PHI to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying our out business operations, we will have a written contract to ensure that our business associate also protects the privacy of your PHI.

Other Uses And Disclosures That Do Not Require Your Consent.
We may use and disclose your PHI without your consent or authorization for the following reasons:

When a disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.

For public health activities. For example, we report information about births, deaths and various diseases to governmental official in charge of collecting that information.

Victims of Abuse, Neglect or Domestic Violence. We may release your PHI to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will may every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

Emergency Situations. We may use or disclose your PHI if you need emergency treatment, but we are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

Communication Barriers. We may use or disclose your PHI if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

Product Monitoring, Repair and Recall. We may disclose your information to a person or company that is required by the Food and Drug Administration to: (1) report or track product defects or problems; (2) repair, replace or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes. We may disclose your PHI if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

Law Enforcement. We may disclose your PHI to law enforcement officials for any of the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your consent because of any emergency or your incapacity; (2) law enforcement officials need the information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect a patient's death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

Military and Veterans. If you are in the Armed Forces, we may disclose your PHI to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates and Correctional Institutions. If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

For research purposes. In most cases, we will ask for your written authorization before using your PHI for research purposes. However, in certain, limited, circumstances, we may use and disclose your PHI without consent or authorization if we obtain approval through a special process to ensure that such research poses little risk to your privacy. In any case, we would never allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing for a future research project, so long as no personally identifiable information leaves our facility.

To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.

Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits we offer and/or provide.

De-identified Information. We may also disclose your PHI if it has been de-identified or unable for anyone to connect back to you. This might occur if you are participating in a research project.

Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your PHI, certain disclosures of your PHI may occur during, or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your PHI.

Uses and Disclosures Require Your Prior Written Authorization.
In any situation, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any actions relying on the authorization).

What Rights You Have Regarding Your PHI

You have the following rights with respect to your PHI:

The Right to Request Limits on Uses and Disclosures of Your PHI.
You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

The Right to Choose How We Send PHI to You.
You have the right to ask that we send information to you to an alternate address or by alternate means. We must agree to your request so long as we can easily provide it to the location and in the format you request.

The Right to See and Get Copies of Your PHI.
In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 10 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we may charge you a fee for each page. We will respond to your request within 30 days after receiving your written request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the associated cost in advance.

The Right to Get a List of the Disclosures We Have Made.

You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already been informed of, such as those made for treatment, payment or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel.

Your request must state a time period for the disclosures you want us to include. We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years (with the oldest date being September 1, 2009) unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same calendar year, we will charge you for each additional request.

The Right to Correct or Update Your PHI.
If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (I) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of you PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it and tell others that need to know about the change to your PHI.

The Right to Get This Notice by E-Mail.
You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

How To Complain About Our Privacy Practices
If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section V below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at:

US Department of HHS Government Center
John F. Kennedy Federal Building- Room 1875
Boston, Massachusetts 02203

Telephone number: 617-565-1340
Fax number: 617-565-3809
TDD: 617-565-1343

We will take no retaliatory action against you if you file a complaint about our privacy practices.

Person To Contact For Information About This Notice Or To Complain About Our Privacy Practices

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact us:

E-mail: privacy@passporthealthusa.com

Mailing Address:
PASSPORT HEALTH, LLC
8324 E Hartford Drive #200, Scottsdale, AZ 85255

Effective Date Of This Notice
This notice is effective as of May 31, 20

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **L. Pattison Counseling** on _____(date).

A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____

Please print your name

_____

Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority

_____.

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Acknowledgement of Office Policies

I hereby acknowledge that the policies of L. Pattison Counseling are the following:

- I will arrive 5-10 minutes before my scheduled appointment
- If I arrive more than 15 minutes late for my scheduled time, I understand that my counselor will cancel my schedule session without changing my payment.
- If I do not cancel my appointment within 24 hours before my scheduled appointment, I understand there will be a $50 cancellation fee that will be due at my next session, on top of my normal session cost.

I hereby acknowledge that the emergency policies of L. Pattison Counseling are the following:

- If I fear for my life or someone else's CALL 911 IMMEDIATELY, then call your counselor at (407) 756-6618.

(This is a personal line, I agree to use it for emergencies only) _____ Initial

- If I am having suicidal thoughts or have a plan of action, CALL:
    - Crisis Hotline **800-784-2433**
    - Teen Hotline **(512) 472-4357**

Print Name: _____

Signature: _____ Date:_____

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Consent for Treatment

I, _____, hereby voluntarily request to receive clinical services from L. Pattison Counseling. I understand that these services may be in the form of:
(Please initial beside each modality to confirm consent for each)

_____ Individual Therapy

_____ Family Therapy

_____ Group Therapy

_____ Couples Therapy

_____ Mental Health Assessments

I also understand that all clinical information will be kept confidential, except as stipulated in HEALTH AND SAFETY CODE, Chapter 181 and the Health Insurance Portability and Privicay Act (HIPPA). The clinical record is the property of, and will be retained by L. Pattison Counseling. Authorized personnel may review clinical records for the purpose of supervision, consultation, auditing and compliance. Portions of my information may be used for billing and payment purposes. My records will be kept for a period of seven (7) years once a client is discharged from services.

I acknowledge I have been given the opportunity to ask questions and I understand my rights and responsibilities. I have been informed by L. Pattison Counseling of the services available through our practice and agree to participate.

I may revoke my consent, verbally or in writing, for any or all services at any time.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

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Client Rights and Responsibilities

All children/adults admitted into L. Pattison Counseling services, are protected by specific rights and have certain responsibilities. These rights and responsibilities provide the structure for the overall individualized treatment plan.

Clients Have The Right:

- To be treated with courtesy, dignity and respect without regard to age, race, gender, religion, disability or orientation.
- To understand the availability and range of the services they need and will be utilizing
- To have communication with all family members as clinically indicated in accordance with dependency case court order(s) and when consistent with the treatment.
- To have their opinions and recommendations considered in the development and evaluation of the therapeutic services they receive.
- To be safe and free from any form of corporal punishment
- To request the services of an attorney through their parent/guardian
- To have the rights to confidentiality, privacy, and appropriate supervision respected within the limits of the law.
- To be the recipient of the highest quality of service delivered in an efficient and ethical manner.
- To file a grievance and to be given a copy of the agency Client Grievance Procedure upon request.

Clients Have the Responsibility:

- To comply with all reasonable rules, policies and requests related to the treatment plan.
- To respect the rights of privacy and confidentiality of others.
- To refrain from any activity that many threaten or endanger organization members and understand that engaging in such behaviors will be cause for reevaluation of appropriateness in treatment services with L. Pattison Counseling.

I hereby agree that I understand my rights and responsibilities.

_____ _____

Client Signature Date

L. Pattison Counseling
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Confidential Communication

Request to Receive Confidential Communications at an Alternative Location Federal law says that you have the right to request that L. Pattison Counseling communicate with you at a different location or by a different means if you believe that you would be endangered if your health information were sent to your current address.

If you need Confidential Communication please fill out the form below. If you do not, please sign to acknowledge that you have read and agreed that you do not need confidential communication.

I, _____, deny any need for Confidential Communication.

_____ *Signature/Date*

I request that L. Pattison Counseling send my health information to the following different address or by the following means. In care of:

_____

Street Address _____ City _____

State _____ Zip _____ Phone Number _____

Disclosure of all or part of this information to my present address or through present means ____will endanger me _____ will not endanger me.

Signature _____ Date_____ OR

Signature of Authorized Representative _____

Date _____

Relationship of Authorized Representative _____
(Attach documentation that you are a personal representative, for example: authorization form, durable power of attorney, court order, guardianship papers)

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Depression Assessment
Alcohol Assessment

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

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1. How often do you have a drink containing alcohol?
(0) Never (Skip to Questions 9-10) (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) 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? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year

Total Number of Points:_____

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Suicide Assessment

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** • Over a year ago? • Between three months and a year ago? • Within the last three months?		

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Anxiety Assessment

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.

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Trauma Assessment

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 someone close to you, (d) you're *not sure* if it fits, or (e) 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	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, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995

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