WILMINGTON
MENTAL HEALTH

To Our Valued Patients,

Welcome to Wilmington Mental Health (WMH) and thank you for allowing us to work with you. We understand choosing to pursue therapy now can be intimidating and a big step in your life – in fact, it is possible that you are experiencing anxiety and hesitation. Hence, our mission is to provide support, privacy, and a safe environment where conversation and exploration can take place.

Before we start, we ask that you complete all the forms in the intake packet and read the instructions below:

- Carefully read the *Consent and Service Agreement*. When you are ready, *please initial, sign, and* confirm that you fully understand and accept the terms and conditions of your treatment.
- Fill out the *Patient Registration* form to the best of your abilities. If you are the parent/legal guardian or authorized representative of the person seeking treatment, you must provide information as it pertains to your child.
- We will ask you to provide some type of identification (i.e., Driver License or Passport) to verify your identify and for the accuracy of our recordkeeping. A copy will be stored in your records.
- A copy of our *Notice of Privacy Practices* will be included in your welcome folder. Please confirm that you received the notice.
- Print your name and initials, and sign and date each document.

Treatment often follows this order: *Exploration*, *Process*, *Maintenance*, and *Termination*. Following registration, you and your therapist will work togetehr in completing a thorough assessment that provides an analysis and interpretation of your presenting problem, including diagnostic criteria, case formulation and treatment recommendations. Next, your therapist will help you identify your goals and develop a treatment plan that best suits you. This plan will be used to guide your treatment and evaluate your progress.

We will be happy to answer any questions or discuss any concerns you might have regarding your treatment. Your feedback is very important to us and a vital part of your ongoing treatment success.

"Perseverence is a quality and virtue we all possess
but struggle to make it relevant when fighting our fears and demons"
– Joseph Rengifo –

Joseph Rengifo
MA, LCMHC, LCAS
Psychotherapist

Havah Henzler
MSW, LCSW, LCAS
Licensed Therapist

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MS, LCMHC, LCAS
Licensed Therapist

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CONSENT AND SERVICE AGREEMENT

It is important to understand the services you will receive and the terms and conditions of these services. Please review this form carefully and feel free to ask any question or share any concerns you might have.

You have the right:

- ◊ To become educated about the nature of any symptom, condition, illness, or disorder affecting you.
- ◊ To be treated with dignity, respect, human care, and without mental, emotional, sexual or physical abuse, neglect. Treatment is a goal-directed and systematic process that progresses as you and your counselor build a therapeutic alliance.
- ◊ To be free from discrimination based on race, religion, gender, or any other unlawful category before, or during treatment.
- ◊ To be free from exploitation for the benefit or advantage of a therapist.
- ◊ To receive treatment that is culturally sensitive to you, including social, psychological, physical, and spiritual aspects of your life.
- ◊ To be informed of the cost of your treatment before receiving services.
- ◊ To have any therapy procedure or method explained to you before it is used.
- ◊ To refuse any test, evaluation, or therapy of any kind - if ordered by court, you may face legal consequences.
- ◊ To refuse to be photographed, audio-taped or video-taped, unless you give consent to these requests.
- ◊ To privacy and confidentiality as defined by rule and law. All information you disclose during session is strictly confidential and private and will not be revealed to anyone outside without your (or an authorized representative's) written permission or consent.
  - o Exceptions to this rule include disclosures required or permitted by law, typically involving substantial risk of physical harm to oneself or to others, suspicion of child abuse or neglect, or when a subpoena by a government agency is issued to compel testimony or produce evidence.
- ◊ To expect treatment from a therapist who has met the minimal qualifications of training and experience required and examine public records about his or her credentials.
- ◊ To receive information on potential risks and possible benefits of mental health and/or substance abuse treatment. Your counselor cannot promise specific results from your therapy treatment, but commitment to your treatment and compliance with treatment recommendation can increase the chance of experiencing positive results during therapy.
  - o Benefits: Significant reduction of adverse or negative symptoms, improved interpersonal satisfaction, greater personal awareness, and insight, as well as enhanced coping and resolution skills, among others.
  - o Risks: During therapy, you may also be asked difficult questions and to recall unpleasant memories, which can bring discomfort to you. Some individuals have even reported feeling worse after receiving therapy. It is important that you talk to your counselor if you experience any symptom or adverse reaction during your treatment.
- ◊ To timely access information pertaining to you, including your clinical records.
- ◊ To refuse follow up calls after your treatment ends or your involvement with the agency is discontinued.
  - o Wilmington Mental Health may conduct follow-up calls three to six months after your discharge to discuss whether the gains made during your treatment have been maintained. Staff might also call you for feedback regarding your experience. If you prefer not to be contacted, simply tell your counselor and your decision will be respected
- ◊ To obtain a copy of the Code of Ethics or Social Worker Certification and Licensure Act.
  - o Board of Licensed Professional Counselors: PO Box 77819, Greensboro, NC 27417, or
  - o North Carolina Social Work Certification and Licensure Board: P.O. Box 1043 Asheboro, NC 27204.
- ◊ The right to an investigation of a complaint.
- ◊ To report complaints, call the North Carolina Board of Licensed Professional Counselors at 844-622-3572 or 336-217-6007 or North Carolina Social Work Certification and Licensure Board at 336-625-1679.

Urinalysis Testing - Urine specimen collections may be collected during your treatment and sent to the lab for testing. The results will be used as information of drug use and to (1) better determine your treatment plan, (2) monitor progress and adherence to treatment, (3) identify needs for further assessment and substance abuse treatment, (4) and better coordinate your care. Collection usually occurs during your initial visit and serves as baseline data. How often samples are collected depends on my decision as your counselor and can vary from patient to patient.

Initials ☐ I certify that I have read, understand, and accept this Consent and Service Agreement. I agree to abide by the rules and regulations of treatment included in this Consent and Service Agreement. This form must be signed by the patient (rather than another person) unless he/she lacks physical or mental capacity to make decisions or sign.

X _____ Name of Patient or Representative

X _____ Signature of Patient or Representative

___/ ___/ ____ Date

NOTICE OF PRIVACY PRACTICE OF WILMINGTON MENTAL HEALTH

Wilmington Mental Health must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of Wilmington Mental Health to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care and for other services relating to your health care.

The purpose of this Notice of Privacy Practices is to inform you about how your health information may be used within Wilmington Mental Health, as well as reasons why your health information could be sent to other service providers outside of this agency.

This Notice describes your rights in regard to the protection of your health information and how you may exercise those rights. This Notice also gives you the names of contacts should you have questions or comments about the policies and procedures Wilmington Mental Health uses to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Patient Acknowledgment

- I have received Wilmington Mental Health's *Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.
- I understand that my health information will be used to conduct, plan and direct my treatment; follow-up with other healthcare providers directly involved in my treatment; obtain payment from third-party payers; and/or conduct healthcare operations such as quality assessments and authorizations.
- I understand that this *Notice* is subject to change and that the most recent version can be found at www.wmhwc.com or the office waiting room.
- I understand that I may obtain a copy of the new Notice by contacting 910-777-5575 or by writing a letter to the Privacy Official at:

  Wilmington Mental Health, PLLC
  3825 Market Street, Ste 4
  Wilmington, NC 28403

X _____ ***X*** _____ ____/____/_____

Name of Patient or Representative | Signature of Patient or Representative | Date

Note: *Patient* received a copy of the Notice of Privacy Practices. *Wilmington Mental Health retains this signed page.*

FOR OFFICE USE ONLY

Wilmington Mental Health attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining acknowledgement.
- ☐ An emergency presented and patient could not provide a signature.
- ☐ Other (Specify)_____

PATIENT INFORMATION

Today's Date: ____/____/_____

Please take a moment to fill in the following information. Leave blank any question you would rather not answer. If anything changes during your treatment, please let us know.

Type of Service: □Individual □Couple □Group □Family □Assessment □Screening □Substance Abuse □EAP

PERSONAL INFORMATION: DOB: ____/____/_____ SSN: _____ - ____ - _____

Gender: □ Female □ Male □ Unknown ▪ Gender Expression: _____ Weight: ____ lbs. Height: __'___ ft

Last Name: _____ First Name: _____ Middle ____

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

Contact Number: _____ - _____ - _____ □ Cell □ Home □ Work ▪ May we leave a message? □ Yes □ No

Email: _____

RESPONSIBLE PARTY INFORMATION: Relationship to patient: □ Parents/Guardians □ Other: _____

Last Name: _____ First Name: _____ Middle ____

DOB: ____/____/_____ SSN: _____ - ____ - _____ Contact Number: _____ - _____ - _____ □ Cell □ Home □ Work

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

MARITAL STATUS
- □ Single
- □ Engaged
- □ Cohabiting
- □ Civil Union
- □ Married
- □ Separated
- □ Divorced
- □ Widowed

RACE/ETHNICITY
- □ American Indian
- □ Asian
- □ African American
- □ Pacific Islander
- □ White / Not Hispanic
- □ Hispanic or Latino
- □ Mixed
- □ Other: _____

EDUCATION

Highest grade/year completed:
- □ Less than High School
- □ High School or GED
- □ Diploma/Specialization
- □ Some college
- □ College degree
- □ Postgraduate degree
- □ Intend to resume education

LIVING SITUATION
- □ Homeless/staying at shelter
- □ Independent/alone
- □ Living with friend(s)
- □ Living with roommate
- □ Living with partner/spouse
- □ Living with child(ren)
- □ Living with parents
- □ Living in a recovery house

LEARNING PROBLEM: □ None □ Speech □ Hearing □ Reading □ Writing □ Concentration □ Attention

EMPLOYMENT:
- □ Unemployed
- □ Seeking employment
- □ Per Diem or Seasonal
- □ Volunteering
- □ Employed Part Time
- □ Employed Full Time
- □ Part time student
- □ Full time student

Current Employer/School: _____ Title/Program: _____

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

WORKPLACE ISSUES: □ None □ Transfer, Layoff □ Harassment □ Discrimination □ Unfair Treatment

FAMILY/SIGNIFICANT OTHERS: Please list all members of your household

Name	Relationship to You	Age	Where does he/she live?	Mental/Medical Conditions

SOCIAL SUPPORT SYSTEM: People who currently play a supportive role in your life

_____

PRESENTING PROBLEM OR HISTORY: Reason(s) you are seeking treatment today.

_____

_____

_____

COPING STRATEGIES: What have you tried so far?

_____

_____

SELF-CARE ACTIVITIES: □Physical □Emotional □Spiritual □Mental □Practical □Social □Personal Safety

MENTAL HEALTH HISTORY:

Type of Treatment	When?	Length of Stay	Reason

Are you, or another family member, currently seeing another therapist/counselor/psychologist? □ No □ Yes. If yes, please provider the therapist's name or treatment agency: _____

What is most important to you? □Family □Friends □Work □Education □Community □Fun □Spirituality □Health

STRESSORS: □ Domestic Violence □ Eating Disorder □ Sleep Disturbance □ Stressful Life □ Abuse/Trauma

EMERGENCY CONTACT: Who should we call?

Name: _____ Contact #: _____ - _____ - _____ Relationship: _____

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

MEDICAL INFORMATION:

Current PCP: _____ Contact #: _____ - _____ - _____ Last Visit On: ___/___/_____

Medical Conditions (if any): _____

Current Health Status: □ Excellent □ Very Good □ Good □ Average □ Poor □ Do Not Know

Current medication	**Dose**	**Frequency**	**What is it for?**	**Prescriber**

Are you allergic to any medication? □ No □ Yes. If yes, please specify: _____

INSURANCE INFORMATION: We will make a copy of your insurance card to have on file.

Primary Insurance

Policyholder Name: _____ DOB: ____/____/_____ Relationship: _____

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

Provider Phone Number: _____ - _____ - _____ Insured's Employer: _____

Insurance Name: _____ Policy #: _____ Group #: _____

Secondary Insurance

Policyholder Name: _____ DOB: ____/____/_____ Relationship: _____

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

Provider Phone Number: _____ - _____ - _____ Insured's Employer: _____

Insurance Name: _____ Policy #: _____ Group #: _____

Is there anything else you have not mentioned that your therapist must know now, such as your spiritual beliefs or any other factor relevant to your treatment? □ No □ Yes. Please explain: _____

_____

REFERRAL SOURCE:

□ Web Search □ Patient □ Family Member □ Friend □ Physician □ Insurance Company □ EAP □ Advertisement

PREFERENCES: □ Morning appointment □ Afternoon appointment □ Evening appointment □ Female therapist □ Group therapy □ Faith-based therapy □ Trauma-focused therapy □ Biofeedback □ Other: _____

PROVIDER: Please indicate the therapist you would like to work with.

□Sarah Mooring □Havah Henzler □Lisa Blackmon □Melisa Kemlage □Sara Scott Ford □Christine Schneider □Joseph Rengifo

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name		Date of Birth:	
Street Address		SSN (Last 4 #):	
City, State, Zip:		Telephone #:	
Email Address:			

I hereby voluntarily authorize the use and disclosure of protected health information (PHI) from my mental health record.

Facility Authorized to Release Information:	Facility or Individual(s) Authorized to Receive Information:
Wilmington Mental Health, PLLC (WMH) 3825 Market St, Ste 4 Wilmington, NC 28403 Telephone: 910-777-5575 / Fax: 910-777-5273	Name: Street Address: City/State/Zip: Telephone: / Fax:

PURPOSE OF RELEASE (check reason):

☐ Continuity of care ☐ Personal use ☐ Disability ☐ Insurance ☐ Legal Purpose ☐ School
☐ At request of Employer ☐ Other: _____

This consent will expire automatically one year from the date on which it is signed unless a date for treatment records to be released is specified next: From (date) _____/_____/_____ To (date) _____/_____/_____

Health Information that may be used / disclosed is limited to the following: [check appropriate box(es)]

☐ ____ Initials - Identifying Information ☐ ____ Initials - Clinical Assessments** ☐ ____ Initials - Attendance Records
☐ ____ Initials - Treatment Plan ☐ ____ Initials - Progress Report ☐ ____ Initials - Discharge Summary
☐ ____ Initials - Entire Record* ☐ ____ Initials – Other: _____

* Mental Health Records do not include psychotherapy notes. ** Comprehensive Clinical Assessments include background history, legal history, previous diagnostic test results, medication list, allergies, operative notes, consults, and psychiatric/behavioral diagnosis.

Sensitive Information:

☐ Substance Abuse Evaluation ☐ Drug/Alcohol Test Results ☐ Psychiatric/Behavioral Diagnoses and Assessment

PATIENT'S RIGHTS: I understand that:

- This request/authorization to release records and information has been explained to me and I fully understand it, including the nature of the records, their contents, and consequences and implications of their release. The release of information is limited to the minimum necessary to accomplish the purpose for which the request is made. This authorization is being completed freely, voluntarily and without coercion.
- I have the right to revoke this authorization at any time unless Wilmington Mental Health has acted in reliance upon it. Such revocation must be in writing and received by Wilmington Mental Health to be effective. Refusing to sign this form will not prevent my ability to get treatment, payment, or eligibility of care.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. WMH will not share or use my health information without my permission other than by ways listed in WMH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at wilmingtonmentalhealth.com. A fee may be charged for providing the protected health information.
- I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including sensitive information as indicated above.

EXPIRATION OF AUTHORIZATION - If this authorization has not been revoked, it will terminate one year from the date of my signature unless another date or event is written here: _____

X _____ ____/____/_____ **OR** ***X*** _____ ____/____/_____
Patient Signature Date Legal Representative*** Date

***** If patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form - written proof may be required.**

NOTICE - This information is to be treated in accordance with (HIPAA) privacy regulations.

This information has been disclosed to you from records the confidentiality of which may protected by federal and/or state law (45 CFR Part 164 and 164; 42 CFR Part 2). You are prohibited from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by G.S. 122C-53 through G.S. 122C-56. A general authorization for the release of other medical information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. The circumstances under which disclosure is permitted or required by state or federal confidentiality rules are described in our Notice of Privacy Practices.

☐ ID Verified ☐ Signature matches DL ☐ Electronic copy requested · Legal representative is: ☐ Guardian ☐ Parent ☐ Adult Child ☐ Spouse

FINANCIAL AGREEMENT

SELF-PAY – Payment is expected to pay at the time of service. Intake assessments are charged at a rate of $200.00. The standard rate is $110 per session (53-60 min). Rates may differ depending on the therapy format. There is a charge for telephone consultations that exceed 15 minutes. Rates and fees will be discussed before treatment starts.

NETWORK PARTICIPATION – If we participate with your insurance plan, we will verify your network benefits and submit claims after each service is rendered; your insurance carrier will pay us accordingly. Payment, however, is your responsibility regardless of insurance coverage and you will be expected to pay any balances on your account if a claim is returned as not paid. Note: If your plan requires an authorization, please obtain it directly from your insurance company prior to starting treatment.

THIRD-PARTY VENDORS – If you are receiving treatment through a third-party vendor Wilmington Mental Health has an agreement with, you must know that any "promise to pay" not satisfied by the vendor is ultimately your responsibility. We will ask you to pay the total balance accrued during your treatment and you will be responsible to collect any reimbursement directly from the vendor.

CREDIT CARD AUTHORIZATION – Please complete this form in its entirety. All patients 18-year-old and older are required to provide a picture ID (school ID, military ID, etc.) for verification to and to prevent insurance fraud.

Name on Card: _____

Address: _____

Billing Zip Code: _____ **Type:** ___ Visa ___ MasterCard ___ American Express ___ Discover

Credit Card #: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ CCV (3-4 digit code) : _____

We accept: 

There is a fee of $35.00 for returned checks. Any standing balance must be paid before treatment is resumed. Refunds cannot be processed once service is provided.

Please keep us informed of any changes in your credit card information or you will be in default under this agreement. Also notify us of any changes in your insurance policy, address, and telephone number.

ATTESTATION: My signature below indicates that I understand that in the event of default, I agree to pay all charges associated with my treatment, including copayments and annual deductibles.

1. I confirm that all information provided on this form is accurate.
2. I give Wilmington Mental Health permission to charge my credit card, bill my insurance company, and request payment for my treatment from third-party companies other than my insurance provider.
3. I authorize Wilmington Mental Health, and/or any of its associates to charge my credit card for any covered service, no-show/late cancellation fees, and any balance that is 30 days overdue.
4. I also understand that if I decide to revoke this privilege and my account is paid up in full, I may withdraw the authorization at any time and will communicate this request by contacting Wilmington Mental Health at 910-777-5575 or by email at info@wmhwc.com.

X _____ _____
Signature of Patient or Representative Date

X _____ _____
Therapist Signature Date

FOR OFFICE USE ONLY

Revocation note: Date: Staff Initials:

AUTHORIZATION FOR APPOINTMENT REMINDERS AND OTHER COMMUNICATIONS

WMH staff may contact via email and/or text messaging to remind you of an appointment or obtain feedback on your experience with our healthcare team. By signing this form, you authorize Wilmington Mental Health, PLLC to:

Contact You (Choose One)

_____ (Initials)	WMH staff may leave a message on my primary phone with detailed information.	_____ (Initials)	WMH staff may leave a message on my primary phone with a call back number only.

Send You Automated Notices (Choose One for Each Category)

_____ (Initials)	Both automated calls and text message appointment reminders to my cell phone and any number forwarded or transferred to that number. *WMH does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*	_____ (Initials)	Only automated text message appointment reminders to my cell phone and any number forwarded or transferred to that number
_____ (Initials)	Only automated call appointment reminders.	_____ (Initials)	Do **NOT** send any appointment reminders.
_____ (Initials)	Emails notifying me of a missed appointment. *WMH is not responsible for the security and confidentiality of email communications once it leaves its control, including what happens to the information both in transit and upon arrival, and who else sees the information.*	_____ (Initials)	Mail written communication with agency name on return envelope.

Communication Policy

E-mail and Texting – We do not recommend sharing confidential health information about you or any of your family members via email or text. If you initiate electronic communication with your therapist, you are consenting to receive a response in like manner. Please consider the following if you choose to do so:

- Email is not a substitute for personal treatment or other mental health care.
- Email and text messages can be both accessed and intercepted by others, putting at risk your privacy.
- Confidentiality cannot be guaranteed as PHI shared electronically can remain stored and potentially be exposed.
- Emails and text messages are not part of your clinical records unless relevant treatment information is shared.
- WMH staff will attempt to reply all messages in a timely manner but cannot guarantee an immediate response.
- It is your responsibility to follow-up with the message recipient and confirm your appointment, if applicable.
- A written consent is needed for all email communications with third parties.
- You can request to stop communicating electronically with your therapist at any time.

Social Media – To protect the development of a patient-therapist relationship built in the confinement of the therapeutic environment, "dual relationships" with your therapist will be avoided. Your therapist will not be able to "friend" you via social media (e.g., Facebook, Twitter, Instagram, etc.) because doing so may compromise your privacy and blur the boundaries of the therapeutic relationship. Feel free to discuss this further with your therapist should you have any questions.

Interactions Outside of Therapy – Your therapist may run into you outside of the therapy room and not acknowledge your current or former relationships with him/her unless you acknowledge him/her first. Likewise, she/he may behave as though he/she does not know you if there is another person with you. This is done to protect your privacy and confidentiality. Any interaction in public is expected to be brief and your therapist will avoid interactions with others in your company.

Teletherapy – Distance therapy is offered using a HIPAA compliant, two-way, real-time interactive audio and video software when face-to-face interaction is not possible. It is important to know that:

1. Online therapy provides convenient access to therapy, continuity of care, and reduction of travel cost.
2. Your therapist may have trouble making visual and olfactory observations of clinical or therapeutic relevant issues during online interactions.
3. Complex issues related to equipment malfunction may be difficult to resolve during the session time.
4. You always retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any benefits to which you would otherwise be entitled.
5. All existing confidentiality protections are equally applicable during a teletherapy session.
6. Your access to information transmitted during distance therapy is guaranteed.
7. Dissemination to researchers or other entities of any identifiable images or information you share online shall not occur.

Execute this _____ **day of** _____ _____ ***X*** _____

Day | Month | Year | Signature of Patient or Authorized Representative

SYMPTOM CHECKLIST

(Circle ⊙ the answer that best applies to you)

Please indicate the severity of each of the following symptoms you have experienced in the last 6 months.	Not at all	Mildly	Moderately	Severely
Grief/Loss (personal or material)	0	1 2 3	4 5 6 7	8 9 10
Depression (sadness, weeping, feelings of guilt)	0	1 2 3	4 5 6 7	8 9 10
Mood swings	0	1 2 3	4 5 6 7	8 9 10
Changes in Sleep Pattern: Sleeplessness/Hypersomnia	0	1 2 3	4 5 6 7	8 9 10
Decreased/Increased Self-Esteem:	0	1 2 3	4 5 6 7	8 9 10
Periods of High Energy/Activity with less need for sleep	0	1 2 3	4 5 6 7	8 9 10
Suicidal Attempts - When?	0	1 2 3	4 5 6 7	8 9 10
Suicide Thoughts - When?	0	1 2 3	4 5 6 7	8 9 10
Suicide Plan (describe):	0	1 2 3	4 5 6 7	8 9 10
Change in weight or eating habits	0	1 2 3	4 5 6 7	8 9 10
Restrictive eating, dieting or purging	0	1 2 3	4 5 6 7	8 9 10
Feelings of insecurity or inferiority	0	1 2 3	4 5 6 7	8 9 10
Stress	0	1 2 3	4 5 6 7	8 9 10
School-related issues	0	1 2 3	4 5 6 7	8 9 10
Change in work habits	0	1 2 3	4 5 6 7	8 9 10
Work/Career changes	0	1 2 3	4 5 6 7	8 9 10
Anxiety, nervousness, or panicky feelings	0	1 2 3	4 5 6 7	8 9 10
Avoiding places or situations	0	1 2 3	4 5 6 7	8 9 10
Brain fog, fuzzy thinking, or dissociation	0	1 2 3	4 5 6 7	8 9 10
Memory problems	0	1 2 3	4 5 6 7	8 9 10
Confusion or disorganized thoughts	0	1 2 3	4 5 6 7	8 9 10
Marriage-related conflict	0	1 2 3	4 5 6 7	8 9 10
Anger or temper problems	0	1 2 3	4 5 6 7	8 9 10
Disability	0	1 2 3	4 5 6 7	8 9 10
Codependency	0	1 2 3	4 5 6 7	8 9 10
Communication issues	0	1 2 3	4 5 6 7	8 9 10
Decreased or Loss of interest in enjoyable activities	0	1 2 3	4 5 6 7	8 9 10
Flashbacks or intrusive memories	0	1 2 3	4 5 6 7	8 9 10
Physical problems, pain, or illness	0	1 2 3	4 5 6 7	8 9 10
Sexual worries or problems	0	1 2 3	4 5 6 7	8 9 10
Inability to stop watching pornography	0	1 2 3	4 5 6 7	8 9 10
Repetitive thoughts or behaviors	0	1 2 3	4 5 6 7	8 9 10
Procrastination (tasks, time management, etc.)	0	1 2 3	4 5 6 7	8 9 10
Trauma (victim of a crime, abuse, natural disaster)	0	1 2 3	4 5 6 7	8 9 10
Cultural (race) or Gender (LGQBT) issue	0	1 2 3	4 5 6 7	8 9 10
Spirituality: God, faith, church/ministry related issues	0	1 2 3	4 5 6 7	8 9 10
Substance abuse or relapse	0	1 2 3	4 5 6 7	8 9 10
Other (Please explain):	0	1 2 3	4 5 6 7	8 9 10

How serious are these matters to you currently?

1	2	3	4
Very serious	Serious	Not too serious	Not at all serious

How long have you had these problems?

0 to 3 months	3 to 12 months	1 to 5 years	More than 5 years

Patient Health Questionnaire (PHQ-9)

(Circle ⊙ the answer that best applies to you)

Over the last 2 weeks, 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
Add columns		**+**	**+**	
Total:				

► 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

Generalized Anxiety Disorder (GAD-7) Scale

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Felling 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
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

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

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SUBSTANCE USE HISTORY

Name: _____ Date: _____ / _____ / _____

Frequency Codes: *0 = None/Sporadic, 1 = 1-2x per week, 2 = 3-6x per week, 3 = 1-3x in past month, 4 = daily* · **Route Codes**: *1 = Oral, 2 = Inhalation, 3 = Nasal, 4 = Injection, 5 = Topical*

Substance	Age at first use	Frequency					Amount	Route					Date of last use	Max. Freq.				
		0	1	2	3	4		1	2	3	4	5		0	1	2	3	4
Caffeine		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Tobacco		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Alcohol		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Cannabis/Hashish		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Methamphetamine		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Cocaine/crack		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Phencyclidine		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
LSD/MDMD		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Inhalants		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Benzodiazepines		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Prescribed Medicine		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐

History of overdose, seizure, blackout, or hospitalization due to drug use? If yes, please explain: ☐ Yes ☐ No

Drug of Choice:

► Provide details about your drug use, progression, sobriety, and history of relapses in this section:

CAGE-AID Questionnaire

When thinking about drug use, include illegal drug use and use of prescription drug other than prescribed.	Yes	No
Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
Have people annoyed you by criticizing your drinking or drug use?	☐	☐
Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

SOURCE: Brown RL, Rounds LA (1995). Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wis Med J.;94:135-40.