



### **Cancellation Policy**

The therapists and physicians have a waiting list to see patients, due to this fact we must insist that you give us at least a 24 hour notice if in fact you need to cancel or reschedule an appointment. This allows us to try and fill the spot with a client that may be on our waiting list.

You may also leave a message on our voice mail if you must cancel an appointment over the weekend or a holiday.

If we do not receive ample notification *prior* to your appointment, you will be charged \$45.

I acknowledge my financial responsibility if I do not comply with The Center for Counseling's Cancellation Policy.

\_\_\_\_\_  
Signature client/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician

\_\_\_\_\_  
Date

Client Name: \_\_\_\_\_

Your therapist name is: \_\_\_\_\_

## CLIENT EMERGENCY PLAN

### FOR A LIFE THREATENING EMERGENCY: CALL 911

***If you believe you are in danger or in imminent risk, suicidal or homicidal with intent:*** Please do not waste time calling our office or the clinician on call! You may want to attempt to contact your physician, but proceed to the emergency room immediately.

#### **Business Hours:**

The Center for Counseling is dedicated to delivering personal, client focused care. Our office is open 9 am-9 pm Monday through Thursday and 9 am – 4 pm Fridays to meet your needs. During business hours if you have the need to speak with your clinician prior to your next appointment, please call our office at 1-586-273.7095. If your clinician is not available, we will make every attempt to contact them in a timely manner to return your phone call within 24 hours. If this is an **EMERGENCY** as defined above, please follow the directions. Your clinician will do their best to provide intervention over the phone. However, your clinician may request after no more than 10 minutes on the phone, that you schedule an appointment within 72 hours.

It will be the policy of The Center for Counseling to formally charge a fee for phone calls. These charges are non-billable to your insurance and will need to be paid by your next session. The fees are: 10-30 minutes = \$45, 30-60 minutes = \$90, and after 60 minutes, the charge will be \$1.00 per additional minute. \_\_\_\_\_

#### **Before/After Business Hours:**

**If an urgent matter arises** which you would like to discuss with your clinician, **dial 1-586-273-7095** to receive the pager number. You will receive instructions to page the on-call clinician and leave a number. You will receive a return call within 15 minutes. If your call is not returned, please re-page the number, or call the **24-HOUR CRISIS LINE at 1-586-307-9100**. The on-call clinician will make every effort to contact your clinician in a timely manner to return your call within 24 hours.

Client Address \_\_\_\_\_

\_\_\_\_\_

Client Phone \_\_\_\_\_

Client/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Clinician Signature/Credentials \_\_\_\_\_

Date \_\_\_\_\_

**WELCOME**

**The Center for Counseling**  
*Your Life Is Precious.<sup>SM</sup>*

**CLIENT INFORMATION**

Client: \_\_\_\_\_ Date \_\_\_\_\_

Sex    M    F Birth date \_\_\_\_\_ Age    Minor Single Married Widow Separated Divorced

SS# \_\_\_\_\_ Address \_\_\_\_\_

Street City Zip

**PHONE NUMBERS**

Home \_\_\_\_\_ Cellular \_\_\_\_\_

What is your preferred method of contact?  Home  Cellular

May we send CFC information to your email? Y N e mail address \_\_\_\_\_

If Minor: Parents name: \_\_\_\_\_

Whom may we contact in the case of an emergency? Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Alternate # \_\_\_\_\_

**INSURANCE INFORMATION**

Who is responsible for this account? \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co \_\_\_\_\_ Contract # \_\_\_\_\_ Group# \_\_\_\_\_

Is client covered by additional insurance    Yes    No

Subscriber Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co \_\_\_\_\_ Contract # \_\_\_\_\_ Group# \_\_\_\_\_

*I have reviewed and signed the Consent for Treatment form and voluntarily consent to participate in treatment.*

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to The Center for Counseling all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and that it is my responsibility to verify if The Center for Counseling is in network with my insurance company I also understand it is my responsibility to pay any deductible amount, co-insurance, or any other balances not paid by my insurance company or pay the full client fee if I have no insurance coverage and to notify The Center for Counseling immediately if my insurance changes. Also, if The Center for Counseling is out-of-network, I am responsible for all charges. In the event that my insurance company does not pay within 120 days I am responsible for all charges and The Center for Counseling will provide receipts so that I may contact my insurance company. In the event that payment in full is not received within thirty(30) days, a service charge will be added to the outstanding balance, computed at the rate of one and a half (1.5%) percent per month. I hereby authorize The Center for Counseling to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Client/Guardian Signature Relationship Date

For further information about this Privacy Notice, please contact:

The Center for Counseling  
Office Manager  
**586.273.7095**

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The Center for Counseling is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

This notice is effective as of July 7, 2003. (This date must not be earlier than the date on which the notice is printed or published.)

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**The Center for Counseling**

*Your Life Is Precious.<sup>SM</sup>*

**32743 23 Mile Road, Suite 130  
New Baltimore, MI 48047**

*www.thecenterforcounseling.net*

## **Notice of Privacy Policies and Practices**

**Our promise to you  
on the privacy of  
your health  
information**

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**The Center for Counseling**

*Your Life Is Precious.<sup>SM</sup>*

## PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND MADE KNOWN, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your private healthcare information may be released to other healthcare professionals within The Center for Counseling for the purpose of providing you with quality mental health and substance abuse care.
- Your private healthcare information may be released to your insurance company for the purpose of The Center for Counseling receiving payment for providing you with needed healthcare services.
- Your private healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your private healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your private healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or problematic event to a biological product (food or medication).
- Your private healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your private healthcare information may be released only after receiving written permission from you. You may withdraw your permission to release private healthcare information at any time.
- You may be contacted by the agency to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to limit the use of your private healthcare information. However, the agency may choose to refuse your limitation if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive private communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your private healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The agency is required by law to protect the privacy of its patients. It will keep private any and all patient healthcare information and will provide patients with a list of duties or practices that protect private healthcare information.
- The agency will abide by the terms of this notice. The agency reserves the rights to make changes to this notice and continue to maintain the privacy of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to the agency if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the agency:

The Center for Counseling  
ATTN: Office Manager  
32743 23 Mile Road  
New Baltimore, MI 48047

All complaints will be investigated. No personal issue will be raised for filing a complaint with the agency.

## CLIENT'S BILL OF RIGHTS

\*Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided.

\*Each client has the right to be free from neglect, exploitation; and verbal, mental, physical and sexual abuse.

\*Each client has the right to expect that all treatment records or information will be kept confidential in compliance with agency policy except as authorized and as required by law. No information/records will be released without written permission of client or other appropriate designee, except to the physician, insurance company or hospital/facility client transferred to. The client will have access to all their health care records.

\*Each client has the right to exercise personal privacy by withholding consent or family's or significant other's participation and to be informed of the possible consequences of that action.

\*Each client has the right to be informed of the nature and purpose of any services rendered and the name and title of personnel providing that service.

\*There are circumstances that would allow for exceptions to obtaining informed consent such as: situations involving threat of harm to self or others, child or elder abuse. Under these circumstances information about the individual served must be disclosed or reported.

\*Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on the service provided and be aware of the process of voicing those grievances.

\*It is the right of each client to receive individualized treatment which includes:

\*Adequate and humane services regardless of the source of financial support.

\*Services provided in the least restrictive environment possible.

\*An individualized treatment plan which is reviewed periodically and as needed.

\*To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate.

\*If at anytime during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency:

They have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.

\*The client has the right to request a referral for services which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.

\*The client will be informed of his/her rights in a language they can understand.

\*Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.

\*Each client has the right to make decisions regarding the withholding or resuscitative measures with these decisions respected per agency policy.

**\*Recipients have rights protected by state and federal law and promulgated rules. For Information contact:**

Office Manager

32743 23 Mile Road, Suite 130

New Baltimore, MI 48047

The above Bill of Rights have been reviewed with me and any questions I may have had were explained to my understanding. A copy of the Client's Bill of Rights was given to me.

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Client/Guardian Signature

Date

**Informed Consent for Treatment**

1. I voluntarily consent to participate in the initial intake, assessment process and ongoing treatment.
2. I have been given the opportunity for discussion of any concerns that I have regarding treatment or any risks that may be involved.
3. I will be informed and take part in my treatment and goal planning and any reasonable alternatives and risks involved in not receiving proposed care.
4. I understand:
  - a. that I may withdraw my consent in writing at any time and have expected consequences explained.
  - b. that I must notify The Center for Counseling if my insurance carrier or coverage changes.
  - c. I am responsible for monitoring my insurance. It is my responsibility to ensure participation and non-participation. I am responsible for payment of any services not covered by insurance and will pay any and all charges, co-pays, and deductibles owing The Center for Counseling in accordance with their regular rates. Any insurance balance not paid within 120 days will become my responsibility, The Center for Counseling will provide receipts so that I may turn them into insurance company.
  - d. Any and all balances will need to be paid off at the time of appointment. Next appointments can not be made until balances are paid.
  - e. That if I must cancel an appointment, I am required to contact the office 24 hours prior to the appointment. Voice mail is available 24 hours a day, 7 days a week. If I fail to contact the office, I will be charged at the rate \$45 NO EXCEPTIONS!! This fee is **not** billable to your insurance, and is due at the beginning of the next session. \_\_\_\_\_. That if I am a late cancellation or no call no show twice in a one year period my case will be closed.
  - f. Balances over 30 days will accrue a service charge of 1.5% monthly, 18% annually. In addition to the above service charge, I agree to pay all costs of collection, including filing fees, court costs, and reasonable attorney fees.
  - g. That I will be charged \$25 for any non-sufficient funds checks.
  - h. That in case of inclement weather, I am to call the office prior to my appointment to confirm that the CFC is open. If we have closed, there will be a message on our recording indicating the closure.
  - i. That if my therapist or physician must write letters or fill out insurance forms there will be a \$35-\$75 charge for this service and that it takes up to a week to complete.
  - j. That my medication reviews are scheduled so that there is no lapse in medication. If I must have a prescription written or called into my pharmacy there is a \$10 office fee for this service.
5. I have read and received a copy of the fire evacuation, fire drill procedure, tornado warning drill procedure and building map.
6. The Center for Counseling will use and disclose personal health information to treat you, to receive payment for the care we provide. We have prepared a detailed NOTICE OF PRIVACY PRACTICES BROCHURE to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notices in our office, on our web-site and have copies available for distribution. I have received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

**PERSONAL HISTORY FORM**

MENTAL HEALTH       SUBSTANCE ABUSE       BOTH      CLIENT ID # \_\_\_\_\_

FORM COMPLETED BY (If someone other than client) \_\_\_\_\_

A) What brought you into treatment: \_\_\_\_\_

B) What are your expectations for treatment \_\_\_\_\_

C) Prior treatment experiences ( Dates and Location \_\_\_\_\_

D) Name of Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

**E) Current Living Arrangements:**

1.  House                       Group Living       Apartment       Other (Specify) \_\_\_\_\_  
 2.  Alone                         With Family       Unrelated Significant Other

**I. CLIENT INFORMATION (past and present)**

**1) Treatment Experiences      Yes      No      Inpat./Outpt/ IOP      When      Where**

	Yes	No	Inpat./Outpt/ IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous)					

**2) Presenting Problem (Check all boxes that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Medical/Organic condition | <input type="checkbox"/> Anxiety                   |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Aggressive Behavior       |
| <input type="checkbox"/> Mania                     | <input type="checkbox"/> Suicidal Ideation's       |
| <input type="checkbox"/> Chemical Abuse/Dependency | <input type="checkbox"/> Self-destructive Behavior |
| <input type="checkbox"/> Delusions/Hallucinations  | <input type="checkbox"/> Anger                     |
| <input type="checkbox"/> Family Issues             | <input type="checkbox"/> Life Decision             |
| <input type="checkbox"/> Relationship Issues       | <input type="checkbox"/> Uncertain                 |
| <input type="checkbox"/> Other (please elaborate)  |  |



3) **Symptoms**

Any recent changes in:

	Yes	No		Yes	No
Sleeping patterns	<input type="checkbox"/>	<input type="checkbox"/>	Physical Activity Level	<input type="checkbox"/>	<input type="checkbox"/>
Eating Patterns	<input type="checkbox"/>	<input type="checkbox"/>	General Disposition	<input type="checkbox"/>	<input type="checkbox"/>
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	Weight	<input type="checkbox"/>	<input type="checkbox"/>
Energy	<input type="checkbox"/>	<input type="checkbox"/>	Increased tension	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please describe

Are you in physical pain  yes  no if yes where/what kind

If yes please rate pain \_\_\_\_\_ 0=none 5=mild(tolerable) 10=severe(referral)

**THERAPY IMPLICATIONS:**

II. **INFORMATION ABOUT FAMILY / SIGNIFICANT OTHERS;** past and present

1. **Family Constellation**

	NAME	CURRENT AGE	CURRENTLY LIVING		CURRENTLY LIVING WITH YOU	
			YES	NO	YES	NO
Client						
Mother						
Father						
Spouse						
Significant Other						
Children						
Significant Others: (Brothers, Sisters, Grandparents, Step-relatives, Half-relatives) <i>Specify Relationship</i>						

**2) FAMILY/EXTENDED FAMILY HISTORY**

	Yes	No	Inpt/Outpt/IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups					

**3) Family History**

1. What City/State were you born? \_\_\_\_\_
2. Where did you grow-up? \_\_\_\_\_
3. Who raised you as a child? \_\_\_\_\_

**4) Parental Information**

- Parents legally married
- Mother remarried (number of times) \_\_\_\_\_
- Parents ever separated
- Father remarried (number of times) \_\_\_\_\_
- Parents ever divorced

Describe relationships with parents, step-parents

1. As a child \_\_\_\_\_  
\_\_\_\_\_
2. Currently \_\_\_\_\_  
\_\_\_\_\_

**5) SIBLING INFORMATION**

Number of living siblings/step siblings \_\_\_\_\_ Number of deceased siblings/step-siblings \_\_\_\_\_

What position are you in the order of siblings (oldest, 2nd, 3rd, youngest, etc.) \_\_\_\_\_

Describe relationships with siblings:

1. As a child \_\_\_\_\_
2. Currently \_\_\_\_\_

- Family will be involved in treatment
- Family uninvolved

**Why/Why Not:** \_\_\_\_\_  
\_\_\_\_\_

6) **Marital Information**

- Single       Unmarried and living with significant other. Length of time \_\_\_\_\_
  - Legally married: Length of time: \_\_\_\_\_      Total number of marriages: \_\_\_\_\_
  - Separated: Length of time \_\_\_\_\_       Divorce in process: Yes  No
  - Divorced: Length of time \_\_\_\_\_       Widowed: Length of time \_\_\_\_\_
- Are there problems in this relationship (check all that apply)
- Money                                       Chemical Dependency
  - Sexual     Mental illness
  - Physical Abuse                               Religion
  - Child rearing/discipline issues       Other

**THERAPY IMPLICATIONS:** \_\_\_\_\_

III. **SOCIAL INFORMATION**

1) **Support System** (check all that apply)

- Adequate social support       Recent move / relocation       Conflict with peers
- Transportation problems       Lack of knowledge of resources       Isolative
- Problems establishing / maintaining relationships

Please list involvement in community resources (e.g. WIC, CMH, Day treatment, groups) \_\_\_\_\_

**THERAPY IMPLICATIONS:** \_\_\_\_\_

2) **Sexuality**

- What is your sexual preference       Male       Female       Both       Uncertain
- Have you been tested for HIV       Yes       No
- Are there sexual issues that you would like to discuss with your therapist?  Yes       No
- Have you ever been sexually and/or physically abused?       Yes       No

**THERPAY IMPLICATIONS:** \_\_\_\_\_

3) **Interests/Hobbies**

- |              |                        |
|--------------|------------------------|
| Art _____    | Book/Films _____       |
| Music _____  | Physical Fitness _____ |
| Crafts _____ | Outdoor Activity _____ |
| Sports _____ | Diet/Health _____      |

Current Memberships (church , clubs, organizations)

Do you participate in any cultural activities related to your ethnic background?       Yes       No

**THERAPY IMPLICATIONS:** \_\_\_\_\_

4) **Spirituality**

- Do you believe in a god or a power greater than yourself?       Yes       No
- What religion were you raised? \_\_\_\_\_
- What religion are you currently affiliated? \_\_\_\_\_
- At this point in your life, what is most important to you? \_\_\_\_\_

**THERAPY IMPLICATIONS:** \_\_\_\_\_

IV. **EDUCATION** (check all that apply)

- High school diploma (GED)  Currently enrolled: Last grade completed \_\_\_\_\_
- Did not complete high school: last grade completed \_\_\_\_\_
- Vocational training:  Training completed, type \_\_\_\_\_  Currently enrolled
- College: Degree earned, type \_\_\_\_\_  Currently enrolled/# of years completed \_\_\_\_\_
- Special circumstances (e.g. learning disabilities, gifted programs, special education, etc.)

**TERAPY IMPLICATIONS:** \_\_\_\_\_

V. **EMPLOYMENT/VOCATIONAL** (Beginning with most recent job, give employment history, include homemaker experience)

Employer	Dates	Job Description	Salary

**TERAPY IMPLICATIONS:** \_\_\_\_\_

VI. **MILITARY**

Branch \_\_\_\_\_  
 Date drafted/enlisted \_\_\_\_\_  
 Combat experience  Yes  No  
 Where \_\_\_\_\_

Type of Discharge \_\_\_\_\_  
 Rank at Discharge \_\_\_\_\_  
 Date of Discharge \_\_\_\_\_ Where \_\_\_\_\_

**TERAPY IMPLICATIONS:** \_\_\_\_\_

VII. **LEGAL DATA**

Are you presently on probation or parole:  Yes  No

If yes reason \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**Current Status:**

Are you currently involved in any active legal cases (traffic, civil, criminal):  Yes  No

If yes, please describe and indicate the court hearing/trial date \_\_\_\_\_

**Past History** (adolescent and adult)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Traffic Violations
<input type="checkbox"/>	<input type="checkbox"/>	Civil Involvement
<input type="checkbox"/>	<input type="checkbox"/>	Criminal Involvement

If yes to any of the above, please complete the following

Charges	Date	Where	Results

**THERAPY IMPLICATIONS:** \_\_\_\_\_

VIII **Nutritional Assessment**

Please circle the answer or indicated number and total the score from both columns at the bottom.

QUESTION	Yes=	No=
Do you have an illness/condition that made you change the type/amount of food you eat?	2	No
Do you eat at least two or more meals per day?	Yes	No=3
Do you eat fruits or vegetables, or milk products every day?	Yes	No=2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	Yes=2	No
Do you have teeth or mouth problems that make it hard for you to eat?	Yes=2	No
Do you always have enough money to buy the food you need?	Yes	No=4
Do you eat alone most of the time?	Yes=1	No
Do you take 3 or more prescription or over-the-counter drugs?	Yes=1	No
Have you lost or gained 10 lbs. in the last six months?	Yes=1	No
Are you always physically able to shop, cook, and/or feed yourself?	Yes	No=2

**TOTAL SCORE** \_\_\_\_\_

0-2= Low Risk      3-5= Moderate Risk      6-21= High Risk\*      \*Referral

**THERAPY IMPLICATIONS:** \_\_\_\_\_

**IX TRAUMA**

Any history of trauma, abuse, neglect or exploitation?  No  Yes

If yes: When and type \_\_\_\_\_  
\_\_\_\_\_

**THERAPY IMPLICATIONS:** \_\_\_\_\_

**X Alcohol/Substance Use**

Substance preferred \_\_\_\_\_

Date of last drink \_\_\_\_\_ / Date of last drug use \_\_\_\_\_

Type and amount of drink at last episode  Beer \_\_\_\_\_ oz  Wine \_\_\_\_\_ oz  Liquor \_\_\_\_\_ oz

Age drinking/ drug use began \_\_\_\_\_

Type of alcohol preferred:  Beer  Wine  Liquor

How often do you drink/use drugs?  Daily  Weekly  Monthly  Other \_\_\_\_\_

Have you ever had any legal problems related to your use of alcohol/drugs?  Yes  No

Have you ever had any relationship problems related to your use of alcohol/drugs?  Yes  No

**\*\*\*Has drinking or drug use ever become a problem?  Yes  No**

**\*\*\*If YES, please complete next page. (Substance Abuse Addendum)**

**If NO go to page 10**

**THERAPY IMPLICATIONS:** \_\_\_\_\_

## SUBSTANCE USE ADDENDUM

### I. USAGE HISTORY

Drug type	Method of use	Age first used	Age of regular, daily use	Date last used	Last 48 hours	Last 30 days	Last year
<b>A. DEPRESSANTS</b>							
Alcohol (beer, wine, liquor)							
Anti-Anxiety Agents (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)							
Barbiturates (Phenobarbital, Tuinal, Seconal, etc.)							
Others (Methaqualone, Paraldehyde, Equanil, Miltown, muscle relaxants, etc.)							
<b>B. NARCOTICS</b> ( Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)							
<b>C. STIMULANTS</b>							
Amphetamines (Benedrine, Dexedrine, Ritalin, etc.)							
Cocaine/Crack							
Caffeine							
Nicotine							
<b>D. CANNABIS</b> (Marijuana, Hashish)							
<b>E. INHALANTS</b> (glue, poppers, gasoline, etc.)							
<b>F. HALLUCINOGENS</b>							

**THERAPY IMPLICATIONS:**

**ALCOHOL/DRUG RELATED PROBLEMS/BEHAVIORS/SYMPTOMS LIST**

Please check all that apply.

PHYSICAL	EMOTIONAL	BEHAVIORAL
<input type="checkbox"/> Blackouts <input type="checkbox"/> Memory Problems <input type="checkbox"/> Tremors/ Shakes <input type="checkbox"/> Seizures <input type="checkbox"/> DT=s <input type="checkbox"/> Hallucinations <input type="checkbox"/> Overdose <input type="checkbox"/> Appetite Problems <input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Sexual Problems <input type="checkbox"/> Injury <input type="checkbox"/> Accidents <input type="checkbox"/> Other Medical Problems <input type="checkbox"/> Other	<input type="checkbox"/> Depression <input type="checkbox"/> Confusion <input type="checkbox"/> Concentration Problems <input type="checkbox"/> Anxiety <input type="checkbox"/> Irritability / Restlessness <input type="checkbox"/> Aggressiveness <input type="checkbox"/> Mood Swings <input type="checkbox"/> Impulsivity <input type="checkbox"/> Euphoria <input type="checkbox"/> Relaxation <input type="checkbox"/> Extreme Jealousy <input type="checkbox"/> Paranoia <input type="checkbox"/> Feelings of Guilt/ Shame <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Homicidal Thoughts <input type="checkbox"/> Other	<input type="checkbox"/> A.M. Use <input type="checkbox"/> Sneaking <input type="checkbox"/> Gulping <input type="checkbox"/> Loss of Control <input type="checkbox"/> Relief Use <input type="checkbox"/> Impulsive Use <input type="checkbox"/> Use less than before <input type="checkbox"/> Use more than before <input type="checkbox"/> Use despite negative Consequences <input type="checkbox"/> Associate with using friends <input type="checkbox"/> Plan activities around use <input type="checkbox"/> Loss of interest in activities <input type="checkbox"/> Change in work/school performance <input type="checkbox"/> Work/school lateness/ absenteeism <input type="checkbox"/> Job loss due to use <input type="checkbox"/> Frequent arguments <input type="checkbox"/> Separation/divorce <input type="checkbox"/> Financial problems <input type="checkbox"/> Legal problems <input type="checkbox"/> Physically abusive to self <input type="checkbox"/> Physically abusive to others <input type="checkbox"/> Suicide attempts <input type="checkbox"/> Homicide attempts <input type="checkbox"/> Other

If any of the above are checked off, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**III. SUBSTANCE ABUSE FAMILY HISTORY**

Please describe the alcohol/drug problems of others in your family, past and present. Also describe treatment and recovery experience.

WHO/RELATIONSHIP	PROBLEM TYPE	TREATMENT/RECOVERY



**XI. MEDICAL INFORMATION (past and present)**

**1. Recent Treatment History**

	Date	Reason	Results
Last physical check-up			
Last Doctor's visit			
Last Dental visit			

**2. Review of Past/Present Conditions**

Please check any of the following medical problems you have, or have had in the past:

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Adrenal problems           | <input type="checkbox"/> Head Injury/Loss of Consciousness | <input type="checkbox"/> Anemia         | <input type="checkbox"/> Brain Tumor |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Kidney/Bladder problems           | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Cancer      |
| <input type="checkbox"/> Thyroid problems           | <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Lung problems  | <input type="checkbox"/> Glaucoma    |
| <input type="checkbox"/> Seizures/Epilepsy          | <input type="checkbox"/> Stroke                            | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma      |
| <input type="checkbox"/> Meningitis or Encephalitis | <input type="checkbox"/> Sexually transmitted disease      | <input type="checkbox"/> Allergies      |                                      |

If yes to any of the above, please describe and give dates: \_\_\_\_\_

**3) Current Medical Symptoms/Problems:**

Please check all that pertain to you now:

**EYES**

- Double Vision
- Eye pain
- Problems with vision

**EARS**

- Hearing Aid
- Buzzing/Ringing in ears
- Infection in ears
- Problems with balancing
- Problems with hearing

**NOSE**

- Nose bleeds
- Stuffy nose

**MOUTH**

- Loss of taste
- Problems with teeth
- Dentures

**RESPIRATORY**

- Shortness of breath
- Chronic cough
- Sputum/mucus production
- Positive TB test
- Coughing up blood

**SKIN/JOINT/MUSCLE**

- Changes in skin
- Changes in nails
- Changes in hair
- Skin rash
- Skin itchy/dry
- Cramps in legs/arms
- Stiff/swollen joints
- Difficulty walking

**GASTROINTESTINAL**

- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool
- Black tarry stool
- Abdominal pain

**GENITO/URINARY**

- Pain/burning with urination
- Frequent urination at night
- Bloody/brown urine
- Difficulty starting urine flow
- Constant need to urinate

**NERVOUS SYSTEM**

- Headaches
- Numbness
- Fainting spells
- Convulsions/seizures
- Memory problems
- Coordination problems
- Tremor/shakes
- Loss of movement
- Loss of sensation

**GENERAL HEALTH**

- Overweight
- Underweight
- Chills
- Fever
- Tire easily
- Night/day sweats

**CARDIOVASCULAR**

- High blood pressure
- Low blood pressure
- Heart skips a beat
- Palpitations
- Fast heart rate
- Chest pains
- Swollen ankles

**FEMALES ONLY**

- Menstrual irregularities
- Menopause
- Problem pregnancy
- Miscarriage # \_\_\_\_\_
- Abortion # \_\_\_\_\_
- Premenstrual problems
- Infertility
- Currently pregnant

If you checked any of the above, please describe: \_\_\_\_\_

4) **Medication and Drug Use**

Include prescription, non-prescription, and illegal drugs

Name of Drug	Prescribed	Prescribing Physician	Date 1st used	Date last used	Amount last used	Used in past 48 hr
	yes no					
	yes no					
	yes no					
	yes no					

Any history of drug overdose:  Yes  No If yes, please describe:

Any medication allergies?  Yes  No If yes, please describe: \_\_\_\_\_

Do you believe you would benefit from any of the following?

- Anger Management Education Series
- Substance Abuse Education Series
- Grief Group

-----  
**STAFF USE ONLY**

**Client currently being treated by Primary Care Physician for symptoms checked on page 10**

- yes
- no
- n/a

Referred for physical  yes  no

\_\_\_\_\_  
**CLINICIAN SIGNATURE/CREDENTIALS**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PSYCHOLOGIST SIGNATURE**

\_\_\_\_\_  
**DATE**

Physician  agrees  disagrees with referral

If disagree reason \_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN SIGNATURE**

**DATE**



# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

## 36-item version, self-administered

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

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

In the past <u>30 days</u> , how much <u>difficulty</u> did you have in:						
<b>Understanding and communicating</b>						
D1.1	<u>Concentrating</u> on doing something for <u>ten minutes</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.2	<u>Remembering</u> to do <u>important things</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.3	<u>Analysing and finding solutions to problems</u> in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.4	<u>Learning a new task</u> , for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.5	<u>Generally understanding</u> what people say?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.6	<u>Starting and maintaining a conversation</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
<b>Getting around</b>						
D2.1	<u>Standing</u> for <u>long periods</u> such as <u>30 minutes</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.2	<u>Standing up</u> from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.3	<u>Moving</u> around <u>inside your home</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.4	<u>Getting out</u> of your <u>home</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.5	<u>Walking a long distance</u> such as a <u>kilometre</u> [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do

***Please continue to next page ...***



# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

36

Self

In the past <u>30 days</u> , how much <u>difficulty</u> did you have in:						
<b>Self-care</b>						
D3.1	Washing your <u>whole body</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.2	Getting <u>dressed</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.3	<u>Eating</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.4	Staying <u>by yourself</u> for a <u>few days</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
<b>Getting along with people</b>						
D4.1	<u>Dealing</u> with people <u>you do not know</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.2	<u>Maintaining a friendship</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.3	<u>Getting along</u> with people who are <u>close</u> to you?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.4	<u>Making new friends</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.5	<u>Sexual activities</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
<b>Life activities</b>						
D5.1	Taking care of your <u>household responsibilities</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.2	Doing most important household tasks <u>well</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.3	Getting all the household work <u>done</u> that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.4	Getting your household work done as <u>quickly</u> as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

***Please continue to next page ...***



# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

36

Self

If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.

Because of your health condition, in the past <u>30 days</u> , how much <u>difficulty</u> did you have in:						
D5.5	Your day-to-day <u>work/school</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.6	Doing your most important work/school tasks <u>well</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.7	Getting all the work <u>done</u> that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.8	Getting your work done as <u>quickly</u> as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

<b>Participation in society</b>						
In the past <u>30 days</u> :						
D6.1	How much of a problem did you have in <u>joining in community activities</u> (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.2	How much of a problem did you have because of <u>barriers or hindrances</u> in the world around you?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.3	How much of a problem did you have <u>living with dignity</u> because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.4	How much <u>time</u> did <u>you</u> spend on your health condition, or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5	How much have <u>you been emotionally affected</u> by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.6	How much has your health been a <u>drain on the financial resources</u> of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7	How much of a problem did your <u>family</u> have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.8	How much of a problem did you have in doing things <u>by yourself</u> for <u>relaxation or pleasure</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do

**Please continue to next page ...**



# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

36

Self

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

This completes the questionnaire. Thank you.

The APA is offering a number of “emerging measures” for further research and clinical evaluation. These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. They should be used in research and evaluation as potentially useful tools to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis. Instructions, scoring information, and interpretation guidelines are provided; further background information can be found in DSM-5. The APA requests that clinicians and researchers provide further data on the instruments’ usefulness in characterizing patient status and improving patient care at <http://www.dsm5.org/Pages/Feedback-Form.aspx>.

**Measure:** DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

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# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Date: \_\_\_\_\_

If this questionnaire is completed by an informant, what is your relationship with the individual? \_\_\_\_\_

In a typical week, approximately how much time do you spend with the individual? \_\_\_\_\_ hours/week

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

## Instructions to Clinicians

The DSM-5 Level 1 Cross-Cutting Symptom Measure is a self- or informant-rated measure that assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the individual's treatment and prognosis. In addition, the measure may be used to track changes in the individual's symptom presentation over time.

This adult version of the measure consists of 23 questions that assess 13 psychiatric domains, including depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning, and substance use. Each item inquires about how much (or how often) the individual has been bothered by the specific symptom during the past 2 weeks. If the individual is of impaired capacity and unable to complete the form (e.g., an individual with dementia), a knowledgeable adult informant may complete the measure. The measure was found to be clinically useful and to have good test-retest reliability in the DSM-5 Field Trials that were conducted in adult clinical samples across the United States and in Canada.

## Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The score on each item within a domain should be reviewed. Because additional inquiry is based on the highest score on any item within a domain, the clinician is asked to indicate that score in the "Highest Domain Score" column. A rating of mild (i.e., 2) or greater on any item within a domain (except for substance use, suicidal ideation, and psychosis) may serve as a guide for additional inquiry and follow up to determine if a more detailed assessment for that domain is necessary. For substance use, suicidal ideation, and psychosis, a rating of slight (i.e., 1) or greater on any item within the domain may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is needed. The DSM-5 Level 2 Cross-Cutting Symptom Measures may be used to provide more detailed information on the symptoms associated with some of the Level 1 domains (see Table 1 below).

## Frequency of Use

To track change in the individual's symptom presentation over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. For individuals with impaired capacity, it is preferable that the same knowledgeable informant completes the measures at follow-up appointments. Consistently high scores on a particular domain may indicate significant and problematic symptoms for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making.

**Table 1: Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: domains, thresholds for further inquiry, and associated Level 2 measures for adults ages 18 and over**

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Depression	Mild or greater	LEVEL 2—Depression—Adult (PROMIS Emotional Distress—Depression—Short Form) <sup>1</sup>
II.	Anger	Mild or greater	LEVEL 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form) <sup>1</sup>
III.	Mania	Mild or greater	LEVEL 2—Mania—Adult (Altman Self-Rating Mania Scale)
IV.	Anxiety	Mild or greater	LEVEL 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form) <sup>1</sup>
V.	Somatic Symptoms	Mild or greater	LEVEL 2—Somatic Symptom—Adult (Patient Health Questionnaire 15 Somatic Symptom Severity [PHQ-15])
VI.	Suicidal Ideation	Slight or greater	None
VII.	Psychosis	Slight or greater	None
VIII.	Sleep Problems	Mild or greater	LEVEL 2—Sleep Disturbance - Adult (PROMIS—Sleep Disturbance—Short Form) <sup>1</sup>
IX.	Memory	Mild or greater	None
X.	Repetitive Thoughts and Behaviors	Mild or greater	LEVEL 2—Repetitive Thoughts and Behaviors—Adult (adapted from the Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale [Part B])
XI.	Dissociation	Mild or greater	None
XII.	Personality Functioning	Mild or greater	None
XIII.	Substance Use	Slight or greater	LEVEL 2—Substance Abuse—Adult (adapted from the NIDA-modified ASSIST)

<sup>1</sup>The PROMIS Short Forms have not been validated as an informant report scale by the PROMIS group.