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

The Center for Counseling
Your Life Is Precious.℠

Client Name: ____

Your therapist name is: ____

CLIENT EMERGENCY PLAN

FOR A LIFE THREATENING EMERENCY: 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.℠

MINOR CLIENT INFORMATION **(must be over 18 to complete form)**

Client: ____ Date _____________________
Last First

Sex __M __F Birthdate _________Age ____

SS# ______________________ Address ____
Street City Zip

PHONE NUMBERS

Home __________________________________ Cellular ____________________________

May we send CFC information to your email? Y N e-mail address _______________________

Father's Name __________________________Birthdate _____________SS#______________

Mother's Name __________________________Birthdate ______________SS#______________

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#__________

Whom may we thank for referring you to us? ____

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. I also understand it is my responsibility to pay any deductible amount, co-insurance, or any other balances not paid by y insurance company or pay the full client fee if I have no insurance coverage. 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 al information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Client/Guardian Signature Relationship Date

CHILD AND ADOLESCENT PERSONAL HISTORY FORM

MENTAL HEALTH SUBSTANCE ABUSE BOTH CLIENT ID # ___________

FORM COMPLETED BY (*Must be over 18 years of age*)__________________________Relation _____________

A) What brought child to 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**

Treatment Experiences	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)

Medical/Organic condition
Depression
Mania
Chemical Abuse/Dependency
Delusions/Hallucinations
Family Issues
Relationship Issues
Other (please elaborate)

Anxiety
Aggressive Behavior
Suicidal Ideation's
Self-destructive Behavior
Anger
Life Decision
Uncertain

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

1. **Family Constellation**

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

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 was child born? ____
2. Where did child grow-up? ____
3. Who raised 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

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:

____
____

Family will be involved in treatment

Family uninvolved

Why/Why Not:____
____
____

III. CHILD'S HISTORY:

Pregnancy: Planned: Yes No Length of pregnancy:___________________

Mother's weight gain:___________________________________

While pregnant, did you smoke: Yes No Amount:____________________________

Did you use alcohol and/or drugs: Yes No Type and amount:___________________

While pregnant, did you have any medical or emotional difficulties: (e.g. Hypertension, surgery, medication, depression etc)

____
____

Birth:

Length of labor: _____________ Induced: Yes No Caesarian: Yes No

Describe any physical or emotional complications with delivery:

____

Baby's birth weight: ___________ Baby's birth length: _______________

Describe any complications for mother or baby after birth:

____
____

Length of hospitalization: Mother: ____________ Baby: ___________________

INFANCY/TODDLERHOOD (check all that apply)

Breast Fed	Milk Allergies	Vomiting	Diarrhea
Bottle Fed	Constipation	Colic	Rashes

Describe any particular eating or feeding problems: (e.g. overeating, under eating):

____
____

Describe your child as an infant: (e.g. happy, nervous, overactive, under active, playful, etc.)

____
____

Describe any changes/differences as a toddler:

____
____

Describe any past/current problems with wetting or soiling:

Describe any past/current sleeping problems:

Other than parents, describe significant caretakers:

Child's Age	Caretaker (babysitter, relative, etc)	Describe arrangements
________________	________________________	________________________
________________	________________________	________________________
________________	________________________	________________________

DEVELOPMENTAL HISTORY:

Age at which child:

Sat alone: _______________

Took first steps: _________

Spoke words: ____________

Spoke sentences:_________

Weaned:________________

Fed self:________________

Toilet trained:____________

Dry during day:__________

Dry during night:_________

Dressed self:_____________

Tied shoelaces:__________

Rode 2-wheel bike:_______________

PAST/CURRENT DIFFICULTIES WITH ANY OF THE FOLLOWING:

Attachment to doll, stuffed animal, blanket, etc	thumb sucking	fears
nervous habits (eye blinking, nail biting, etc	teeth grinding	fascinations
over activity	social contacts	head banging
imaginary friends	temper tantrums	masturbation
sexual difficulties	short attention span	other
separation difficulties		

If yes, describe when and nature of problem:

AGE FOR FOLLOWING DEVELOPMENTS: (to be completed where applicable)

Voice change: ______ Breast development:__________ Body hair: _________ Menstruation:_________

MEDICAL:

Immunization Record:

	DTP	POLIO
2 months:	________	________
4 months:	________	________
6 months:	________	________
1 ½-2 years:	________	________
4-5 years:	________	________

15 months _____ MMR(Measles, Mumps, Rubella)

24 months _____ HBPV (hib)

Hepatitis Series _____ _____ _____

IV. SOCIAL BEHAVIOR:

How well does your child get long with other children his/her own age:

____

____

Does child have friends: yes no Duration of best friendship: ______________________________

Your opinion of child's choice of friends:

____

Family members your child is close to:

____

Family members your child has difficulties with:

____

THERAPY 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:____

DESCRIBE THE FOLLOWING:

Recent change in child's feelings/attitudes toward family members:

____

Physical, emotional, sexual abuse, past or present:

____

Child's problem behavior (s):

____

Effect of problem behaviors on other family members:

____

Child's response to authority figures and reasonable limit setting:

____

Geographical moves (how many, when, where, and child's response)

____

EDUCATION:

Present School:________________________School Phone#: ________________________

Grade:_________________________ Teacher:______________________ School Counselor:_____________

DESCRIBE THE FOLLOWING:

Placement in gifted/special education program:

Retention or acceleration in grade placement:

Past/current behavioral adjustment in school:

Past/current academic performance in school:

Your opinion of child's academic performance:

Child's attitude toward school:

Other pertinent information:

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: ______

V. **EMPLOYMENT/VOCATIONAL**

Has child had any after school jobs? yes no

If yes: Where ______ Dates ______

THERAPY IMPLICATIONS:

VI. **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/trail date ______

THERAPY IMPLICATIONS: ______

VII 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?	Yes=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:

VII. 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:

Adrenal problems
Diabetes
Thyroid problems
Seizures/Epilepsy
Meningitis or Encephalitis
Head Injury/Loss of Consciousness
Kidney/Bladder problems
High Blood Pressure
Stroke
Sexually transmitted disease
Anemia
Liver problems
Lung problems
Heart problems
Allergies
Brain Tumor
Cancer
Glaucoma
Asthma

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

____

____

3. Is child in any physical pain? yes no

If yes: where/what kind? ____

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

4) **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:____
____

5) **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 history of drug allergies: Yes No If yes, please describe:____________________________

THERAPY IMPLICATIONS:____

8. **Trauma**

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

If yes: When and type ____

____

THERAPY IMPLICATIONS: ____

Do you believe child 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 8
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

For further information about this Privacy Notice, please contact:

The Center for Counseling
Office Manager
586.273.7095

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.

The Center for Counseling
Your Life Is Precious.℠

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

The Center for Counseling
Your Life Is Precious.℠

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 chose 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.

The Center for Counseling
Your Life Is Precious.℠

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 with holding 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 with holding 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.

____

Client/Guardian Signature Date

The Center for Counseling
Your Life Is Precious.℠

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

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 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Rights granted: This measure can be reproduced without permission by researchers and by clinicians for use with their patients.
Rights holder: American Psychiatric Association
To request permission for any other use beyond what is stipulated above, contact: http://www.appi.org/CustomerService/Pages/Permissions.aspx

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: ______________________________ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**___________

Relationship with the child: ____

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

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
	In the past **TWO (2) WEEKS,** has your child …							
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

Copyright © 2013 American Psychiatric Association. All Rights Reserved.
This material can be reproduced without permission by researchers and by clinicians for use with their patients.

Instructions to Clinicians

The DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17 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 child's treatment and prognosis. The measure may also be used to track changes in the child's symptom presentation over time.

The measure consists of 25 questions that assess 12 psychiatric domains, including depression, anger, irritability, mania, anxiety, somatic symptoms, inattention, suicidal ideation/attempt, psychosis, sleep disturbance, repetitive thoughts and behaviors, and substance use. Each item asks the parent or guardian to rate how much (or how often) his or her child has been bothered by the specific symptom during the past 2 weeks. The measure was found to be clinically useful and had good test-retest reliability in the DSM-5 Field Trials in pediatric clinical samples across the United States.

Scoring and Interpretation

Nineteen of the 25 items on the measure are each 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 suicidal ideation, suicide attempt, and substance abuse items are each rated on a "Yes, No, or Don't Know" scale. 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. Table 1 (below) outlines threshold scores that may be used to guide further inquiry for each domain. With the exception of inattention and psychosis, a rating of mild (i.e., 2) or greater on any item within a domain that is scored on the 5-point scale may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment for that domain is needed. A parent or guardian's rating of "Don't Know" on the suicidal ideation, suicide attempt, and any of the substance use items, especially for a child age 11–17, may be used as a guide for additional inquiry of the issues with the child. The DSM-5 Level 2 Cross-Cutting Symptom measures in Table 1 may be used as a resource to provide more detailed information on the symptoms associated with some of the Level 1 domains.

Frequency of Use

To track change in the child's symptom presentation over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status, and preferably by the same parent or guardian. Consistently high scores on a particular domain may indicate significant and problematic symptoms for the child that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making.

Table 1: DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17: domains, thresholds for further inquiry, and associated Level 2 measures

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Somatic Symptoms	Mild or greater	LEVEL 2—Somatic Symptom—Parent/Guardian of Child Age 6–17 (Patient Health Questionnaire 15 Somatic Symptom Severity (PHQ-15)
II.	Sleep Problems	Mild or greater	LEVEL 2—Sleep Disturbance—Parent/ Guardian of Child Age 6–17 (PROMIS—Sleep Disturbance—Short Form)[1]
III.	Inattention	Slight or greater	LEVEL 2—Inattention—Parent/Guardian of Child Age 6–17 (SNAP-IV)
IV.	Depression	Mild or greater	LEVEL 2—Depression—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Depression—Parent Item Bank)
V.	Anger	Mild or greater	LEVEL 2—Anger—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Parent)
VI.	Irritability	Mild or greater	LEVEL 2—Irritability—Parent/Guardian of Child Age 6–17 (Affective Reactivity Index)
VII.	Mania	Mild or greater	LEVEL 2—Mania—Parent/Guardian of Child Age 6–17 (adapted from the Altman Self-Rating Mania Scale)
VIII.	Anxiety	Mild or greater	LEVEL 2—Anxiety—Parent/Guardian of Child Age 6–17 (adapted from PROMIS Emotional Distress—Anxiety—Parent Item Bank)
IX.	Psychosis	Slight or greater	None
X.	Repetitive Thoughts and Behaviors	Mild or greater	None
XI.	Substance Use	Yes/ Don't Know	LEVEL 2—Substance Use—Parent/Guardian of Child Age 6–17 (adapted from the NIDA-modified ASSIST)/LEVEL 2—Substance Use—Child Age 11–17 (adapted from the NIDA-modified ASSIST)
XII.	Suicidal Ideation/ Suicide Attempts	Yes/ Don't Know	None

[1]Not validated for children by the PROMIS group but found to have acceptable test-retest reliability with parent informants in the DSM-5 Field Trial.

Copyright © 2013 American Psychiatric Association. All Rights Reserved.
This material can be reproduced without permission by researchers and by clinicians for use with their patients.