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.℠

CLIENT INFORMATION

Client: ____ Date ______________________
Last First

Sex __M __F Birth date _________Age ____ Minor Single Married Widow Separated Divorced

SS# _____________________ Address ____
Street City Zip

Preferred Language __________________________ Special Communication Needs _________________

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

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

Informed Consent Statement

1. I voluntarily consent to participate in the initial intake and assessment process.

1. I have been given the opportunity for discussion of any concerns that I have regarding treatment.

2. I have been informed of the planned course of treatment.

3. I understand:
    - **that I may withdraw my consent at any time**.
    - **That if there are any changes in my insurance coverage, I will be notified within 15 days.**
    - **That I must notify The Center for Counseling if my insurance carrier or coverage changes**.
    - **that at this time and unless otherwise notified, my financial responsibility will be $ per session.**
    - **that I am responsible for payment of any services not covered by third party payors and I will pa any and all charges, co-pays and deductibles owing The Center for Counseling in accordance with their regular rate.**
    - **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 a <u>$45.00</u> fee.**
    - **that this fee is not billable to insurance, and is due at the beginning of the next session.**
    - **that I will be charged <u>$25.00</u> for any non-sufficient funds checks**.
    - **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.**

4. I have read and received a copy of the fire evacuation/fire drill procedure, tornado warning drill procedure and building map.

5. It will be the policy of The Center for Counseling to formally charge a fee for phone calls either before or after business hours. These charges are non-billable to your insurance and will need to be paid by your next session. The fees are: up to 30 minutes = $25.00, 30-60 Minutes = $45.00, after 60 minutes, the charge will be .75 cents per additional minute.

____

Client Signature **Date**

____

Clinician Signature/Credentials **Date**

PERSONAL HISTORY FORM

☐ MENTAL HEALTH ☐ SUBSTANCE ABUSE

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**

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

3) **Symptoms**

Any recent changes in:

	Yes	No		Yes	No
Sleeping patterns	☐	☐	Physical Activity Level	☐	☐
Eating Patterns	☐	☐	General Disposition	☐	☐
Behavior	☐	☐	Weight	☐	☐
Energy	☐	☐	Increased tension	☐	☐

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	
Client			YES	NO	YES	NO
Mother						
Father						
Spouse						
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 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.)

THERAPY IMPLICATIONS:____

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

Employer	Dates	Job Description	Salary

THERAPY IMPLICATIONS:____

VI. **MILITARY**

Branch_______________________________
Date drafted/enlisted___________________
Combat experience Yes No

Where ___________________

Type of Discharge
Rank at Discharge
Date of Discharge__________Where

THERAPY 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/trail date________________________________

____

Past History (adolescent and adult)

Yes	No	
☐	☐	Traffic Violations
☐	☐	Civil Involvement
☐	☐	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		
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:

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**
A. DEPRESSANTS							
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. NARCOTICS (Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)							
C. STIMULANTS							
Amphetamines (Benzedrine, Dexedrine, Ritalin, etc.)							
Cocaine/Crack							
Caffeine							
Nicotine							
D. CANNABIS (Marijuana, Hashish)							
E. INHALANTS (glue, poppers, gasoline, etc.)							
F. HALLUCINOGENS							

THERAPY IMPLICATIONS:

ALCOHOL/DRUG RELATED PROBLEMS/BEHAVIORS/SYMPTOMS LIST

Please check all that apply.

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

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

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

- Cramps in legs/arms
- Stiff/swollen joints
- Difficulty walking

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**

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

Please continue to next page ...

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

Please continue to next page ...

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

Participation in society						
In the past 30 days:						
D6.1	How much of a problem did you have in joining in community activities (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 barriers or hindrances in the world around you?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.4	How much time did you spend on your health condition, or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7	How much of a problem did your family 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 by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page ...

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

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
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 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**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**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	

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 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)[1]
II.	Anger	Mild or greater	LEVEL 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form)[1]
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)[1]
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)[1]
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)

[1]The PROMIS Short Forms have not been validated as an informant report scale by the PROMIS group.

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.