River Walk Counseling, Inc.

Contract for Services

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating that you have fully read and understand the information contained in this document.

Client/Provider Relationship

You and your provider have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your provider can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. If you were to encounter your therapist in any public place outside of therapy, your therapist will be careful to not acknowledge you or the relationship or engage in conversation in order to protect your privacy and confidentiality.

Available Services

River Walk Counseling, Inc. offers counseling services, including couples, families and individuals. Effective psychotherapy is founded on mutual understanding and good rapport between client and provider. It is our intent to convey the policies and procedures used in our practice and we will be pleased to discuss any questions or concerns you may have.

Risks and Benefits

Counseling and psychotherapy are beneficial, but as with any treatment there are inherent risks. During counseling, you will have discussions about personal issues, which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

Counseling Process

Your first visit will be an assessment session in which you and your provider will determine your concerns. If both agree that your provider can meet your therapeutic needs, a plan of treatment will be developed.

The goal of your provider is to offer the most effective therapeutic experience available to you. If at any time you feel that you and your current provider are not a good fit, please discuss this matter with your provider to determine if transferring to a more suitable provider is right for you. If you and your provider decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Our mission is to promote the growth of every client and hope that each individual, family and couple we serve discovers well-being, wholeness and greater life satisfaction.

Appointments

Appointment frequency will vary by client. Your first appointment will be approximately 1 hour long. Subsequent appointments will be approximately 50 minutes long. Frequency of appointments will be as determined is appropriate by you and your provider. If you must cancel or reschedule your appointment, we ask that you call our office at (218) 531-1424 at least 24 hours in advance. This will free your appointment time for another client.

Appointments that are missed without 24-hour notice will be recorded in the client's chart as "no show" and will be charge the standard missed appointment fee of $75. These fees are not covered by insurance and will be billed to the patient directly.

**Cancellations due to inclement weather or illness will not be charged a no-show fee.*

Telehealth/Telemedicine

When appropriate or necessary, your therapist may offer the option for telehealth psychotherapy. We utilize a secure, encrypted audio/video transmission software to deliver this service. All confidentiality laws remain in effect for telehealth services. You can improve your confidentiality by using headphones and a private space for your session. The risks and consequences of telehealth include the possibility that the transmission of services could be disrupted or distorted by technical failures and services and care may not be as complete as in person services. All policies and procedures for in-person therapy, as detailed in this document, also remain in effect for all telehealth therapy.

Emergencies

Our phones are answered during regular business hours; after hours you can leave a voice mail and we will try to return your call during the next business day. Remember if you are calling with an emergency, please hang up and dial 911 or go to the closest hospital emergency room. If this is a non-emergency and your therapist if unavailable, you can call the 24-hour Mental Health Crisis Response Team at 800-223-4512.

Fees

Psychotherapy	$ 180.00	per hour
Evaluations	$ 210.00	per hour*

**Court ordered evaluations must be paid by client in advance, these are not covered by insurance*

Court Testimony	$ 1,000.00	per half-day, plus mileage
Appointment No Show	$ 75.00	per missed appointment (without 24 hour notice)
Consultations	$ 100.00	per hour plus mileage
Couple's Counseling	$ 150.00	per hour paid at time of service if no insurance coverage

Payment/Insurance

Payment of fees, including any copays designated by your insurance company, are due at time of service. Any amounts not covered by your copayment or by insurance will be billed on a monthly basis. Clients who fail to pay or make payment arrangements will not be allowed to schedule appointments until payment arrangements are made. Payment arrangements must be made in writing and can be completed by any office staff member. It is the client's responsibility to be informed on their policy i.e. deductible, coinsurance, and co-pay.

A credit or debit card will need to be kept on file in order to process any unpaid financial responsibilities. River Walk Counseling, Inc. maintains PCI compliance to protect client information. Your card will only be charged for copayment, coinsurance, and deductible payments if payment is not made within two weeks of your monthly statement. Missed appointment fees will be charged within 3 business days following the missed appointment.

River Walk Counseling, Inc. participates with and are in-network with, most of the common insurance companies in our local area and are also listed as an EAP (Employee Assistance Program) provider. We will file insurance and EAP claims for you. It is your responsibility to keep us informed of any changes to insurance coverage.

Confidentiality

River Walk Counseling, Inc., along with your individual counselor, follow all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a provider and a client are confidential. To ensure your confidentiality, recording audio or video in our session without written consent is prohibited. No information will be released without the client's written consent unless mandated by law. If you have any questions regarding confidentiality, you should bring them to the attention of your provider to discuss further.

By signing this Information and Consent form, you are giving consent to the provider to share confidential information with all persons mandated by law and the insurance carrier responsible for

providing your mental health care services and payment for those services. You are also releasing and holding harmless the provider from any departure from your right of confidentiality that may result.

Duty to Warn/Duty to Protect

As a mandated reporter in the State of Minnesota, your therapist is legally obligated to violate confidentiality under the following circumstances:

- When the therapist has reason to suspect the client has been, or is currently, involved in the abuse or neglect of a child.
- When the therapist has reason to suspect that the client has been, or is currently, involved in the abuse or neglect of a vulnerable adult.
- If the client is a serious danger to themselves (suicidal) or a danger to someone else (homicidal)
- If a client reports sexual misconduct by another medical provider.
- A court order for specific information, signed by a judge in a pending legal case.

Other circumstances where confidentiality is waved/limited:

- Information (diagnosis and dates of service) shared with your insurance company to process your claims.
- When you sign a release of information to have specific information shared.
- Minor clients: parents and guardians do have legal right to access a minor client's records. Minor clients do have rights to complete confidentiality in obtaining counseling for pregnancies and associated conditions, sexually transmitted diseases, and information about alcohol or drug abuse.

Consent to Treatment

X_____
Client Name (Please Print)

By signing this Client information and Consent as the Client or Guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for myself (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. I understand that I am responsible, however for any balance for services rendered.

x_____
Client/Guardian Signature *Date:*

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X_____
Client/Guardian Signature *Date:*

I authorize the payment of medical benefits to the provider of services.

X_____
Client/Guardian Signature *Date*

I authorize the release of information to my emergency contacts listed on the Client Intake Form in the case of an emergency. I understand that this information may include diagnosis, records, or other information necessary to obtain emergency care.

X_____
Client/Guardian Signature *Date:*

I have read and understand the information provided regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent and authorization for the use of telemedicine by River Walk Counseling, Inc. in the course of my diagnosis and treatment as deemed appropriate.

X_____
Client/Guardian Signature *Date:*

Notice of Privacy Practices Acknowledgement

I acknowledge that I have received a written copy of the River Walk Counseling, Inc. Notice of Privacy Practices. I understand that this form will be part of my permanent record and I acknowledge that I have been allowed to ask questions concerning this notice. I understand this does not affect the care I receive at River Walk Counseling, Inc.

In accordance with the federal government HIPAA rules, please sign this form.

X_____
Client Name (Please Print)

X_____
Client Signature *Date:*

X_____
Parent/Guardian Signature *Date:*

X_____
Counselor Signature *Date:*

Credit Card Authorization

By signing below, I agree to have my credit card information stored securely by River Walk Counseling, Inc. until my file is closed. I also authorize River Walk Counseling, Inc. to charge this card for any outstanding financial responsibilities as described above.

X_____
Client Name (Please Print)

Name as it appears on card: _____

Card Number: _____

Expiration Date: _____ **CVC**: _____

Signature: _____

** This authorization form will be destroyed per PCI security standards.*

River Walk Counseling, Inc.

Client Intake Form **Date:**

Client Information

Client's Last Name First Middle			Mr.____ Mrs._____	Marital Status Single / Married / Other	
Is this your legal name? Yes_____ No _____	If not, what is your legal name?	(Former Name)		Birth Date:	Age: Sex:
Street Address or P.O. Box City State Zip Code				Social Security:	
Home Phone No. ( )	Cell Phone No. ( )			Work Phone No. ( )	
On what phone number may we leave a message? Home____ Cell_____ Work_____					
Occupation:		Employer:			
Referred to Provider by: Doctor_____ Insurance Plan_____ Website_____ Family_____ Friend_____ Close to Home/Work_____ Other_____					
Email Address:					

Insurance Information

Person Responsible for Bill:		Birth Date:		Home Phone:	
Address:		Social Security #:		Cell Phone:	
Email Address:				Work Phone:	
Is this client covered by insurance? _____Yes _____No		Is this an EAP visit: _____Yes _____No Authorization # (if known) _____			
Name of Primary Insurance:					
Insured's Name:	Insured's Date of Birth:		Insured's Social Security #:		
Policy Number:	Group Number:		Insured's Relationship to Client: _____Self _____Spouse ____Child ____Other		
Secondary Insurance (if any):		Policy Number:			
Client's Relationship to Insured: _____Self _____Spouse _____Child _____Other					

Emergency Contact

Name:	Relationship	Phone:
Name:	Relationship	Phone:

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____ Date_____

Date of Birth _____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease	( )	( )	_____
Anemia	( )	( )	_____
Liver Disease	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Kidney Disease	( )	( )	_____
Diabetes	( )	( )	_____
Asthma/respiratory problems	( )	( )	_____
Stomach or intestinal problems	( )	( )	_____
Cancer (type)	( )	( )	_____
Fibromyalgia	( )	( )	_____
Heart Disease	( )	( )	_____
Epilepsy or seizures	( )	( )	_____
Chronic Pain	( )	( )	_____
High Cholesterol	( )	( )	_____
High blood pressure	( )	( )	_____
Head trauma	( )	( )	_____
Liver problems	( )	( )	_____
Other	( )	( )	_____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason	Date Hospitalized	Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

	Dates	Dosage	Response/Side-Effects
Antidepressants			
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			
Mood Stabilizers			
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			
Sedative/Hypnotics			
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			
ADHD medications			
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other			
Antianxiety medications			
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Other			

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other			_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No

Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____

In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Please describe when, where and by whom: _____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____ Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

_____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

Signature _____ Date _____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____ Date _____

Reviewed by _____ Date _____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all	(#) _____	x 0 = _____
Several days	(#) _____	x 1 = _____
More than half the days	(#) _____	x 2 = _____
Nearly every day	(#) _____	x 3 = _____

Total score: _____

Interpreting PHQ-9 Scores

Minimal depression	0-4
Mild depression	5-9
Moderate depression	10-14
Moderately severe depression	15-19
Severe depression	20-27

Actions Based on PH9 Score

Score	Action
< 4	The score suggests the patient may not need depression treatment
> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	○0	○1	○2	○3
2. Not being able to stop or control worrying	○0	○1	○2	○3
3. Worrying too much about different things	○0	○1	○2	○3
4. Trouble relaxing	○0	○1	○2	○3
5. Being so restless that it is hard to sit still	○0	○1	○2	○3
6. Becoming easily annoyed or irritable	○0	○1	○2	○3
7. Feeling afraid, as if something awful might happen	○0	○1	○2	○3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

CAGE-AID Questionnaire

Patient Name: _____ Date of Visit: _____

When thinking about drug use, include illegal drug use and the use of prescription drugs other than prescribed.

Questions:	**Yes**	**No**
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

PCL-5

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

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

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household <u>often</u>:

   Swear at you, insult you, put you down, or humiliate you?

   Or

   Act in a way that made you afraid that you might be physically hurt?

   ☐ Yes ☐ No If Yes, enter 1 _____

2. Did a parent or other adult in the household <u>often</u>:

   Push, grab, slap, or throw something at you?

   Or

   Ever hit you so hard that you had marks or were injured?

   ☐ Yes ☐ No If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you <u>ever</u>:

   Touch or fondle you or have you touch their body in a sexual way?

   Or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   ☐ Yes ☐ No If Yes, enter 1 _____

4. Did you <u>often</u> feel that:

   No one in your family loved you or thought you were important or special?

   Or

Your family didn't look out for each other, feel close to each other, or support each other?

☐ Yes ☐ No If Yes, enter 1 _____

5. Did you <u>often</u> feel that:

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   Or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   ☐ Yes ☐ No If Yes, enter 1 _____

6. Were your parents <u>ever</u> separated or divorced?

   ☐ Yes ☐ No If Yes, enter 1 _____

7. Were any of your parents or other adult caregivers:

   <u>Often</u> pushed, grabbed, slapped, or had something thrown at them?

   Or

   <u>Sometimes or often</u> kicked, bitten, hit with a fist, or hit with something hard?

   Or

   <u>Ever</u> repeatedly hit over at least a few minutes or threatened with a gun or knife?

   ☐ Yes ☐ No If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   ☐ Yes ☐ No If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   ☐ Yes ☐ No If Yes, enter 1 _____

10. Did a household member go to prison?

    ☐ Yes ☐ No If Yes, enter 1 _____

ACE SCORE (Total "Yes" Answers): _____