THE ART OF LIVING
COUNSELING CENTER

Date_____ Therapist_____

Client Information:

Full Name_____Age_____ Sex: M F DOB_____ SSN_____

Address_____City_____State_____Zip_____

Home Phone (___)_____Work Phone(___)_____Cell Phone(___)_____

Email Address_____

Emergency Contact _____Relationship_____Phone_____

Who Referred you?_____

Medications and dosages_____MD Prescribing_____

Payment Information:

Please circle one: Self Pay Insurance

Insurance Information: (skip if self pay)

Insurance Company_____ Identification #_____

Insured's Name_____ Group #_____

Insured's SS# _____ Insurance Address & phone #

Insured's DOB_____ _____

Insured's Employer_____ _____

Client's relationship to the insured: (circle) self wife husband child other

Name of parent or guardian responsible for bill (if other than client):

Name_____Address_____

Home Phone_____Work Phone_____

I guarantee payment for services rendered to me.

_____ Date_____

I **authorize payment of medical services to undersigned physician or supplier for services.**

_____ Date_____

I authorize the release of any medical information necessary to process the claim for services rendered.

_____ Date_____

Deductible _____

For office use only: DSM AXIS I _____ _____ _____ Co-pay _____

900 Pyott Road, Suite 102
Crystal Lake, IL 60014
815.444.9076

Therapy Information - Read Carefully

Description of Treatment Offered
Counseling (individual, family, or group) consists of discussions between the client(s) and the therapist that are designed to understand the client's immediate problems and symptoms and to develop a plan that will aid in resolving these problems. Counseling has potential benefits (e.g. improvement in identified problems, increase insight or understanding or increase skills to assist in coping) and potential risks (e.g. experiencing strong emotions, changes in ways of relating, or feeling worse before feeling better). Due to the variety of conditions that make therapy successful, no guarantees of outcomes can be made. Please discuss any concerns about treatment with your therapist. Your therapist may also suggest or recommend that you be seen for a psychiatric evaluation or psychological testing is the therapist believes this will improve your progress in therapy.

Appointments and Fees
Appointments are scheduled by each individual therapist for specific dates and times**. You must provide at least 24 hours notice of cancellation or you will be billed for the full session fee.** Insurance companies cannot be billed for late cancellations or missed appointments. Payment for the missed sessions is due at the rescheduled appointment unless other arrangements are made with your therapist. Your therapist will discuss any questions you may have regarding the fees for service during your first session. Payment in full, or the client's deductible or copayment, is due at the time of service (i.e. at each session). You are responsible to know your benefits. Please complete a *check your benefits form* so you are aware of your benefits. A $25.00 fee will be charged for any returned checks. An administrative fee of $25.00 will be applied to any past due accounts. Past due accounts will be sent to a recovery service and any fee incurred will be the client's responsibility. Should you desire for us to send a bill to your insurance company, you must complete and sign a credit guarantee form. There is a 3% processing fee for all credit card payments. Please discuss and questions or concerns with your therapist.

Confidentiality
You treatment is confidential within the limits prescribed by law. In general, no information will be released without your written consent. Relevant laws, however, require you therapist to contact others if you appear to be in danger to yourself or to someone else, if your therapist learns about child abuse/neglect, or if ordered by a court.
If you (client) are under 12 years of age, your therapist may discuss your treatment with your parent or legal guardian. If you are between 12 and 18 years of age, your therapist may discuss your case with you parent or legal guardian with your consent. If you are engaging in behavior that your therapist believes places you in danger of harming yourself or others your therapist will help you to discuss this with your parent or legal guardian.
Your therapist may consult or review you case with other therapists within The Art of Living Counseling Center to improve the quality of your treatment. Information may also be released to insurance companies or their agents (i.e. manage care) if you are using these benefits.

Disclosure Regarding Third-Party Access to Communications
Please know that if we use electronic communications methods – such as email, texting, online video – there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others.
Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND THE INFORMATION ABOVE.

Client (print name) _____Signature_____Date_____

Parent/Guardian _____Signature_____Date_____

Therapist Name _____Signature_____Date_____

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Notification to Primary Physician of Client Receiving Mental Health Services

Pursuant to Illinois law, you are informed that it is desirable that you confer with your primary care physician, if you have one. If you have a primary care physician, I am required to notify him or her that you are seeking mental health treatment unless you waive such notification. Please indicate your wishes:

☐ Yes, I would like you to notify my primary care physician that I am seeking or receiving mental health services. My signature below serves as an authorization to release information and permitting you to communicate with my said physician and share and release information to him or her regarding my receiving treatment.

☐ My Primary Care Physician _____
Office Address _____

_____

Phone Number _____

☐ I WAIVE NOTIFICATION of my primary care physician that I am seeking or receiving mental health services and I direct you NOT to notify him or her.

I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a primary care physician that I am seeking or receiving mental health services.

Date_____ _____
Client Signature

_____
Parent/Guardian Signature

Notice of Privacy Practices

The notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who will follow this notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use And Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your Name, address, office visit dates, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use and disclose medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Care Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and disclosures of protected health information requiring your written authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will therefore no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Office at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to request restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to request confidential communications. You have a right to request how we should send communications to you about medical maters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request is it imposes an unreasonable burden on the practice.

Right to inspect and copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiles for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of coping, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcomes of the review.

Right to amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment is it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an accounting of non-standard disclosures. You have the right to request a list of disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before June 1, 2004. Your request should indicate in what form you want this list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to copy this Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request on in writing from the Privacy Officer at this practice.

Changes to this Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effected for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND THE INFORMATION CONTAINED IN THIS NOTICE. I FURTHER UNDERSTAND THAT I MAY REQUEST A COPY OF THIS NOTICE AT ANY TIME.

Client: _____Date_____ Parent/Guardian _____Date_____

900 Pyott Road, Suite 102
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815.444.9076

Fees For Services

Initial Diagnostic Evaluation (CPT Code 90791)	$210.00
Individual Counseling 55 min (CPT Code 90837/90834)	$130.00
Family Counseling 45-50 min (CPT Code 90847)	$160.00
Marital Counseling 45-50 min (CPT Code 90847)	$160.00
Group Counseling (CPT Code 90853)	$60.00
Consultation (i.e.. school staffing, court appearance) $150.00 per hour including travel time, contact hours, and time for documentation preparation)	
Missed Appointment or Late Cancelation	$130.00

All scheduled sessions may be cancelled with an actual 24 hours notice with no charge. Any appointments not cancelled within that time frame will be charge $130.00. Missed appointments can not be billed to an insurance carrier and the full amount of the missed session is due at next scheduled appointment or will be charged to designated credit card.

All prices are subject to change.

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artoflivingcounseling.com
815.444.9076

Credit Guarantee Agreement

Insurance Assignment: As a courtesy to you, we will bill your insurance company on your behalf. Please remember that **you** are ultimately responsible for payment. At the time of service, full payment for services OR your responsibility portion (deductible, co-pay, or co-insurance), is due. Please call your insurance company and complete an *AOL insurance pre-determination of benefits* form found on our website, to determine your responsibility should you desire to use insurance. We will submit claims and any portion of the bill that is not paid by your insurance company within 60 days will be charged to your designated credit card.

Personal Balances: Payment is due at time of service. Any balances due past 60 days will be charge to your designated credit card.

Missed Sessions/Cancelations: Any missed session or cancelations without a 24 hour notice will be automatically billed to your credit card. Please complete and sign below.

Credit Card (circle): Visa Master Card Discover

Cardholder Name: _____

Credit Card Number: _____

Expiration Date: _____

Security Code (3 numbers on back of card): _____

Email my receipt to: _____

* All credit card charges are subject to a 3% processing fee.

I agree to the terms above and authorize you to bill my credit card for unpaid balances due.

_____ _____

Signature Date

Should you desire to use your insurance benefits, please call your insurance and complete the following form.

900 Pyott Road, Suite 102
Crystal Lake, IL 60014
815.444.9076
NPI # 1235253824
Insurance pre-determination of Benefits

PLEASE COMPLETE THIS FORM AND FAX TO US AT 815.444.9079

Client's Name_____ DOB _____
Insured Name_____ DOB _____
Insured Place of Employment _____
Insurance Company _____
ID Number_____ Group Number _____
Insurance Phone Number _____
CALL YOUR INSURANCE COMPANY AND ASK THEM THE FOLLOWING QUESTIONS TO DETERMINE YOUR BENEFITS:

1. Ask if your therapist and *The Art of Living Counseling Center* is considered in or out of network.
   IN-NETWORK _____ OUT OF NETWORK_____
2. Ask if your benefits are managed by any other manage care company. YES ___ NO ____If so who? _____
3. What is your effective date? _____
4. Do you have a pre-existing clause? YES _____ NO _____ If yes, until when? _____
5. Ask them what your benefits are for outpatient mental health in an office setting. Ask if you have separate levels of benefits for SERIOUS and NON-SERIOUS diagnosis.YES___NO____
6. What is your INDIVIDUAL deductible? _____ FAMILY deductible? _____
7. If you have a deductible, how much of it is met this year? _____
8. Do you have a co-payment? YES ____ NO____ How much? _____
9. Do you have a co-insurance (Percentage that you are responsible for)? YES ____ NO _____ How much? ___
10. Do you have coverage for the following services and CPT codes?
    a. INITIAL DIAGNOSTIC EVALUATION (CPT code 90791) YES ___ NO ___
    b. INDIVIDUAL COUNSELING 55 min (CPT code 90837) YES___ NO ___
    c. INDIVIDUAL COUNSELING 35 min (CPT code 90834) YES ___ NO ___
    d. FAMILY/MARITAL COUNSELING (CPT code 90847) YES ___ NO ___
    e. GROUP COUNSELING (CPT code 90853) YES ___ NO ___

11. How many session do you have yearly? _____ Lifetime? _____
12. How many of those session are already used? _____
13. Do you need pre-authorization for treatment? YES ___ NO ____
14. If yes, how many sessions are authorized? _____
15. What is the authorization number? _____
16. Where does your insurance company want their claims to be sent?

_____

PLEASE BRING YOUR INSURANCE CARD WITH YOU TO YOUR FIRST SESSION SO WE CAN MAKE A COPY OF IT.

AS A REMINDER, ALL DEDUCTIBLES, COPAYS, AND CO-INSURANCE AMOUNTS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND CREDIT CARDS.

THANK YOU!

THE ART OF LIVING
COUNSELING CENTER

Client Questionnaire

Client Name _____ Date_____
Please explain why you are seeking our services at this time. As specifically as possible, describe the problem:

How long have you been experiencing these problems?

How are they affecting you daily life? Are there any limitations because of these problems?

How would you like us to help you with this problem?

Is this an emergency situation? Yes No
Are you currently suicidal? Yes No
Have you ever been suicidal before? Yes No Have you ever made an attempt? Yes No

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Are you currently under the care of any other Therapist, Physician or Psychiatrist? Yes No
Who?
For what reasons?

Do you attend any support groups? Which ones? Yes No

Have you ever seen a therapist, psychiatrist or counselor before? Yes No
For what reasons?
Where and when?
Was it helpful?
Have you ever participated in an outpatient program at a hospital or been hospitalized for psychiatric reasons before? Yes No
For what reasons?
Where and when?
Was it helpful?
Are you currently taking medication for anxiety, your nerves, depression, or other mental health or emotional problems? Yes No
Name of Physician who prescribed it:
What medications and dosages?
For what reasons and how long have you been on it?
Was it helpful?

Do you have any significant health problems that your therapist should know about? (Specify)
Yes No

When was your last medical examination? ____/___/____

Background Information:

Are you: Single Divorced In a committed relationship
Married Separated Remarried Widowed

Do you live: Alone With a roommate With my significant other
Parents At school With my family/spouse

What is your race/ethnic origin? (optional)
Caucasian American Indian Other: _____
African American Asian
Hispanic Bi-racial

Do you have children? Yes No Please list their names and ages: _____
_____

What level of education have you completed?

Do you have any specialized education or training?

Are you employed? Yes No
What kind of work do you do?
How long have you held this job?
Do you like what you do?

Do you have any spiritual issues/concerns that your therapist should know about? Yes No (specify)

Are there any particular family problems or situations recently or currently that are influencing your life at this time? Yes No (specify)

Is there any family history of mental health or emotional problems? Yes No (specify)

Is there any family history of alcohol or substance abuse? Yes No (specify)

Do you have any specific early childhood events, illness or problems that your therapist should know about?
Yes No (specify)

Directions: Please read and answer the questions below regarding specific problems or symptoms. If you respond YES to the numbered questions, please complete the additional questions in that section. If you answer NO to the numbered question, please skip to the next numbered question. Feel free to add any comments as needed.

1. Would you describe your mood as generally sad, down in the dumps or depressed? Yes No

If Yes: For how long? _____

Is your mood (circle all) : sad anxious irritable other _____

Have you ever been treated for depression?	Yes	No
Have you experienced a significant change or loss within the past 12 months?	Yes	No
Have you ever experienced an episode like this before?	Yes	No
Do you have trouble being happy or enjoying things that use to bring you joy?	Yes	No
Have you experienced any weight loss or change in your appetite?	Yes	No
Do you have difficulty falling asleep or staying asleep?	Yes	No
Do you find yourself without energy or easily fatigued?	Yes	No
Do you have feelings of worthlessness or guilt?	Yes	No
Do you have difficulty with concentration or indecisiveness?	Yes	No
Do you think about death or have suicidal thoughts currently?	Yes	No
Have you ever made a suicide attempt before?	Yes	No

2. Would you describe your mood as euphoric, irritable, or beyond your normal? Yes No

If yes: For how long? _____

Have you ever been treated for manic-depression (Bipolar) before?	Yes	No
Have you ever experienced a manic episode before?	Yes	No
Have you ever experienced a depressive episode before?	Yes	No
Do your thoughts race?	Yes	No
Do you need less sleep than you usually do?	Yes	No
Do other people tell you that you talk too fast or they can't get a word in?	Yes	No
Are you more destructible or have trouble paying attention than usual?	Yes	No
Are you finding yourself more productive that usual?	Yes	No
Are you finding that you are more impulsive and/or making risky choices?	Yes	No

3. Have you ever seen things others couldn't or heard things others couldn't? Yes No

If Yes, were you treated for it? Yes No

4. Do you experience episodes of anxiety, panic or fear in daily life? Yes No

If yes: For how long? _____

Have you ever been treated for anxiety, panic or related problems?	Yes	No
Have you ever experienced an anxiety or panic attack?	Yes	No

Have you ever experience the following symptoms during an anxiety or panic attack?

racing heart	feel unreal	shortness of breath
sweating	faint or dizzy	fear of dying
choking	chest pain	fear of going crazy
shakiness	nausea	fear of loosing control

Do you have anxiety about being in situations or places where leaving might be difficult, embarrassing, or where you might have an anxiety or panic attack? Yes No
Do you change your plans or avoid situations or activities because of anxiety? Yes No
Do you worry about having an anxiety or panic attack? Yes No
Do you have fears about certain objects or situations? Yes No
Do you think your fear is excessive or unreasonable? Yes No
Do you worry about reactions of others or being humiliated in front of others? Yes No
Would you describe yourself as generally anxious or worried about a number of events or situations in your life? Yes No

5. Do you find yourself having recurrent thoughts or impulses that won't go away and/or repetitive behaviors or actions (including praying, counting, etc.) in response to your thoughts? Yes No

If Yes: For how long? _____

Have you ever been treated for obsessional thinking or compulsive behaviors? Yes No
Do you have specific thoughts that recur, and won't go away? Yes No
Do you have specific behaviors that you feel you have to do? Yes No
Do you experience significant fear or anxiety if these behaviors do occur? Yes No
Do other people tell you that your behaviors are strange or odd? Yes No
Do you wash your hands, or clean a great deal to manage feelings? Yes No
Do you check things repeatedly as a behavior to manage feelings? Yes No
Do you count things as a behavior to manage feelings? Yes No

6. Have you experienced a traumatic event or series of events in your life, or been emotionally, sexually or physically abused? Yes No

If Yes: Approximately, at what age or ages did this occur? _____

Do you experience recurrent or intrusive distressing thoughts about it? Yes No
Do you experience intense fear or helplessness when faced with situations that seem familiar or similar? Yes No
Do you ever feel like the events were happening again? Yes No
Do you seem to lose time or have unexplained periods of time? Yes No
Have you ever experienced a flashback? Yes No
Do you experience emotional numbness and feeling disconnected? Yes No
Do you avoid things because they remind you of the traumatic event? Yes No
Are you always on guard for things to go wrong? Yes No
Do you use food as a way to manage feelings? Yes No
Do you use alcohol or drug to manage feelings? Yes No
Do you ever self-injure (cut, burn, scratch, etc.) to manage feelings? Yes No

7. Have you been told that you are too thin, or do you have a great fear of becoming fat? Yes No

If Yes: Have you ever been treated for anorexia before? Yes No
Do you work to keep your weight low, or keep trying to lose more weight? Yes No
Has your period stopped? Yes No
Do you maintain a limited diet? Yes No
What do you restrict?
Do you exercise to manage your weight? Yes No
What do you do and how often?

Do you ever binge? Yes No
Do you use diuretics, laxatives or diet pills/products to lose weight? Yes No
Do you use alcohol or drugs as a way to manage feelings? Yes No
Do you ever self-injure (cut, burn, scratch, etc.) to manage feelings? Yes No

8. Do you have episodes of binge eating? Yes No

If yes: Have you ever been treated for compulsive overeating or bulimia? Yes No
Do you experience a feeling of being out of control with food? Yes No
Do you try to prevent weight gain after eating? Yes No
What do you restrict?
Do you exercise to manage your weight? Yes No
What do you do and how often?
Do you use diuretics, laxatives or diet pills/products to lose weight? Yes No
Do you use alcohol or drugs as a way to manage feelings? Yes No
Do you ever self-injure (cut, burn, scratch, etc.) to manage feelings? Yes No

9. Do you gamble? Yes No

If Yes: Have you ever tried to stop or cut down? Yes No
Are you preoccupied with gambling? Yes No
Do you gamble to escape your problems? Yes No
Do you ever lie to people to hide your losses or extent of gambling? Yes No
Has your gambling ever caused you financial trouble? Yes No
Have you ever done anything risky or illegal to get money to gamble? Yes No

10. Do you use alcohol? Yes No

During an average week, how much alcohol do you consume?
When was your last drink? How much did you consume?
When was the last time you were under the influence?

11. Do you use street drugs, IV drugs or prescription drugs (beyond their prescribed use)? Yes No

What do you use?
How much and how often?
When was the last time you used?

12. Do you use drugs or alcohol to help you manage or cope with life? Yes No

If Yes: Have you ever been treated for substance abuse? Yes No
Have you noticed that you need more to get the desired effect? Yes No
Do you have withdrawal symptoms? Yes No
Do you use anything to help you manage the withdrawal symptoms? Yes No
Do you ever end up using mare or longer that you had intended? Yes No
Have you ever tried to cut down or know that you should but can't? Yes No
Do you spend a great deal of time and effort to get the drug? Yes No
Do you have hangovers? Yes No
Do you miss work or other events because of hangovers or use? Yes No
Do you continue to use even though you have noticed physical problems? Yes No
Have your substance use caused problems with family members or friends? Yes No

Do you have blackouts?	Yes	No
Have you ever had a DUI?	Yes	No
Have you had other substance related legal problems?	Yes	No

Please answer the questions YES if the question "fits" you, and NO if it doesn't. There are no right or wrong answers.

I THINK THAT I AM, OR PEOPLE CLOSE TO ME WOULD DESCRIBE ME OR SAY THAT:

What I think or how I think about things can be distorted or not true.	No	Yes
I have been told that I overreact to things.	No	Yes
I have been told that I am moody or temperamental.	No	Yes
I have trouble managing personal relationships.	No	Yes
I can be impulsive, not always in a good way.	No	Yes
I distrust people or am suspicious about others intentions.	No	Yes
I am too trusting.	No	Yes
I hold grudges.	No	Yes
I am too forgiving.	No	Yes
I don't want or enjoy close relationships, I'd rather be alone.	No	Yes
I can't stand being alone.	No	Yes
I don't have many close relationships.	No	Yes
I want to be loved by others.	No	Yes
I want to be loved by others, but I am scared by it too.	No	Yes
I care about what people say about me.	No	Yes
I don't care what people say about me.	No	Yes
I really don't care about what the rules are.	No	Yes
I don't like getting in trouble.	No	Yes
I don't like getting consequences for my behaviors (getting in trouble).	No	Yes
I plan things out before I do them.	No	Yes
I like to do risky or dangerous things.	No	Yes
I am irresponsible or reckless and had difficulties because of it.	No	Yes
I feel guilty about things in my life.	No	Yes
I don't have regrets.	No	Yes
My friendships don't seem to last very long.	No	Yes
I don't know who I really am.	No	Yes
I don't think I am a valuable or worthwhile person.	No	Yes
I have low self esteem.	No	Yes
I am good at a lot of things.	No	Yes
I like being the center of attention.	No	Yes
I want people to pay attention to me. I like it.	No	Yes

People say I do things just for attention.	No	Yes
People think I don't have any problems. I am good at keeping things private.	No	Yes
I am good at making things work around me, I am a good problem solver.	No	Yes
If people really knew me, I'm afraid they wouldn't like me.	No	Yes
Compared to others, I can do many things faster, better and more effectively.	No	Yes
I'd be lost without my spouse/partner/significant other.	No	Yes
I have to be in a relationship in order to feel good about myself.	No	Yes
People say I am rigid or inflexible.	No	Yes

Is there anything else you would like your therapist to know?