DBT Institute of Michigan
Providing Evidence-Based Practice to build lives worth living

Welcome to the DBT Institute of Michigan. As a new client we ask that you print out the forms below and bring them, completed, with you for your assessment appointment. If you are unable to print this packet we'd be happy to mail one to you.

Check list to bring:

- Client Registration Information
- Client Medical Information
- Release of Information
- Emergency Medical Information
- Consent To Use or Disclose Protected Health Information
- Consent To Treatment
- Insurance, Payment and No-Show Policy
- Credit/Debit Card Payment Authorization (optional)
- Audio/Videotape Consent Form
- HIPPA Privacy Policy
- Crisis Safety Plan
- Borderline Symptom List 23 (BSL-23)
- Life Problems Inventory (LPI)
- Symptom Questionnaire
- Insurance card(s)
- Driver's License and/or State issued ID and/or School ID (if minor is in possession of one)
- If the client is a minor, with divorced parents, a copy of the court documents showing legal custody.

Thank you!

4205 Charlar Dr., Ste. 3, Holt, MI 48842 23995 Novi Road, Ste. C-101, Novi, MI 48375
Phone: 517-367-0670 Fax: 517-367-0681 Web Page: dbtimi.com Email: adminstaff@dbtimi.com

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CLIENT REGISTRATION INFORMATION

Full Legal Name:	Nick Name or Preferred Name:	Gender:
Home Street Address:	Home City/State/Zip:	Date of Birth:
Preferred Phone Number: Cell/Home/Work	Secondary Phone: Cell/Home/Work	Marital Status:
The DBT Institute of Michigan may leave messages on the phone line, listed directly above, regarding appointments, billing or other items regarding my care: Y or N	The DBT Institute of Michigan may leave messages on the phone line, listed directly above, regarding appointments, billing or other items regarding my care: Y or N	Email Address:
If minor, parents and/or guardians name:	If minor, parents and/or guardians phone:	** If minor's parents are divorced, provide a copy of legal documents to show who has legal custody **

Whom do you or the minor client live with:

Name:	Relationship to you:	Age:

PAYMENT RESPONSIBILITY INFORMATION:

Person responsible for payment and relations to client:	Phone:	
Person responsible for payment home address:	Employer:	
Insurance company:	Phone number on the back of the insurance card:	
Name of policy holder on insurance card:	Address on the back of the insurance card:	
Policy number:	Group number:	Date of birth of policy holder:

(continued on next page)

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SECONDARY INSURANCE (If applicable):

Person responsible for payment and relations to client:	Phone:	
Person responsible for payment home address:	Employer:	
Insurance company:	Phone number on the back of the insurance card:	
Name of Policy Holder on insurance card:	Address on the back of the insurance card:	
Policy number:	Group number:	Date of birth of Policy Holder:

I hereby authorize payment directly to the DBT Institute of Michigan (DBTIMI), PLLC, of all insurance benefits otherwise payable to me for services rendered. I understand that I'm financially responsible for all charges whether or not paid by insurance, for all services on my behalf or my dependents. I understand that insurance Explanation of Benefits (EOB) will be sent to the policy holder and may include service information. I authorize the above providers/supplier of services at DBTIMI to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Client/Parent/Guardian Date

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EMERGENCY MEDICAL INFORMATION

Full Legal Name:	Nick Name or Preferred Name:	Gender:
Home Street Address:	Home City/State/Zip:	Date of Birth:
Preferred Phone Number: Cell/Home/Work	Secondary Phone: Cell/Home/Work	Marital Status:
The DBT Institute of Michigan may leave messages on the phone line, listed directly above, regarding appointments, billing or other items regarding my care: Y or N	The DBT Institute of Michigan may leave messages on the phone line, listed directly above, regarding appointments, billing or other items regarding my care: Y or N	Email Address:
If minor, parents and/or guardians name:	If minor, parents and/or guardians phone:	** If minor's parents are divorced, provide a copy of legal documents to show who has legal custody **

Whom do you or the minor client live with:

Name:	Relationship to you:	Age:

Employer Name:

Emergency Contact Name:	Emergency Contact Primary Phone:	Emergency Contact Secondary Phone:

Emergency Contacts Employer Name and Location:

Client's Car Make & Model:	Color:	License Plate Number:
Psychiatrist Name:	Psychiatrist Phone Number:	Which hospital do you prefer:

If the client has been hospitalized for psychiatric reasons please list the dates, length and reason:

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CLIENT MEDICAL INFORMATION

Full Legal Name:	Date of Birth:	Gender:
Psychiatrist Name:	Psychiatrist Phone Number:	Psychiatrist Address:
How often to you see your psychiatrist:		
Primary Doctor's Name:	Primary Doctor's Phone Number:	Primary Doctor's Address:
How often to you see your primary doctor:		

List all current medications:

Medication	Dosage	Frequency	Additional Information

List any allergies:
List any health issues:
If the client has been in therapy before please list the name of the therapist(s), date(s) seen and length of treatment (This is for informational purposes only. We can't contact anyone without your written permission):

I understand that therapists are mandated reporters and in the event of harm or threat of harm to myself or other they are required by law to report this information. I understand that in the event of suicidal threat and/or intent my therapist will need to contact my designated contact person and/or local authorities.

_____ _____

Signature of Client/Parent/Guardian Date

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RELEASE OF INFORMATION

CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Federal Standards requires The DBT Institute of Michigan, PLLC to inform you of its privacy practices before using or disclosing your protected health information to carry out treatment, payment or health care operations (45 CFR § 164.506). Your consent to The DBT Institute of Michigan, PLLC does not allow any other covered health care person or organization to use or disclose your protected health information.

You may revoke this consent in writing at any time, except to the extent that The DBT Institute of Michigan, PLLC has already acted on this consent.

The DBT Institute of Michigan, PLLC reserves the right to change its privacy practices. You have a right to ask your therapist to restrict how your protected health information is used or disclosed for treatment, payment or health care operations. The DBT Institute of Michigan, PLLC is not required to agree to every restriction you request. If your therapist does agree to a restriction, the restriction is binding on them.

We may refuse to release information to a 3rd party, even if a signed consent form is on file with either party, if it is determined by your individual therapist at The DBT Institute of Michigan to be detrimental to the progress of your treatment.

Please list any restrictions on uses or disclosures you are requesting:

I authorize The DBT Institute of Michigan, PLLC to disclose, release, or obtain to the following individuals, organizations, or parties, if necessary, my protected health information for treatment purposes:

_____No One **_____Only the Following** (Please initial choice)

Individual or Agency:_____

Address & Phone Number:_____

_____ This person has permission to only have information regarding and/or to make financial payments.

_____ This person has permission to only have information regarding and/or scheduling appointments.

This authorization will expire on:

Specific Date:_____ On Termination of Therapy:_____

Other Reason:_____

_____

Signature of Client/Parent/Guardian **Date**

_____

Printed Name of Client **Printed Name of Parent/Guardian**

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CONSENT TO TREATMENT (1/2)

PURPOSE: "Provide psychotherapeutic services to those in need."
GOAL: "Improve mood, behaviors and general functioning to enhance quality of life."
TECHNIQUE: "Evidence-Based and other researched therapy (counseling) techniques. Within the parameters of ethical and acceptable therapy practice, we have relationships with our clients that are real relationships between equals and will act in the client's best interest."

A DBT client is offered access to their therapist on an as needed, on-call basis for purposes of skills coaching, crisis or suicide prevention, or relationship repair. On-call options include the use of texting toward this end. I understand the use of texting reduces the protection of my privacy as others may have access to my own text messaging. I will discuss with my therapist any concerns I may have with this mode of communication.

I am aware that the development and review of the process, or of a Treatment Plan, is in my best interest and may be required by governmental, funding, accrediting or other agencies and I agree to actively participate in this process.

I acknowledge I have received, read and understand the HIPAA form.

I am aware that the practice of psychotherapy or counseling is not an exact science, so predictions of the effects and effectiveness are neither precise nor guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by The DBT Institute of Michigan, PLLC.

I am aware that DBT is a team oriented therapy and my therapist may need to consult with other members of the team if necessary to discuss my treatment.

Telephone consultation is a mode of treatment employed for skills coaching, suicide protocols, relationship repair, or good news practice. It is not intended to replace emergency medical treatment if such treatment is deemed necessary. Therapists do their best to answer within a reasonable time frame, but unforeseen circumstances or other determined contingencies may prevent prompt or timely reply. I understand that I am to reach out to emergency services if I engage in life-threatening behaviors, and that telephone consultation is not a life-saving service.

In the event of the loss of your therapist to death, leaving the practice, etc., your files will be reviewed and handled by one of the licensed owners of the DBT Institute. You will be referred to another therapist within the DBT Institute or to an outside agency for services. The DBT Institute will make every consideration possible to have this done in a timely manner, dependent on remaining therapist availability.

I am aware that I may terminate my treatment at any time without consequence, but that I will still be responsible for payment for the services I had received.

I am aware that any cancellations of appointments must be made more than 24 hours in advance of the appointment and that if I do not cancel and do not show up <u>I will be charged a cancellation fee</u>. I understand that the charge for a missed appointment is my responsibility and that my insurance company will not pay for this.

I am aware that if I have not paid for services received, reach a cash balance of $250.00, and have not made payment arrangements, The DBT Institute may discontinue my treatment by instituting a DBT vacation from therapy. I also understand that if I neglect to take care of any balance, the DBT Institute may seek outside collections services to collect the balance, and any additional fees will be assessed to my account.

I am aware that neither this office nor any therapist is responsible for any personal property or valuables I bring into its facilities. I acknowledge that, if I or anyone else for whom I am legally responsible, deliberately causes damage or steals any property of this office, I will be held financially responsible for its replacement.

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CONSENT TO TREATMENT (2/2)

In the event of a minor receiving service from The DBT Institute of Michigan, I am aware documentation of legal custody and or guardianship may be required. Also, transportation of minors to and from the DBT Institute facility is the responsibility of the legal guardians. The DBT Institute will not be responsible for any transportation issues or problems regarding minors.

I understand that if my minor child is receiving services, they are the primary client and as such hold the confidentiality of their therapist. I understand that information will not be automatically released to the parent or guardian, except as deemed necessary to secure the safety or well-being of the child or another identified person. I understand that if the minor child discloses information to their therapist of any type of abuse the therapist is mandated by law to report to an agency.

I understand that if I disclose to my therapist the intent to harm another person, or to end my life, that my therapist is mandated by law to take measures to inform appropriate authorities.

I do hereby seek and consent to participate in treatment with The DBT Institute of Michigan, PLLC. I certify, with my signature below, that I have read, had explained to me where necessary, fully understand, and agree with the contents of this Consent to Treatment.

_____ _____

Signature of Client/Parent/Guardian Date

_____

Printed Name of Client Printed Name of Parent/Guardian

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INSURANCE, PAYMENT AND NO-SHOW POLICY

The DBT Institute of Michigan, PLLC has a strict insurance, payment and no-show policy. Please read the following carefully and sign at the bottom if you agree to abide by this policy.

- If you plan on canceling your appointment (individual or group session), a 24-hour notice is required. Failure to provide a 24-hour notice of cancellation will result in a fee billed directly to you. Insurance companies are not responsible for late fees.
- Payment/co-pay is due AT THE TIME OF SERVICE.
- **You are solely responsible for understanding your insurance coverage as it relates to mental health services.** This includes knowing if your insurance covers your therapy sessions and how many (individual/group), your co-pay for each session and what your deductible is (if any). It is your responsibility to check with your insurance provider if your individual therapist or group therapist is an "in-network" or "out-of-network" provider.
- You will be held accountable to pay for sessions your insurance does not authorize.
- I understand if my outstanding cash balance reaches $250.00, I will need to make arrangements to get the balance paid or my therapist may institute a DBT vacation until the balance is paid.
- I understand if I do not make payment in a timely manner, my outstanding bill may be turned over to a collections agency.

If you have any questions or comments, please feel free to discuss this with your therapist.

_____

Signature of Client/Parent/Guardian Date

_____

Printed Name of Client Printed Name of Parent/Guardian

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CREDIT/DEBIT CARD PAYMENT AUTHORIZATION

As a courtesy, The DBT Institute of Michigan, PLLC offers you the option for fees to be applied directly to your credit/debit card. This form authorizes the DBT Institute of Michigan, PLLC to charge your credit/debit card for fees incurred.

Client Name (please print):_____

Name on Card (if different)(please print):_____

I authorize, by initialing below, the DBT Institute of Michigan, PLLC to keep my signature on file and charge my credit/debit card account for:

_____Session fee/copay/coinsurance for appointments attended
_____No show fees for missed appointments (with less than 24 hour notice)
_____Balance of charges not paid within 90 days

Type of Card: _____Visa ____MasterCard _____Discover _____American Express

Credit/Debit Card Number: _____-_____-_____-_____

Expiration Date: _____ CVV Number: _____

Card holder's billing address for credit card statements:

_____

Street City State Zip Code

I understand that by signing this form the DBT Institute of Michigan will automatically charge my card once fees are put onto my account. I understand this information will be kept confidential and I may revoke this agreement at any time by written request.

Card Holder's Signature: _____ Date: _____

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AUDIO/VIDEOTAPE CONSENT FORM

I agree to (audio/video) taping at The DBT Institute of Michigan, PLLC for therapeutic or training purposes.

I also understand my therapist at The DBT Institute of Michigan, PLLC will keep these recordings confidential unless of:

a) threats of suicide made by patient
b) threats of homicide made by patient
c) any lawsuit filed against one of the therapists at The DBT Institute of Michigan, PLLC
d) training performed by therapists of The DBT Institute of Michigan, PLLC

Recordings may be kept by The DBT Institute of Michigan, PLLC for two years and will then be erased.

By signing below, I consent to having sessions audio/videotaped

_____ _____
(Signature) (Date)

_____ _____
(Parent/Guardian Signature if Under 18) (Date)

_____
(Print Name of Child)

I also understand that at any point I wish to withdraw this consent, I may do so by signing and dating below.

_____ _____
(Signature) (Date of Withdrawal)

_____ _____
(Parent/Guardian Signature if Under 18) (Date of Withdrawal)

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HIPAA PRIVACY POLICY

When you sign our Consent for Treatment and fee agreement, you are giving us permission to release your personal health information for the following purposes:

1. Treatment: for your initial therapist, or anyone from the DBT Institute of Michigan therapeutic team to provide back-up, crisis coverage, or consultation regarding your care.
2. Payment: Any necessary information required by insurance companies for treatment authorizations, payment approvals, and billing needs according to your current policy. If you are requiring payment be made by someone other than yourself or an insurance company, you will need to provide a signed consent form allowing the DBT Institute billing department to communicate with that person(s).

If you want anyone other than yourself to be able to schedule appointments or discuss payment or scheduling issues you will need to sign a Consent for Release of Information form.

Exceptions where confidential information may be released without your consent would involve:
Any form of abuse for minors or the elderly.
Any suicidal or homicidal threats or behaviors to yourself or others.
Licensing board investigations.

Patients' Rights: You have the right to:
- Put restrictions on disclosures
- Request confidential information (billing, etc.) be sent to alternate locations to protect your privacy
- Receive a listing of disclosures made
- Request and receive a full copy of the privacy policy
- Submit a request to inspect, copy, or amend your records (in coordination with your therapist, see below)
- Right to restrict disclosures when you have paid out of pocket for your treatment
- To be notified if there is a breach of confidentiality regarding your information that violates HIPAA Privacy Rules

Therapists' Responsibilities: Under HIPAA your therapist has the right to deny your request to inspect, copy, or amend your records, but will make every reasonable effort to discuss this with you.

Privacy Complaints: If you feel your privacy rights have been violated please contact our office at the Holt office numbers listed at the bottom of this page.

Effective Date: July 1, 2016

KEEP THIS PAGE FOR YOUR RECORDS

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HIPAA PRIVACY POLICY SIGNATURE PAGE

I have received and read the HIPAA Privacy Policy and understand my privacy rights.

_____ _____
Client Signature Date

_____
Printed Name of Client

_____
Parent or Guardian if Client is a Minor

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CRISIS AND SAFETY PLAN

Step 1: Warning signs (What thoughts, images, mood, situation, behavior occurs that alerts me that a crisis may be developing or is currently happening):

a)

b)

c)

Step 2: Internal coping strategies (Things I can do to take my attention and mind off of my crisis without contacting another person):

a)

b)

c)

Step 3: People (name and phone number) and social distractions (name of place) that provide me support:

Person and Phone Number)

Person and Phone Number)

Place)

Place)

Step 4: People whom I can ask for help:

Name and Phone Number)

Name and Phone Number)

Name and Phone Number)

Step 5: Professionals and Agencies I can contact during a crisis:

Professional's Name and Phone Number)

Professional's Name and Phone Number)

Step 5: Professionals and Agencies I can contact during a crisis, cont:

Local Urgent Care and Phone Number)

Nearest Emergency Room)

Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

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Step 6: Ways to making my environment safe:

a)

b)

c)

Step 7: Things most important to me that are worth living for:

a)

b)

c)

Helpful resources:
www.dbtselfhelp.com
www.healingfrombpd.com
www.crisischat.org
www.get.gg/freedownloads2.htm

By signing below, you agree to utilize this safety plan when you find yourself in crisis or you believe your life is in imminent danger. If you believe that your life is still in imminent danger after using this plan and you cannot keep yourself, call 911 or go to your nearest emergency room.

_____ _____
(Print Name) (Date)

_____ _____
(Sign Name) (Date)

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BORDERLINE SYMPTOM (BSL-23)

Client Name: _____ Date: _____

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you *think you might have felt*. Please answer honestly. **All questions refer to the last week. If you felt different ways at different times in the week, give a rating for how things were for you on average. Please be sure to answer each question.**

In the course of last week...		not at all	a little	rather	much	very strong
1	It was hard for me to concentrate	**0**	**1**	**2**	**3**	**4**
2	I felt helpless	**0**	**1**	**2**	**3**	**4**
3	I was absent-minded and unable to remember what I was actually doing	**0**	**1**	**2**	**3**	**4**
4	I felt disgust	**0**	**1**	**2**	**3**	**4**
5	I thought of hurting myself	**0**	**1**	**2**	**3**	**4**
6	I didn't trust other people	**0**	**1**	**2**	**3**	**4**
7	I didn't believe in my right to live	**0**	**1**	**2**	**3**	**4**
8	I was lonely	**0**	**1**	**2**	**3**	**4**
9	I experienced stressful inner tension	**0**	**1**	**2**	**3**	**4**
10	I had images that I was very much afraid of	**0**	**1**	**2**	**3**	**4**
11	I hated myself	**0**	**1**	**2**	**3**	**4**
12	I wanted to punish myself	**0**	**1**	**2**	**3**	**4**
13	I suffered from shame	**0**	**1**	**2**	**3**	**4**
14	My mood rapidly cycled in terms of anxiety, anger, and depression	**0**	**1**	**2**	**3**	**4**
15	I suffered from voices and noises from inside or outside my head	**0**	**1**	**2**	**3**	**4**
16	Criticism had a devastating effect on me	**0**	**1**	**2**	**3**	**4**
17	I felt vulnerable	**0**	**1**	**2**	**3**	**4**
18	The idea of death had a certain fascination for me	**0**	**1**	**2**	**3**	**4**

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19	Everything seemed senseless to me	**0**	**1**	**2**	**3**	**4**
20	I was afraid of losing control	**0**	**1**	**2**	**3**	**4**
21	I felt disgusted by myself	**0**	**1**	**2**	**3**	**4**
22	I felt as if I was far away from myself	**0**	**1**	**2**	**3**	**4**
23	I felt worthless	**0**	**1**	**2**	**3**	**4**

Now we would like to know in addition the quality of your **overall** personal state in the course of the last week. 0% means **absolutely down**, 100% means **excellent**. Please check the percentage which comes closest.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
(very bad)										(excellent)

BSL - Supplement: Items for Assessing Behavior

	During the last week.....	Not at all	once	2-3 times	4-6 times	Daily or more often
1	I hurt myself by cutting, burning, strangling, head banging etc.	**0**	**1**	**2**	**3**	**4**
2	I told other people that I was going to kill myself	**0**	**1**	**2**	**3**	**4**
3	I tried to commit suicide	**0**	**1**	**2**	**3**	**4**
4	I had episodes of binge eating	**0**	**1**	**2**	**3**	**4**
5	I induced vomiting	**0**	**1**	**2**	**3**	**4**
6	I displayed high-risk behavior by knowingly driving too fast, running around on the roofs of high buildings, balancing on bridges, etc.	**0**	**1**	**2**	**3**	**4**
7	I got drunk	**0**	**1**	**2**	**3**	**4**
8	I took drugs	**0**	**1**	**2**	**3**	**4**
9	I took medication that had not been prescribed or if had been prescribed, I took more than the prescribed dose	**0**	**1**	**2**	**3**	**4**
10	I had outbreaks of uncontrolled anger or physically attacked others	**0**	**1**	**2**	**3**	**4**
11	I had uncontrollable sexual encounters of which I was later ashamed or which made me angry.	**0**	**1**	**2**	**3**	**4**

Please double-check for missing answers

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LIFE PROBLEMS INVENTORY (LPI)

Client Name: _____ Date: _____

Below is a list of problems people sometimes have. Please read each one, and then circle the number that describes the way you are MOST OF THE TIME.

	Item	Not at all like me	A little bit like me	Somewhat like me	Quite a bit like me	Extremely like me
1 (SD)	I am not sure who I am or what I want in life.	1	2	3	4	5
2 (BD)	I usually act quickly, without thinking.	1	2	3	4	5
3 (ED)	I sometimes get so upset that I want to hurt myself seriously.	1	2	3	4	5
4 (ID)	I worry a lot about being left alone.	1	2	3	4	5
5 (SD)	I sometimes go into a daze and lose awareness of things going on around me.	1	2	3	4	5
6 (BD)	Sometimes I plan to go to class, but will change my mind if something better comes along.	1	2	3	4	5
7 (ED)	Killing myself may be the easiest way of solving my problems.	1	2	3	4	5
8 (ID)	I often feel sad and unloved.	1	2	3	4	5
9 (SD)	I sometimes feel very unhappy with who I am.	1	2	3	4	5
10 (BD)	If I want to do something, I just do it without thinking of what might happen.	1	2	3	4	5
11 (ED)	More and more I think of ending my own life.	1	2	3	4	5
12 (ID)	Relationships with people I care about have a lot of ups and downs.	1	2	3	4	5
13 (SD)	Other kids my age seem surer than I am of who they are and what they want.	1	2	3	4	5
14 (BD)	I often have too much to drink or get really drunk.	1	2	3	4	5
15 (ED)	When I don't get my way I quickly lose my temper.	1	2	3	4	5
16 (ID)	I hate to spend time alone.	1	2	3	4	5
17 (SD)	I feel lonely and empty most of the time.	1	2	3	4	5
18 (BD)	I often get high on street drugs like marijuana or other drugs.	1	2	3	4	5
19 (ED)	Even little things get me really depressed.	1	2	3	4	5
20 (ID)	I will sometimes to almost anything to avoid feeling alone.	1	2	3	4	5
21 (SD)	I feel pretty lost and don't know where I am going in life.	1	2	3	4	5
22 (BD)	I have deliberately hurt myself without meaning to kill myself (such as cutting or scratching myself).	1	2	3	4	5
23 (ED)	When things don't go my way, I give up and feel hopeless.	1	2	3	4	5
24 (ID)	I feel very depressed when I'm alone.	1	2	3	4	5
25 (SD)	I'm not that mature for my age, and I don't know what I want to do in life.	1	2	3	4	5
26 (BD)	I have made at least one suicide attempt.	1	2	3	4	5
27 (ED)	Once I get upset, it takes me along time to calm down.	1	2	3	4	5
28 (ID)	I feel very nervous, angry, or empty when I'm alone.	1	2	3	4	5
29 (SD)	I often feel empty or bored.	1	2	3	4	5
30 (BD)	I have eaten so much food that I was in a lot of pain or had to throw up.	1	2	3	4	5

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31 (ED)	I feel angry a lot of the time.	1	2	3	4	5
32 (ID)	I often fear that I will be abandoned by people I feel close to.	1	2	3	4	5
33 (SD)	I often feel like I'm not real, as if I am physically separated from my feelings.	1	2	3	4	5
34 (BD)	I have spent money on things I didn't need or couldn't afford.	1	2	3	4	5
35 (ED)	I often get furious at people.	1	2	3	4	5
36 (ID)	I often fear I will totally fall apart if someone important abandons or rejects me.	1	2	3	4	5
37 (SD)	I am so different at times different times that I sometimes don't know who I really am.	1	2	3	4	5
38 (BD)	I've lost my temper and really yelled or screamed at someone.	1	2	3	4	5
39 (ED)	I get into arguments very easily.	1	2	3	4	5
40 (ID)	Many of my relationships have been full of intense arguments.	1	2	3	4	5
41 (SD)	I am often confused about my goals.	1	2	3	4	5
42 (BD)	I have threatened to physically hurt someone (such as hit or punch them).	1	2	3	4	5
43 (ED)	I have had lots of break ups with people I have been close to.	1	2	3	4	5
44 (ID)	I often change my mind about the kind of friends I want.	1	2	3	4	5
45 (SD)	I feel very worried and anxious about things.	1	2	3	4	5
46 (BD)	I have physically hurt or attacked someone (such as slapped, punched, or gotten into fist fights)	1	2	3	4	5
47 (ED)	I get very moody, where I change quickly from feeling OK to feeling really bad or angry.	1	2	3	4	5
48 (ID)	In close relationships, I often think the other person is perfect some times, but I think they're terrible at other times.	1	2	3	4	5
49 (SD)	I'm often not sure what I really believe in.	1	2	3	4	5
50 (BD)	I have damaged property (such as smashing dishes or braking things).	1	2	3	4	5
51 (ED)	Sometimes I get so angry that I lose control.	1	2	3	4	5
52 (ID)	My relationships with other are often very strong or intense, but they don't go that smoothly.	1	2	3	4	5
53 (SD)	Sometimes it seems as things around me are not real, as though I'm in a dream.	1	2	3	4	5
54 (BD)	I have done something against the law (like shoplifting, selling drugs, etc.).	1	2	3	4	5
55 (ED)	Even little things get me really angry.	1	2	3	4	5
56 (ID)	Sometimes I beg someone to try and stop them from leaving me.	1	2	3	4	5
57 (SD)	I often have trouble keeping my attention on what I need to do (like homework or solving a problem).	1	2	3	4	5
58 (BD)	I have had sex with people I hardly knew, or had unsafe sex.	1	2	3	4	5
59 (ED)	I get so angry that I hit people or throw things.	1	2	3	4	5
60 (ID)	I don't get along with authority figures (such as parents or teachers)	1	2	3	4	5

DBT Institute of Michigan
Providing Evidence-Based Practice to build lives worth living

SYMPTOM QUESTIONNAIRE

Name:_____ Intake Date:_____

Please mark the box next to any of the items below that you believe are true for you.
Please make any explanations on the back of this page.

	Helplessness		Muscle tension		Often loses things
	Been arrested		No pleasure		Unstable/intense relationships
	Physical fights		Accelerated heart rate		Identity disturbance
	Has used a weapon		Sweating		Risky behaviors
	Physically cruel to people or animals		Trembling/shaking		Suicidal behavior, gestures/threats
	Wets the bed		Shortness of breath		Self-harm
	Brain doesn't seem to shut off		Choking feeling		Instable mood/reactions
	Forced someone into a sexual activity		Chest pain		Feelings of emptiness
	Deliberate fire setting		Nausea/upset stomach		Anger problems
	B&E, mugging, shoplifting		Dizzy, lightheaded		Paranoid ideation-stress related
	Vandalism		Feelings of detachment		Dissociative symptoms
	Lies		Fear of losing control		Family problems
	Nightmares, terrors		Fear of going crazy		Losses
	Breaks curfew		Fear of dying		Access to firearms
	Runs away		Numbness		Fitting in (acculturation challenges)
	Truancy		Chills		Suicide plan
	Behavior affects social, school, or work life		Hot flashes		Distress & suspiciousness
	Easily loses temper		Appetite changes		No friends
	Argumentative		Sleep problems		No support system
	Defiant behavior		Low energy/fatigue		Holds grudges
	Trouble with school		Low selfesteem		No closerelationships
	Deliberately annoys others		Concentration problems		Indifferent to praise/criticism
	Blames others		Hopelessness		Coldness/detachment
	Easily annoyed, irritated		Suicide thoughts		Odd beliefs/magical thinking
	Angry &resentful		Suicide attempts		Excessive physical complaints

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	Spiteful or vindictive		Worry a lot		Excessive social anxiety
	Use drugs/alcohol		Feel sad		Auditory hallucinations
	Do things without thinking		Feel scared		Visual hallucinations
	Fear of abandonment		Hyperactivity		Dramatic
	Abused: sexual, physical, other: witnessed, victim		Organization difficulty		Preoccupied with details, lists, etc.
	Fidgety		Forgetful		Thinks highly of self
	Seems to get hurt often		Talks a lot, interrupts		Persistent worry about accidents