South Point Counseling Services, LLC

Court Referred Client Intake Form

Client Name:	Date:
Name of Parent or legal guardian (if under 18 years of age):	Date of Birth:
Referred by:	Client's Social Security Number:
Address:	
City: State: Zip Code: -	

Cell Phone: Ok to leave message? ☐ or ☐	Home: ☐ or ☐	Work: ☐ or ☐	Other: ☐ or ☐
Email address:		May we e-mail you? ☐ or ☐ (appointment reminders will be sent via email)	

Emergency Contact:

Name & Relation:	Address:	
Home Phone:	Cell:	Work:

Court Information:

Type of treatment on order. Please check one or write description of other: ☐ Domestic Violence ☐ DUI ☐ Other: ☐ Theft ☐ Substance Abuse	
Court:	Case #:

Important Deadlines:

Assessment:	Case #:
Group treatment hours ordered: Deadline: Type:	Individual treatment hours ordered: Deadline: Type:

Credit Card Information:

Credit/Debit Card Number:	Expiration Date:	Security Code: (3 digit code on back of card)
Full Name on Credit/Debit Card:		

I have read and understand the enclosed clinic policies. Payment in full is due at the time of service. If I fail to cancel my appointment within the guidelines of the No Show Policy Disclosure, there will be a $50.00 fee which will be charged to my credit card. This credit card will also be used toward any unpaid account balances.

Signed:_____ **Date:**_____

Patient name _____ **Date** _____

BIOPSYCHOSOCIAL HISTORY

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed mood	☐	☐	☐	☐	Binging/purging	☐	☐	☐	☐
Appetite disturbance	☐	☐	☐	☐	Guilt	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	Elevated mood	☐	☐	☐	☐
Paranoia	☐	☐	☐	☐	Fatigue/low energy	☐	☐	☐	☐
Self-mutilation	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐	Mood swings	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Emotionality	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	Panic attacks	☐	☐	☐	☐
Obsessions/compulsions	☐	☐	☐	☐	Physical trauma victim	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	Paranoia	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Aggressive behaviors	☐	☐	☐	☐
Conduct problems	☐	☐	☐	☐	Oppositional behavior	☐	☐	☐	☐
Sexual dysfunction	☐	☐	☐	☐	Grief	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Substance abuse	☐	☐	☐	☐
Social isolation	☐	☐	☐	☐	Worthlessness	☐	☐	☐	☐
Emotional trauma victim	☐	☐	☐	☐	Sexual trauma victim	☐	☐	☐	☐

EMOTIONAL/PSYCHIATRIC HISTORY

No Yes Prior outpatient psychotherapy?
If yes, on _____ occasions.

No Yes Prior inpatient psychotherapy?
If yes, on _____ occasions.

FAMILY HISTORY

Present during childhood:

	Present entire childhood	**Present part of childhood**	**Not present at all**
Mother	☐	☐	☐
Father	☐	☐	☐
Stepmother	☐	☐	☐
Stepfather	☐	☐	☐
Brother(s)	☐	☐	☐
Sister(s)	☐	☐	☐

Parent's current marital status:

- ☐ married to each other
- ☐ separated for ____ years
- ☐ divorced for ____ years
- ☐ mother remarried _____ times
- ☐ father remarried _____ times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for ____ years
- ☐ father deceased for ____ years

Describe childhood family experiences:

- ☐ outstanding home environment
- ☐ normal home environment
- ☐ chaotic home environment
- ☐ witnessed physical/verbal/sexual abuse toward others
- ☐ experienced physical/verbal/sexual abuse from others

Patient name _____ **Date**_____

IMMEDIATE FAMILY

Marital Status:

- ☐ single, never married
- ☐ engaged _____ months
- ☐ married for _____ years
- ☐ divorced for _____ years
- ☐ separated for _____ years
- ☐ divorce in process
- ☐ widowed for _____ years
- ☐ live-in for _____ years
- ☐ ____ prior marriages (self)
- ☐ ____prior marriages (partner)

Intimate Relationship:

- ☐ never been in a serious relationship
- ☐ not currently in relationship
- ☐ currently in serious relationship

Relationship satisfaction:

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied
- ☐ dissatisfied with relationship

List all persons living in client's household:

Name	Age	Relationship to client
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List children <u>not</u> living in the same household as client:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY

(check all that apply for client)

Describe current physical health: ☐ Good ☐ Fair ☐ Poor

List name of primary care physician:

Name_____ Phone_____

List name of psychiatrist (if any):

Name _____ Phone_____

List any know allergies: _____

_____

Is there a history of any of the following in the family?

- ☐ tuberculosis
- ☐ birth defects
- ☐ emotional problems
- ☐ behavior problems
- ☐ thyroid problems
- ☐ cancer
- ☐ mental retardation
- ☐ heart disease
- ☐ high blood pressure
- ☐ alcoholism
- ☐ diabetes
- ☐ drug abuse
- ☐ Alzheimer's disease/Dementia
- ☐ stroke
- ☐ other chronic or serious health problems _____

_____

Check any of the following problems you have or have had:

☐ Asthma	☐ Bladder problems	☐ Cancer	☐ Chronic pain	☐ Diabetes
☐ Epilepsy	☐ Gastrointestinal problems	☐ Glaucoma	☐ Headaches	☐ Heart disease
☐ High blood pressure	☐ Infections	☐ Kidney Disease	☐ Liver disease	☐ Neurological problems
☐ Prostrate problems	☐ Thyroid disease	☐ Menopause	☐ Premenstrual syndrome	☐ Postpartum depression

List any medications you are currently taking

(Give dosage and reason)

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient name _____ **Date**_____

SUBSTANCE USE HISTORY

Substances used (complete all that apply)	Currently using? (Yes/No)	First use age	Last use age	Frequency	Amount
☐ alcohol	_____	_____	_____	_____	_____
☐ amphetamines/speed	_____	_____	_____	_____	_____
☐ barbiturates/owners	_____	_____	_____	_____	_____
☐ caffeine	_____	_____	_____	_____	_____
☐ cocaine	_____	_____	_____	_____	_____
☐ crack cocaine	_____	_____	_____	_____	_____
☐ hallucinogens (e.g., LSD)	_____	_____	_____	_____	_____
☐ inhalants (e.g., glue, gas)	_____	_____	_____	_____	_____
☐ marijuana or hashish	_____	_____	_____	_____	_____
☐ nicotine/cigarettes	_____	_____	_____	_____	_____
☐ PCP	_____	_____	_____	_____	_____
☐ prescription _____	_____	_____	_____	_____	_____
☐ other_____	_____	_____	_____	_____	_____

Family alcohol/drug abuse history:

☐ father
☐ mother
☐ grandparents(s)
☐ sibling(s) [ ] children
☐ other
☐ stepparent/live-in
☐ uncle(s) aunt(s)
☐ spouse/significant other

Substance use status:

☐ no history of abuse
☐ active abuse
☐ early partial remission
☐ sustained full remission
☐ sustained partial remission

Treatment history:

☐ outpatient (age)(s) _____
☐ inpatient (age)(s)_____
☐ 12-step program (age)(s)_____
☐ stopped on my own (age)(s)_____

SOCIO ECONOMIC HISTORY (check all that apply for client)

Living situation:

☐ housing adequate
☐ homeless
☐ housing overcrowded
☐ dependent on other for housing

Social support system:

☐ supportive network
☐ few friends
☐ substance-use-friends
☐ no friends
☐ distant from family

Sexual history:

☐ heterosexual orientation
☐ homosexual orientation
☐ bisexual orientation
☐ currently sexually active
☐ currently sexually dissatisfied
☐ age first sex experience
☐ age first pregnancy/fatherhood_____
☐ history of promiscuity age ___ to _____

Employment:

☐ employed
☐ unemployed
☐ retired
☐ coworker conflicts
☐ supervisor conflicts
☐ unstable work history
☐ disabled
☐ student

Legal history:

☐ no legal problems
☐ now on parole/probation
☐ arrest(s) not substance-related
☐ arrest(s) substance-related
☐ court ordered this treatment
☐ jail/prison _____ times

Financial Situation:

☐ no current financial problems
☐ large indebtedness
☐ poverty or below-poverty income
☐ impulsive spending
☐ relationship conflict over finances

Patient name _____ **Date**_____

CULTURAL/SPIRITUAL/RECREATIONAL HISTORY

Cultural identity (e.g., ethnicity, religion):_____

Currently active in community/recreational activities? Yes [ ] No [ ]

Formally active in community/recreational activities? Yes [ ] No [ ]

Currently participate in hobbies? Yes [ ] No [ ]

Currently participate in spiritual activities? Yes [ ] No [ ]

Check any of the following words which apply to you:

Horrible thoughts	☐	worthless	☐	useless	☐	a nobody	☐	life is empty	☐	inadequate	☐	stupid	☐
Can't do anything right	☐	incompetent	☐	naïve	☐	guilty	☐	evil	☐	morally wrong	☐	considerate	☐
Hostile	☐	full of hate	☐	anxious	☐	agitated	☐	cowardly	☐	unassertive	☐	panicky	☐
Aggressive	☐	ugly	☐	deformed	☐	unattractive	☐	repulsive	☐	depressed	☐	lonely	☐
Unloved	☐	misunderstood	☐	bored	☐	restless	☐	confused	☐	unconfident	☐	in conflict	☐
Full of regrets	☐	worthwhile	☐	sympathetic	☐	intelligent	☐	attractive	☐	confident	☐		

South Point Counseling Services, LLC

Empowering individuals, couples, and families

Disclosure Statement and Informed Consent to Treatment

Your Rights and Responsibilities as a Psychotherapy Client

Therapy works best when it is a collaborative effort between the clinician and client and when the rights and responsibilities of each person is well defined. As a client, you have certain rights and responsibilities that you should be aware of since this is your therapy and our goal is your well-being. There are certain limitations to those rights that you should be familiar with. As a therapist, I also have responsibilities to you.

My Responsibilities to You as Your Therapist

Confidentiality: I am committed to keeping complete confidentiality of your therapy with the exception of the following instances described below. I cannot and will not tell anyone about whatever you tell me in therapy, or even the fact that you are in therapy with me without your prior written consent. It will be my responsibility to always act in a way as to protect your privacy, even when you allow me to share information about you with someone else. You can allow me to share information about you with whomever you want, and you can change your mind and revoke that permission whenever you want.

The following are exceptions to your right to confidentiality. I will let you know whenever I have to act on those exceptions.

1. If I find out that you have intention of harming someone, I will try to inform that person and warn them of your intentions. I will also contact the police and ask them to protect your intended victim.
2. If I have reason to believe that you are abusing a child or a vulnerable adult, or if you let me know of anyone else that is doing so, I will inform Child Protective Services or the police within 48 hours.
3. If I believe that you intend to harm yourself or are in danger of hurting yourself, I will call the police, crisis team, or someone that can ensure your safety. I will discuss my decision with you and we will explore your options before I decide what must be done.
4. I may use and disclose your information in order to bill and collect payment for the services that you are receiving from me. I may also use your information to obtain payment from third parties that may have been identified by you as responsible for your bill.
5. Please be advised that even though we make every effort to protect your information when using electronic communication such as e-mail, computer, cell phone, or fax, I cannot guarantee that there will not be any interception of it by someone else.
6. If you are filing a complaint or are a plaintiff in a lawsuit where your mental health information is needed, you will already have waived your right to the confidentiality of your records in the context of the complaint or lawsuit. Even though that might be the case, I will make every effort not to release your records unless you authorize me to do so. Please be aware that I may not always be able to do so.

Your Rights as a Psychotherapy Client

1. You have the right to ask questions about anything that happens in therapy. I will always be willing to discuss how and why I have decided to do what I am doing and look at different alternatives that might work better. You are welcome to let me know of an approach that you think will be helpful. You can ask me about my training and to transfer you to someone else if you are not comfortable with me. You are free to leave therapy at any time.
2. You have the right and responsibility to let me know if you are not in agreement with my treatment plan. At any time during therapy, you are encouraged to let me know if there is anything that you don't like or feel comfortable with, and if there is something else that you would like. Your input, no matter what it is, is very important to me.

3. You have the right to confidentiality and safe treatment. You have the right to be treated with respect and dignity.

Your Responsibilities as a Psychotherapy Client

1. You are responsible for coming to therapy on time and at the time that we have scheduled for you. If you are late, we will end on time and not run over into the next person's session. If you miss a session or cancel it with less than 24 hours, you will be charged a no-show fee of $50.00. Most places charge you for the price of the whole session. We choose to charge you only $50.00 but warn you that this fee will apply even in cases of emergency. All cancelations must be made within a 24-hour period for appointments Tuesday through Saturday. Appointments on Monday must be cancelled by 5:00 PM the Friday prior. This fee will be charged to the client or parent only and not the insurance company or the bishop. Payment will be immediately charged out of your credit card when possible or by the time of your next session.

2. You are responsible for supervising your children at all times while in the office. Please bring an adult with you to watch your children if you are going to be in a session. When waiting for therapy with your children, please be aware that they should not jump up and down or run around the office since we have other therapists providing therapy and this would be disruptive to our clients in the office.

3. You are responsible for paying for your session or your child's session at the beginning of each session unless we have made other arrangements in advance. South Point Counseling Services' fee is $150.00 for a 55-minute session and $185.00 for the initial assessment. If your account becomes past due, and collection becomes necessary, I will give your name and the amount due to a collection agency. In this case, you will be responsible for payment of an additional 33.3% collection fee and all legal collection fees, with or without suit, including attorney fees and court fees. When requested, we can assist in billing for insurance or authorized payment from your bishop or other sources. You should be aware that insurance companies require diagnostic labels and in cases where your diagnosis is not payable by your insurance, you will be responsible for the payment. Furthermore, some insurances require that you contact them for pre-authorization. It is your responsibility to obtain approval from your insurance and keep track of the number of authorized sessions. If services are provided to you without insurance approval, you will be responsible for payment.

Complaints:
If there is anything that you are not satisfied with in your therapy, I would hope that you can talk to me about it. I will take your criticism very seriously and with care and respect. If you don't feel comfortable talking to me about it, you can contact Roselene Dalanhese, our clinical director. She will be happy to assist you in finding another therapist that might be a better fit for you or addressing your concerns.

Client Consent to Psychotherapy:
I have read this statement. I had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to the release of that information to my insurance company if I request so. I agree to pay the amount described in this statement at the beginning of each session. I agree to have my credit card billed for any no-show fees for sessions which I have not given a 24-hour prior notice cancelation and for any outstanding unpaid balance by my insurance. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me.

I agree to undertake therapy with _____

Print Client's name:_____

Client Signature:_____ Date: _____

Parent/Guardian Signature (if applicable):_____ Date: _____

Therapist's Signature:_____ Date: _____

South Point Counseling Services, LLC

Empowering individuals, couples, and families

Consumer Rights Disclosure

As a state licensed program, our clinic is required to comply with all consumers rights. As a consumer, you to have the right to:

-Privacy of information for current and closed records,

-Understand the reasons for involuntary termination (failure to make payments and unwilling to engage in treatment plan) and criteria for re-admission (pay any outstanding balance, be evaluated again, and comply with treatment recommendations).

-Understand your consumer rights as outlined on this form and responsibilities (be engaged in treatment) in the development and implementation of an individual treatment plan,

-Be informed of the approximate duration of treatment (generally between 12 to 24 sessions) and desired outcome of recommendations in the treatment plan,

-Be aware of fees that are expected to be paid when services are rendered ($185 for the first session or assessment and $100 for the subsequent sessions).

-Freedom from discrimination,

-Be treated with dignity,

-A nicotine free facility in accordance with the Utah Clean Air Act (smoking is not allowed inside of this facility or within 25 feet),

-Obtain emergency mental health services during periods outside our normal operating hours by calling the University of Utah Crisis Line at 801-587-3000,

-File a grievance or complaint by contacting our Clinical Director Roselene Dalanhese at 801-403-7345 and/or the Utah Department of Human Services at 801-538-4242 or at hslic.utah.gov.

_____ _____

Signature Date

South Point Counseling Services, LLC

Empowering individuals, couples, and families

No Show Policy Disclosure

The therapists at South Point Counseling Services strive to provide all clients with the best possible care. A huge component to the overall success of your treatment with us, is your commitment to the treatment plan you will create with your therapist. That commitment includes attendance to your scheduled appointments.

We require prior cancellation to all missed appointments. Most offices will charge you the full cost of your appointment; however, **you will be charged only $50.00 for consultations, $150 for medication management and $150 for tests, if you do not call and or email us within the time frame outlined in our policy.** All missed appointment fees will be charged to the credit/debit card on file and will not be refunded. If you do not have a working card on file, the missed appointment fee will be added to your account and will be due along with any other co-pay or co-insurance at your next appointment.

Our policy for cancellations is as follows:

- All appointments scheduled on Monday must be cancelled by 5:00 PM on the Friday prior.
- All appointments Tuesday through Saturday must be cancelled with a full 24-hour notice.
- Regardless of an emergency, you will be charged.
- All of our clinicians have a waiting list for appointments. If your cancelled appointment can be filled, you will not be charged. Filling an appointment usually requires 24-hour notice, but we will always contact clients on your therapist's waiting list and offer them the opening.
- All clients who are put on a regular re-occurring schedule, must cancel their appointment within the guidelines of our policy. After the second no show occurrence, you will be taken off your therapist's schedule until you contact us to reschedule.
- Clients taken off a therapist's re-occurring schedule, forfeit their regular time slot and may not be given the same appointment time. You must then call our office to schedule a new appointment. If an opening is not available, we will call you back as soon as there is an opening.
- Any questions or concerns about this policy, can be directed to our office manager or clinical director.

Our time is as valuable as yours. Thank you in advance for helping us provide reliable treatment to our clients.

(Acknowledgment of disclosure)

I _____(patient name/guardian signature) have read the No Show Policy Disclosure and agree to provide the required advanced notice to South Point Counseling Services in the event that I must miss an appointment.

_____ Date

South Point Counseling Services, LLC

Empowering individuals, couples, and families

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been out of practice for years. This form is a "friendly" version. A more complete text is available upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. WE balance these needs with our goal of providing you with quality professional services and care additional information is available from the U.S. Department of Health and Human Services: www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. I have also been offered a copy of this HIPAA form.

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Empowering individuals, couples, and families

Subpoena Agreement

I understand that should I or a third party subpoena any therapist who is part of South Point Counseling Services as a factual case witness or involve him/her in court-related processes, he/she will charge me a retainer fee of $1,000.00 and a charge of $200.00 every hour he/she is involved in case preparation, research, paperwork, phone calls, travel, witness time, etc.

I understand that if I do issue any therapist who works for South Point Counseling Services a subpoena with or without his/her approval (see above) that my subpoena may be directly turned over to his/her attorney and a bill will be rendered for an immediate attorney's retainer fee. I will also be billed accordingly by him/her and I agree to pay all attorney's fees plus my therapist's fees as invoiced.

I understand that if a child who is in therapy has parents who are divorced and/or part of a joint custody arrangement, I must furnish South Point Counseling Services, LLC with a copy of the custody agreement/divorce decree.

_____ _____

Signature Date

South Point Counseling Services, LLC

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Authorization for Release of Information

Client Name:

I authorize South Point Counseling Services (hereinafter "Provider") to disclose/exchange mental health treatment information and clinical records obtained during psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

_____ _____

Name Phone

_____ _____

Address Fax (Secured)

_____

City State Zip

I am requesting this disclosure of information and clinical records for the following purpose:

☐ At the request of the client or guardian ☐ Other: _____

The specific uses and limitations of the types of health information to be released are as follow: (Check all that apply)

A separate authorization, as defined by HIPAA, is required for Psychotherapy Intake and Progress Notes.

☐ Intake and Progress Notes (ONLY) ☐ Psychological Testing Results

☐ Treatment Coordination ☐ Entire Treatment Record except progress notes

☐ Treatment Plans ☐ Other: _____

Such disclosures shall be limited to the following specific types of information: (Check all that apply)

☐ Psychiatric Diagnosis(es) ☐ Initial or Intake Treatment Plan

☐ Dates of Treatment ☐ Other: _____

This authorization will expire automatically after one year.

I understand that I have the right to receive a copy of this document. Upon request, I may revoke this authorization at any time by sending a written notice to South Point Counseling Services. Any disclosures that have been made to the individual or entity listed above prior to this written notice will not be affected by the revocation. Provider shall not condition treatment upon my signing this authorization, and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information.

_____ _____

Client Signature Date

_____ _____

Signature of Legal Guardian (Relationship to Client) Date

NAME: _____ **DATE:** _____

DRUG USE QUESTIONNAIRE (DAST – 20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Adult Version

These questions refer to the past 12 months.	Circle Your Response
1. Have you used drugs other than those required for medical reasons?	Yes No
2. Have you abused prescription drugs?	Yes No
3. Do you abuse more than one drug at a time?	Yes No
4. Can you get through the week without using drugs?	Yes No
5. Are you always able to stop using drugs when you want to?	Yes No
6. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes No
7. Do you every feel bad or guilty about your drug use?	Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes No
10. Have you lost friends because of your use of drugs?	Yes No
11. Have you neglected your family because of your use of drugs?	Yes No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes No
13. Have you lost your job because of drug abuse?	Yes No
14. Have you gotten into fights when under the influence of drugs?	Yes No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes No
16. Have you been arrested for possession of illegal drugs?	Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes No
19. Have you gone to anyone for help for drug problem?	Yes No
20. Have you been involved in a treatment program specifically related to drug use?	Yes No

Patient Name:_____ Date:_____

The Michigan Alcoholism Screening Test (MAST)

Please circle either Yes or No for each item as it applies to you.

1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	Yes	No
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes	No
3. Does your wife, husband, a parent , or other near relative ever worry or complain about your drinking?	Yes	No
4. Can you stop drinking without a struggle after one or two drinks?	Yes	No
5. Do you ever feel guilty about your drinking?	Yes	No
6. Do friends or relatives think you are a normal drinker?	Yes	No
7. Are you able to stop drinking when you want to?	Yes	No
8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	Yes	No
9. Have you gotten into physical fights when drinking?	Yes	No
10. Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	Yes	No
11. Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	Yes	No
12. Have you ever lost friends because of drinking?	Yes	No
13. Have you ever gotten into trouble at work or school because of drinking?	Yes	No
14. Have you ever lost a job because of drinking?	Yes	No
15. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Yes	No
16. Do you drink before noon fairly often?	Yes	No
17. Have you ever been told you have liver trouble? Cirrhosis?	Yes	No
18. After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices or seen things that really were not there?	Yes	No
19. Have you ever gone to anyone for help about your drinking?	Yes	No
20. Have you ever been in a hospital because of drinking?	Yes	No
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	Yes	No
22. Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem?	Yes	No
23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times? _____)	Yes	No
24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? If YES, how many times?_____)	Yes	No

THE BURNS DEPRESSION INVENTORY

Name:_____

Date:_____

Score:_____

Key:
0=Not at All
1=Somewhat
2 =Moderately
3=A lot
4= Extremely

THOUGHTS AND FEELINGS

	0	1	2	3	4
1. Feeling sad or down in the dumps.					
2. Feeling unhappy or blue.					
3. Crying spells or tearfulness.					
4. Feeling discouraged.					
5. Feeling hopeless.					
6. Low self-esteem.					
7. Feeling worthless or inadequate.					
8. Guilt or shame.					
9. Criticizing yourself or blaming yourself.					
10. Difficult making decisions.					

ACTIVITES AND PERSONAL RELATIONSHIPS

	0	1	2	3	4
11. Loss of interest in family, friends or colleagues.					
12. Loneliness.					
13. Spending less time with family or friends.					
14. Loss of motivation.					
15. Loss of interest in work or other activities.					
16. Avoiding work or other activities.					
17. Loss of pleasure or satisfaction in life.					

PHYSICAL SYMPTOMS

	0	1	2	3	4
18. Feeling tired.					
19. Difficulty sleeping or sleeping too much.					
20. Decreased or increased appetite.					
21. Loss of interest in sex.					
22. Worrying about your health.					

SUICIDAL URGES

	0	1	2	3	4
23. Do you have any suicidal thoughts?					
24. Would you like to end your life?					
25. Do you have a plan for harming yourself?					

Please Total your score on items 1 to 25 here

THE BURNS ANXIETY INVENTORY

Name:_____

Date:_____

Score:_____

Key:
0=Not at All
1=Somewhat
2 =Moderately
3=A lot

Category 1: Anxious Feelings	0	1	2	3
1. Anxiety, nervousness, worry or fear.				
2. Feeling that things around you are strange or unreal.				
3. Feeling detached from all or part of your body.				
4. Sudden unexpected panic spells.				
5. Apprehension or a sense of impending doom.				
6. Feeling tense, stressed, "uptight," or on edge.				
Category II: Anxious Thoughts	0	1	2	3
7. Difficulty concentrating.				
8. Racing thoughts.				
9. Frightening fantasies or daydreams.				
10. Feeling that you're on the verge of losing control.				
11. Fears of cracking up or going crazy.				
12. Fears of fainting or passing out.				
13. Fears of physical illness or heart attacks or dying.				
14. Concerns about looking foolish or inadequate.				
15. Fears of being alone, isolated, or abandoned.				
16. Fears of criticism or disapproval.				
17. Fears that something terrible is about to happen.				
Category III: Physical Symptoms	0	1	2	3
18. Skipping, racing, or pounding of the heart (palpitations).				
19. Pain, pressure, or tightness in the chest.				
20. Tingling or numbness in the toes or fingers.				
21. Butterflies or discomfort in the stomach.				
Category III: Physical Symptoms continued	0	1	2	3
22. Constipation or diarrhea.				
23. Restlessness or jumpiness.				
24. Tight, tense muscles.				
25. Sweating not brought on by heat.				
26. A lump in the throat.				
27. Trembling or shaking.				
28. Rubbery or "jelly" legs.				
29. Feeling dizzy, lightheaded, or off balance.				
30. Choking or smothering sensations or difficulty breathing.				
31. Headaches or pains in the neck or back.				
32. Hot flashes or cold chills.				
33. Feeling tired, weak, or easily exhausted.				
Total Score on items 1-33 ➥				