INFORMED CONSENT FOR PSYCHOTHERAPY 2018

In the interest of assuring that you are informed of the conditions of involvement with our services, please be informed the following:

1. PARTICIPATION IN SERVICES

Treatment is most effective when there are occasional discussions about your progress and counseling experience. You will develop a treatment plan collaboratively with your counselor, and participate in periodic reviews of your treatment and progress,

If you feel your treatment is not helping you, please inform your counselor, so that your treatment plan can be revised to most effectively meet your needs.

Your time is reserved for you. If you must cancel, please provide a courtesy 24 hour notice. Individual sessions generally last fifty to sixty minutes. If you do not call to cancel your appointment by 8AM on the day of your appointment and fail to show, this will cancel any recurring appointments that you have scheduled. If this happens more than twice, you will have to schedule your appointments weekly, or daily, if more than three times. If you are more than ten minutes late for a session (either in-person or teletherapy), this could be considered a “no show”. If you arrive late, your appointment will still end at the designated time.

A returned check fee of $35 will be applied to your bill for all returned checks. If you do not have insurance or your insurance should lapse for any reason, you will be required to pay the sliding scale fee, calculated by your income. You can set up monthly payments with the billing department.

After 4 repeated absences/failure to participate in services may result in discontinuation or vacation from services.

If you are not scheduling sessions and/or arriving for sessions for a continuous period, we will assume you are voluntarily terminating services with us, and your client file will be closed. Should your file be closed, you will be eligible to participate in another intake and assessment process, and this would be considered a new admission.

2. DIAGNOSIS

If you are eligible for services through Plum Behavioral Health, you meet criteria for a qualifying diagnosis. We are required to give a diagnosis to document that you meet criteria for services. Your clinician will discuss your diagnosis with you, and how you meet criteria for the diagnosis. Note a diagnosis is a representation of presenting issues, and is something that is experienced on a continuum. You may meet criteria for a diagnosis during one stage of your life, and not meet criteria at another. It is estimated that a majority of people will meet criteria for a mental health diagnosis at some point in their lives.

3. LIMITS OF CONFIDENTIALITY

a. In accordance with State and Federal laws, Behavioral Health staff are legally obligated to make a report to the appropriate entities if they have reason to suspect the following.

· A child is in danger of abuse or neglect.

· An elder (65 years or older) is in danger of being abused or neglected. (Note, for elders, financial abuse is considered a form of abuse).

· Someone appears to be in imminent danger of harming themselves or others.

b. Your mental health record can be subject to a legal subpoena in a legal proceeding.

c. If you are paying for services through your insurance company, we are obligated to let your insurance company know your diagnosis and, in some cases, details of your treatment, as a condition of insurance reimbursement.

d. Our clinicians meet with colleagues weekly for Consult with a consultation team. Therapists and mental health professionals on my consultation team with which I work and consult are bound by law to maintain confidentiality and to protect confidential information. All client records are maintained according to HIPAA* regulations and ethical guidelines.

*Please see our website PlumBHS.org for a copy of the HIPAA Confidentiality and Privacy Act/Rules.

If your clinician is out of town, they may reveal your/your child's identity and confidential information about your situation to a therapist that is covering for them.

e. DBT offers Phone Coaching for DBT-IOP enrolled clients. The phone coaching responsibilities may be shared with a Plum BHS therapist other than your therapist. The Plum BHS therapist is a therapist that is on a consult team with your therapist and one that has full knowledge of DBT skills and techniques. I agree that my therapist may reveal necessary information about me or my child for the purposes of crisis coverage if my therapist is not available.

f. Plum BHS works with a variety of contractors in order to expedite the documentation process and other administrative tasks. In these circumstances, our contractors are bound by confidentiality and nondisclosure agreements, which are enforceable by law.

4. SOCIAL CONTACT WITH MENTAL HEALTH STAFF

Note it is against professional Codes of Ethics to engage in social relationships with clients or former clients. If your counselor or another mental health employee sees you in public, you are welcome to initiate a conversation. They may avoid initiating a conversation with you, in order to protect your privacy. If you wish

to discuss your case, you are encouraged to contact your counselor at the office during regular business hours. We avoid discussing confidential matters in public.

5. GRIEVANCES

You may file a grievance if you are dissatisfied with our service. The information described below regarding filing grievances is posted in our waiting room. You may call any of the following entities to register a complaint: Antwion Butler Plum Behavioral Health Services LLC LLC, Operations 320-336-0036 ex. 7 or Minnesota Board of Behavioral Health (612) 548-2177.

6. CLIENT RIGHTS

Your rights as a client of Plum Behavioral Health include the following:

1. The right to be treated with respect and with due consideration for your privacy.

2. The right to receive information on available treatment options and alternatives presented in a manner understandable to you.

3. The right to participate in decisions regarding your health care, including the right to refuse treatment.

4. The right to file a grievance or appeal a decision without being subject to discrimination or penalty.

5. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

6. The right to request and receive a copy of your health Information.

7. The right to request that your health record be amended.

7. CAUSE FOR DISCHARGE

If it appears that the services we offer are not beneficial for you, a decision could be made to discontinue services.

· Failure to treat other clients and staff with respect can result in discharge from program services.

· Failure to maintain the confidentiality of others accessing services can result in discontinuation of services.

· Plum Behavioral Health reserves the right to discharge clients for reasons not mentioned in this informed consent, should the need arise. Such dismissal from services would not happen without good cause.

8. WEAPONS

Individuals are prohibited from possessing guns, knives (other than kitchen utensils), or other weapons (except for law enforcement officers acting in the line of duty) while at Plum Behavioral Health Services LLC.

9. FOLLOW-UP

Upon discharge from the program, someone from Plum Behavioral Health Services LLC may attempt to contact you to participate in a follow-up client satisfaction survey, with your permission. These surveys assist us with maximizing the effectiveness of our services. If you are willing to participate in a follow-up contact, please initial one of the following: I am willing to participate in a follow up contact, following discharge from services I am not willing to participate in a follow up contact, following discharge of services.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Signature Date

_____

Print Name

NOTICE OF PRIVACY PRACTICES

Plum Behavioral Health Services LLC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:
I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information (“PHI”) that identifies you is kept private.
• Give you this notice of my legal duties and privacy practices with respect to health information.
• Follow the terms of the notice that is currently in effect.
• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client’s personal health information without the patient’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management

of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of

disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on September 20, 2013

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Signature Date

_____

Print Name

PRACTICE POLICIES

Plum Behavioral Health Services LLC

PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS
Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

A $10.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

TELEPHONE ACCESSIBILITY If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. In the event that you are out of town, sick or need additional support, phone coaching are available. If a safety risk or emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION
Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION
I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver

medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:
(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
(2) All existing confidentiality protections are equally applicable.
(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel
costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he
or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS
If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION
Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

TELETHERAPY SERVICES AGREEMENT AND INFORMED CONSENT

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Plum Behavioral Health Services LLC providing health care services to me via teletherapy. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. I understand that the policies and regulations outlined in the agency privacy practices, practice policies, and Informed Consent for Psychotherapy, also apply to teletherapy. As always, your insurance carrier will have access to your medical records for quality review/audit.

I further understand that there are risks unique and specific to telehealth, including but not limited to, the possibility that therapy sessions or other communication by my therapist to myself and others regarding my treatment, could be disrupted or distorted by technical failures or could be interrupted or accessed by unauthorized persons. The risks involved with telehealth include the potential release of private information due to the complexities and abnormalities involved with the Internet, such as, viruses, Trojans, or other involuntary intrusions, which have the ability to access information that you may desire to keep private. Plum Behavioral Health Services LLC and your therapist will take every reasonable measure to protect your private information. The telecommunications platform is HIPAA compliant and completely encrypted.

Furthermore, there is the risk of being overhead by anyone near you if you do not place yourself in a private area and open to other's intrusion. While telehealth offers the advantage of being treated from any location at any time, it is your responsibility to create an environment on your end of the Telecommunications transmission that is not subject to unexpected or unauthorized intrusion of your personal information. It is your therapist's responsibility, to do the same.

In addition, I understand that telehealth treatment is different from in-person therapy, in particular, you accept that Teletherapy does not provide emergency services and if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

For clients residing outside the state of your therapist's licensure: By utilizing services offered by Plum Behavioral Health Services LLC, you agree that you are soliciting the services of a professional outside of your state of residence. By doing this, you agree that the "point-of-service" of therapy is to occur in the therapist's state of licensure, not your state of residence. In essence, when receiving telecommunications services, you are virtually traveling to the therapist (the therapist's state of professional practice). Hence, therapists are accountable to and agree to abide by the ethical and legal guidelines prescribed by their state of licensure. By agreeing to solicit the therapist's services, you agree to these terms. If you do not understand, or have any questions regarding this issue, please feel free to call Plum Behavioral Health Services and ask to speak to someone about teletherapy for out of state clients.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Plum Behavioral Health Services LLC in writing at 208 Fire Monument Road Hinckley, MN 55037. As long as this consent is in force (has not been revoked) Plum Behavioral Health Services LLC may provide health care services to me via telemedicine without the need for me to sign another consent form.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

_____ _____

Signature Date

_____

Print Name

Adult Intake form

** indicates a required field*

PRESENTING PROBLEMS

*** Presenting problem in your own words**

*** What are your symptoms?**

*** How frequently do you experience these symptoms?**

*** On a scale of 1-10, how strongly do you feel these symptoms?**

*** How long do long (at a time) do the symptoms last?**

*** What things make the problem worse?**

*** What things make the problem better?**

MEDICAL HISTORY

*** Have you experienced any major illness such as chicken pox, fever above 104 degrees, head injury, and problems or hospitalizations, etc (indicate age):**

- Yes
- No

Date of last physical:

*** Primary care physician**

*** Have you ever been on any long-term medication (more than 6 months)?**

- Yes
- No

If yes, when, what type, and why was it prescribed? Also, please list any current medications that you are taking.

- [ ] Names of medication
- [ ] Start date
- [ ] End Date
- [ ] Dosage
- [ ] Frequency
- [ ] Prescribed by?
- [ ] Additional information

*** Do you have a psychiatrist?**

- ( ) Yes
- ( ) No

*** Do you have any current medical conditions (asthma, heart murmur, etc.) or other physical ailments (frequent colds, gastrointestinal issues, skin problems, allergies, ear infections, vision problems, etc)?**

- ( ) Yes
- ( ) No

*** Do you have any neurological symptoms? (seizures/convulsions, speech deficits, accident prone, bites nails, sucks thumb, grinds teeth, has tics/twitches, bangs head, rolls back and forth, sensory concerns, etc.)?**

- ( ) Yes
- ( ) No

LEGAL HISTORY

*** Is there a history of legal issues in the family?**

- Yes
- No

*** Do you personally have any legal involvement?**

- Yes
- No

*** Number of arrests in the last 30 days?**

HISTORY OF SUBSTANCE USE

*** Is there history of substance use on either side of the family?**

- Yes
- No

*** Have you ever been treated for substance abuse?**

- Yes
- No

FAMILY MEMBERS & CULTURAL/RELIGIOUS BACKGROUND

*** What cultural, ethnic, or religious background should be considered in your treatment?**

*** Are there family relational problems?**

- ○ Yes
- ○ No

MENTAL HEALTH HISTORY

* Have you had similar or other problems in the past?

- ○ Yes
- ○ No

* Have you previously received mental health services?

- ☐ None
- ☐ Outpatient
- ☐ Residential
- ☐ Inpatient/Hospitalized
- ☐ Skills training
- ☐ Day Treatment/Partial

Previous diagnosis (if known):

* Are you depressed or do you have a history of depression?

- ○ Yes
- ○ No

Have you experienced any of the following?

- ☐ Death of a parent
- ☐ Accident/Serious injury
- ☐ Sexual abuse
- ☐ Legal difficulties

- [ ] Eating disorders (anorexia/bulimia)
- [ ] Death of someone very close
- [ ] Childhood prolonged separation from parent
- [ ] Physical abuse
- [ ] Witness to domestic violence
- [ ] Childhood Neglect
- [ ] Parental separation/divorce
- [ ] Frightening experience
- [ ] Emotional abuse
- [ ] Death of a pet

*** List and describe any other highly stressful/traumatic experience**

*** Is there any history of mental health problem on either side of the family?**

- ( ) Yes
- ( ) No

*** Has anyone on either side of your family attempted or completed suicide?**

- ( ) Yes
- ( ) No

RISK ASSESSMENT

*** Do you acknowledge thoughts/plans of suicide/homicide/self-harm**

- ( ) Yes
- ( ) No

*** Please check any below that apply to you over the PAST 2 WEEKS.**

- [ ] Past suicide attempts
- [ ] Current suicidal thoughts
- [ ] Current suicidal plans
- [ ] Current suicidal acts
- [ ] Current self-injurious behavior
- [ ] Current homicidal intent/violence toward others
- [ ] Is there lethal means of self-harm?
- [ ] Support system available?
- [ ] Family history of suicide or violence?
- [ ] Are you making plans for the future?
- [ ] None

CURRENT LIVING SITUATION

What is your current living arrangement?

*** How many people, other than you, currently living in the home?**

*** Who do you currently live with (describe relationship, age, gender, etc.)?**

Living environment/condition of home

- [ ] In good condition

- [ ] Needs repair
- [ ] Other

*** How many times has your residence changed in the last two years?**

*** What is the current home atmosphere?**

- [ ] Loving
- [ ] Abusive
- [ ] Comfortable
- [ ] Supportive
- [ ] Chaotic
- [ ] Other

PAST SIGNIFICANT EVENTS

*** Please check any that apply.**

- [ ] Significant medical condition of parent/caregiver
- [ ] Difficulty after giving birth
- [ ] Substance abuse of parent/caregiver
- [ ] Adoption
- [ ] Other
- [ ] None

EDUCATIONAL/WORK HISTORY

*** Employment status**

- ( ) Full-time (>32 hours/week)
- ( ) Part-time (<32 hours/week)
- ( ) Looking for work

- [ ] Not in labor force

* Not in labor force

- [ ] Homemaker
- [ ] Retired
- [ ] Student
- [ ] Hospital patient or resident of other institutions
- [ ] Sheltered employment
- [ ] Other reported classification (volunteers)
- [ ] Employed

* Highest level of education completed

- [ ] Grade 1
- [ ] Grade 2
- [ ] Grade 3
- [ ] Grade 4
- [ ] Grade 5
- [ ] Grade 6
- [ ] Grade 7
- [ ] Grade 8
- [ ] Grade 9
- [ ] Grade 10
- [ ] Grade 11
- [ ] Grade 12/GED
- [ ] Some College
- [ ] Voc/Tech School
- [ ] College Freshman
- [ ] College Sophomore
- [ ] College Junior
- [ ] College Senior
- [ ] Grad/Professional school

* Are you currently enrolled in school?

- Yes
- No

Check the item that best describes your employment interactions in the following areas:

Attendance

- Rarely Absent
- Sometimes absent
- Often Absent

Performance

- Above Average
- Average
- Below Average

Coworkers Relationships

- Above Average
- Average
- Below Average

Management relationships

- Above Average
- Average
- Below Average

SUPPORTS AND STRENGTHS

*** Do you participate in any community activities (mentor, YMCA, etc.)?**

- ○ Yes
- ○ No

*** Who is included in your support system?**

*** Coping Resources**

- ☐ I am a good employee
- ☐ I make good decisions
- ☐ I learn from my mistakes
- ☐ I am creative
- ☐ I am patient
- ☐ I am athletic
- ☐ I am independent
- ☐ I am cheerful and optimistic
- ☐ I am assertive
- ☐ I am healthy
- ☐ I am responsible
- ☐ I adapt to change well
- ☐ I have a good memory
- ☐ I have a good sense of humor
- ☐ I am honest
- ☐ I am smart
- ☐ Other strength

*** Are you currently participating in any of the following services?**

- ☐ Case management
- ☐ ARMHS
- ☐ Social worker

- [ ] Individual therapy
- [ ] DBT
- [ ] CBT
- [ ] Mindfulness based therapy
- [ ] Grief counseling
- [ ] Chemical dependency treatment
- [ ] Inpatient mental health services
- [ ] Medical Doctor
- [ ] Psychiatry
- [ ] Any other services?
- [ ] None

*** How were you referred to us?**

Questionnaire

In the last week have you...

had serious thoughts about suicide?

- Yes
- No

made suicidal threats?

- Yes
- No

planned and/or prepared for suicide?

- Yes
- No

written or begun writing a suicide note?

- Yes
- No

accessed or could easily access the means to commit suicide?

- Yes
- No

taken precautions against discovery or intervention; deception or concealment about timing, place, etc. ?

- Yes
- No

made indirect references to your own death, arrangements for death?

- Yes
- No

experienced a recent disruption or loss of an interpersonal relationship; negative environmental changes in the last month; recent psychiatric hospital discharge?

- Yes
- No

experienced recent isolation?

- Yes
- No

experienced indifference to or dissatisfaction with therapy?

- Yes
- No

experienced recent medical care?

- Yes
- No

experienced an abrupt clinical change (either negative or positive)?

- Yes
- No

experiencing current hopelessness, anger, both?

- Hopelessness
- Anger

- ○ Both

experiencing depressive turmoil, severe anxiety, panic attacks, severe mood cycling?

- ○ Yes
- ○ No

experienced insomnia?

- ○ Yes
- ○ No

experienced anhedonia (the inability to experience pleasure)?

- ○ Yes
- ○ No

experienced diminished concentration?

- ○ Yes
- ○ No

consumed alcohol?

- ○ Yes
- ○ No

used mood altering substances?

- ○ Yes
- ○ No

Do you have a history of ...

- ☐ suicide attempts
- ☐ self-harm

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

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

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

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

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Borderline Symptom List 23 (BSL-23)

Code: _____ **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**
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, headbanging 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

WE THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

PLEASE RETURN THE QUESTIONNAIRE TO YOUR THERAPIST

AUDIT

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?

   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  **~5% alcohol**	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  **~7% alcohol**	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz.  **~12% alcohol**	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  **~40% alcohol**	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm