Karla Hale Gerdes, Ph.D.
Licensed Psychologist, Marriage & Family Therapist

PATIENT INFORMATION

If services are for a couple or family, please fill out according to whose first name you want on receipts.

Name: _____ Date: _____

Email: _____ Date of birth: _____

Home address: _____ City/State/Zip: _____

Phone: Home: _____ Mobile: _____

__Single __Married __Divorced __Living Together __Widowed Sex: ___M ___F Age: _____

Employed by: _____ Occupation: _____

Bus. phone: _____ Extension: _____

Spouse: _____ Occupation: _____

Employed by: _____ Bus. phone: _____

Emergency contact name: _____ Contact's #: _____

Family MD/Psychiatrist: _____ Referred by: _____

Permission to contact your referral source to thank them? Yes _____ No _____

CHILD OR ADOLESCENT

School name: _____ Grade: _____

Are parents divorced? ___ Yes ___ No Child lives with: _____

Home phone: _____ Bus. phone: _____

According to the divorce decree, who is allowed to seek treatment on child's behalf? *

___Only mom ___Only dad ___Either ___Other: _____

* Please bring a copy of the pages from the divorce decree identifying who has the right to seek treatment.

RESPONSIBLE PARTY

Name: _____ Relationship to client: _____

Address: _____ Home phone: _____

City/State/Zip: _____ Bus. phone: _____

Employed by: _____

Karla Hale Gerdes, Ph.D.
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Patient Information & Consent to Treatment

Welcome to my practice. I look forward to working with you regarding the concerns that brought you here, and I hope that you find our work together beneficial. Please read carefully the following information concerning my professional services and business policies, and discuss with me any questions you may have. Your signature at the end of this document indicates you have read and understand this information, thus providing an agreement for proceeding with treatment.

Qualifications: I am licensed by the State of Texas as a psychologist with a doctoral degree in Counseling Psychology. I am also a licensed marriage and family therapist. I have been in private practice in the North Dallas area for nearly 25 years, with extensive experience working with individuals (children, adolescents, and adults), couples, families, and groups. I am a member of the American Psychological Association (APA), the American Association of Marriage and Family Therapists (AAMFT), and various local and regional psychological associations. Additionally, for several years I provided consulting services to the Cancer Center of Richardson Regional Medical Center.

Orientation: I am trained in a variety of approaches to therapy, including cognitive-behavioral, family systems and family of origin approaches, and solution-oriented, short-term therapy. I employ a variety of techniques to assist you in clarifying your goals for change and taking steps in the desired direction. My overall goal in therapy is to assist you in being as healthy as possible physically, mentally, emotionally, relationally, and spiritually. I believe all people are created with a need for purpose and meaning, a need for significant connection with others, and a capacity for growth. Thus I am committed to providing quality psychological care to assist you in achieving these goals.

Nature of Psychological Services: The purpose of psychological treatment may include relieving distress; decreasing symptoms of a mental or emotional disorder; improving one's mood, self-esteem, or overall well-being; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges. As such, psychotherapy is not an exact science and it is not like a visit to a medical doctor, but rather requires your active participation in identifying problems and goals, and working to make changes. In order for therapy to be most successful, I will at times ask you to take specific steps to work on the issues we discuss, both during our sessions and in the time in between our appointments. I will work to create a safe setting in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable. I will be sensitive to the pacing and timing of these discussions to maximize a therapeutic result.

Therapy Relationship: Sessions are usually 45-50 minutes, on a weekly basis. Less frequent sessions will be scheduled as improvements occur, goals are met, and you near the end of treatment. Feel free to express your preferences for scheduling of sessions, as your needs will likely change over the course of therapy. While psychotherapy often addresses very personal issues, for our work to be therapeutic the relationship must be a professional relationship rather than a social one. Personal and/or business relationships undermine the effectiveness of therapy. Payment for services rendered is the only remuneration I expect, and our contact will be limited to sessions you schedule at my office. Emergency phone calls after hours will be handled as follows: if it is life-threatening, you will be directed to call 911 or go to your nearest emergency room. Crisis management calls will be brief and aimed at stabilizing the situation for processing at our next scheduled appointment.

Effects of Therapy: Psychotherapy can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However I cannot guarantee your specific results. Progress depends on many factors including motivation, effort, and how well we work as a team. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing. Whenever possible, we

will anticipate these risks and discuss them throughout the course of therapy. Together we will work to achieve the best possible results for you.

Patient Rights: Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Our first 1-3 sessions will involve an evaluation of your needs and goals. I will then offer you some initial impressions of what our work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with me are crucial to your success in therapy. You have the right to discontinue our professional relationship at any time, though I recommend a termination session for reaching closure. You also have the right to refuse any recommendations I make. If your refusal, in my professional opinion, compromises my ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), I may determine to discontinue treatment. In such cases, I will provide you with referrals to another competent mental health professional, if you desire.

My services will be rendered in a professional manner consistent with the legal and ethical standards established by the licensing board for psychologists. If at any time or for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns to your satisfaction, you may report your complaints to the Texas State Board of Examiners of Psychologists at (512) 305-7700.

Referrals: Throughout the course of therapy, I will be making recommendations concerning treatment, some of which may involve alternative treatment options that I do not provide, e.g. hypnotherapy, medication evaluations, inpatient or intensive outpatient treatment, to name a few. If at any time you or I believe a referral is needed, I will provide recommendations for other providers or programs to assist you. Alternative treatment options and/or adjuncts to therapy may also be discussed at your request (e.g. support groups, community services). You will be responsible for contacting and evaluating those referrals or alternatives.

Fees and Payment: Initial evaluations are billed at $175 for 60 minutes or $260 for 90 minutes. Individual therapy sessions (45-50 min.) are billed at $155 ($235 for 90 min.) and marital or family therapy sessions (45-50 min.) are billed at $165 ($245 for 90 min.). Sessions may be scheduled for more or less than 45-50 minutes and will be billed in proportion to the hourly rate. Payment is expected at the time services are rendered. For your convenience, I accept Visa and MasterCard, as well as personal checks and cash. If payment becomes a hardship for you, please discuss this with me so we can arrange a suitable payment plan. As of February 2008, I am no longer an in-network provider for any insurance plans. If you wish to use your out-of-network benefits, you will be provided a receipt so that you can file for insurance reimbursement. Insurance benefits usually cover only "medically necessary" treatment, requiring a mental health diagnosis. **Any diagnosis made will become part of your permanent insurance records and may have implications concerning future applications for life insurance or future coverage in the event of a change in health care plans.** If you have concerns regarding your diagnosis, please discuss these with Dr. Hale Gerdes.

Other services for which additional fees apply that are not covered by insurance include: telephone calls (>5-10 min.), clinical consultations with other providers that you give consent for me to speak with; preparation of treatment summaries or treatment plans; letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to you, to another provider, attorneys, or insurance companies.

For legal proceedings that require my response, I bill $225 per hour (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). **Payment will be expected from you, regardless of whose attorney subpoenas my involvement.** Patient records will not be released without written consent, unless court ordered to do so. Please note: a subpoena does not constitute a court order.

Cancellation Policy: If you are unable to keep a scheduled appointment or need to change an appointment, please notify my office as soon as possible. Appointments not kept or cancelled less than 24 hours in advance will be billed for the time scheduled. **Insurance will not pay for missed appointments or late cancellations.**

Records and Confidentiality: Adult records may legally be disposed of seven years after the file is closed. Records for minors may be disposed of seven years after the child's 18th birthday. Trust and openness are essential for effective therapy. Our communications over the course of therapy become part of your **protected health information,** recorded in your patient file, which will remain confidential and stored securely. When disclosure of your records is required by law, you will be notified. Most of these provisions were described to you in the **notice of privacy practices** that you received with the intake packet.

You should be aware of the following **exceptions to confidentiality:**

1. You provide consent to release your records or to share information regarding your treatment.
2. You are at risk of imminent serious harm to yourself or others*;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. You disclose sexual misconduct of a physician or therapist;
5. Information is requested by your insurance company pertinent to processing claims for payment;
6. I receive a court order to disclose information (e.g. child custody or mental competency cases);
7. You file a complaint with my licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.

*In the event that you are deemed an imminent danger to yourself or others, I have a professional duty to contact the proper authorities. ***Medical and/or law enforcement officials may be notified with or without your consent.***

Please indicate in the spaces below who you give consent for me to contact in the event of any emergency:

Name	**Phone Number**	**Relationship to Patient**
_____	_____	_____
_____	_____	_____

Couples/Family Therapy: When seeing couples or families, I will treat as confidential (within the limits cited above) information you disclose to me that you specifically request not be shared with your partner or family member. However, I encourage open communication between couples and families, and I reserve the right to terminate treatment if I judge a secret to be detrimental to the therapeutic process. **Marital or family therapy will be billed as such, not as individual therapy. You should be aware that some insurance plans do not cover marital and/or family therapy.** One clinical file will be maintained for the couple or family. Be aware that that this file may be accessed in its entirety **only with the written consent of all the adult participants (age 18 and above), unless court ordered.**

Phone Messages, Fax Transmissions, and Email: Please initial the following:

I authorize that messages may be left for me regarding appointments or returned calls…(initial all that apply)
____My home answering machine ____With a family member ____My cell phone ____My work voicemail

____ I acknowledge that telephone calls from Dr. Hale may be returned by cell phone. Any messages I leave on Dr. Hale Gerdes' cell phone will contain my return phone number.
____ I acknowledge that voice messages regarding life-threatening emergencies should not be left on Dr. Hale Gerdes' cell phone. In the case of a life-threatening emergency, I will call 911 or go to the nearest ER.
____ I acknowledge that medical records, insurance information, or other information concerning my treatment may be sent by fax transmission when a release of information has been authorized.
____ I acknowledge that emails sent to Dr. Hale Gerdes are checked only during business hours (not on weekends), and thus should not be used for conveying urgent or highly sensitive information. Be aware that information sent via email is not guaranteed to be secure.

Transfer of Records: In the case of death or incapacity, Dr. Hale Gerdes has made provision for another mental health provider to take possession of all her patient records. In this event, you may contact Dr. Hale Gerdes' office for information concerning how to access a copy of your record or how to have your record transferred to another mental health professional of your choosing.

I hereby give my consent for psychological treatment by Dr. Hale Gerdes. I have read this document carefully and understand the information regarding consent and Dr. Hale Gerdes' services and policies contained herein. Any questions I had were discussed and answered to my satisfaction. I agree to comply with the policies stated. I understand that, should I require services when the Dr. Hale Gerdes is on vacation, this consent is transferable to the covering professional as designated by Dr. Hale Gerdes.

Patient Signature_____ Date _____

Parent/Legal Guardian _____ Date_____
(If patient is under age 18)

Karla Hale Gerdes, Ph.D.

5168 Village Creek Dr, Suite 200, Plano, TX 75093 PHONE: 972-248-4673

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and how you have access to it.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with DR. KARLA HALE GERDES. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

DR. KARLA HALE GERDES is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with DR. KARLA HALE GERDES.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, with your permission, we may disclose your protected health information to other physicians who may be involved in your care and treatment. We may use or disclose your protected health information to contact you by phone or email, to set, confirm, or reschedule your appointments.

For Payment – We do not release your protected health information to insurance companies, since we do not file insurance. However, upon your request we will provide you a receipt containing your protected health information, including dates of service, mental health diagnosis, treatment codes, and payment information, which you may use at your discretion, to obtain

out-of-network reimbursement for your appointments. In this case, you are in control of whether and when you release your protected health information for reimbursement purposes. One exception may involve instances wherein you direct us to bill a third party (other than an insurance company) for payment, e.g. another family member, or a church, who is paying for your treatment. When we make a bank deposit, we list checks on the deposit slip using initials only. However, your check contains your name and other identifying information, such as your address.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

_____ _____

(Signature of client, or in the case of a minor, their legal guardian) (Date)

_____

(Printed name of client)

Karla K. Hale, Ph.D.
Licensed Psychologist, Marriage & Family Therapist

Comprehensive Assessment Questionnaire – CHILD/ADOLESCENT

Name: _____ Date: _____

What are the main problems that brought you to the doctor? _____

When did the problems first begin? _____

Have you had a similar problem in the past? ___ Yes ___ No If so, when? _____

Below are listed several areas of functioning. Please check any of the below which have been worsened due to your current problems:

___ School performance
___ My relationship with my family
___ My interest in keeping up my appearance
___ My ability to control my temper
___ My ability to carry out my usual leisure interests and hobbies
___ My ability to plan for my future and set goals for myself
___ My relationships with my friends
___ My ability to manage my usual chores
___ My ability to get along with my parents
___ My ability to control my behavior

Medical History

Please list all prescription medications you are currently taking:

Medication	Dose	Times per day	When did you start?

Please list any health problems: _____

Mental Health History

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name	Dates seen	Medications prescribed	Reason seen

List blood-relatives (parents, siblings, grandparents, aunts, uncles, cousins, etc.) who have any history of emotional problems (depression, anxiety, schizophrenia, drug/alcohol abuse, suicide)

Relation	Dad's side	Mom's side	Problem	Ever Hospitalized?

Substance Use

Do you smoke?_____ How much? _____ For how many years? _____
Do you drink?____ How many days per month? ____ How many drinks do you have in a week?___
Have you ever felt that you were drinking too much? _____
Have you tried unsuccessfully to stop drinking? _____
Have you ever used any of the following?

___marijuana ___cocaine ___ecstasy
___crack ___amphetamines ___heroin
___LSD ___PCP ___other: _____

Have you ever felt you had a problem with any of the above drugs?_____
Have you ever used IV drugs? _____

Patient's Name: _____

Developmental History

Was the child ever adopted? _____ Contact with biological parents? _____
List any complications with pregnancy or delivery_____
List age (in months) when achieved the following developmental milestones:
First word_____ First walked alone _____ Bladder/bowel training complete _____
Please note any difficulties with bedwetting or soiling _____
Any difficulties with behavior, attention, or speech as a child? _____
_____

Family Background

Describe how the child/teenager gets along with parents _____
_____
Please list everyone who currently lives at home (current main residence)

Parent's Name	Age	Relation		Date (since Mo/Yr)	Date (since Mo/Yr)
_____	____	__Biological Father	__Step Father	__/__	__Adoptive Father__/__
_____	____	__Biological Mother	__Step Mother	__/__	__Adoptive Mother__/__

Sibling's Name	Age	Relation		
_____	____	__Biological sibling	__Half sibling	__Step sibling
_____	____	__Biological sibling	__Half sibling	__Step sibling
_____	____	__Biological sibling	__Half sibling	__Step sibling

Others _____ Age ____ Relation? _____
IF biological parents are divorced, how long have they been divorced or separated? _____
Where does the other parent live? _____
How much time is spent with that parent?_____
List names and ages of everyone who lives in that parent's home_____
_____

Parent	Occupation	Highest educational level	Where employed	How long
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Step Father	_____	_____	_____	_____
Step Mother	_____	_____	_____	_____

Educational History

Current grade_____ School Name_____

Subject	Failing	Below Average	Average	Above Average
Math	_____	_____	_____	_____
Reading/English	_____	_____	_____	_____
Science	_____	_____	_____	_____

Describe any recent changes in school performance_____
Describe any academic or disciplinary problems at school_____
If any grades have been repeated, describe circumstances_____
List any extracurricular activities or hobbies_____
Describe relationships with peers at school_____

Social Information

List any current or past jobs _____
List any legal charges, probation or arrests _____
Describe current or past dating relationships _____
What is your religious preference? _____ How often do you attend services? _____

Please complete the attached symptom checklist

Name _____ Date _____

Adolescent Symptom Checklist

(Check all that apply, then circle up to 10 items which are especially bothersome to you)

1) Please check any of the following which may have been particularly stressful to you:

Recent	Past	
☐	☐	Academic problems at school
☐	☐	Conflict with peers at school
☐	☐	Conflict with teachers at school
☐	☐	Conflict with parents
☐	☐	Conflict between parents (e.g. divorce , separation or frequent arguing)
☐	☐	Death or loss of loved one
☐	☐	Move to a new place and losing contact with friends or family
☐	☐	Family member with an alcohol or drug problem
☐	☐	Being abused by someone
☐	☐	Financial pressure in the family

2) Any of the following symptoms for most of the day, nearly every day, for periods longer than several days at a time:

Recent	Past	
☐	☐	Depressed or sad mood
☐	☐	Loss of interest or pleasure in activities that used to be enjoyable to you
☐	☐	Difficulty falling asleep
☐	☐	Difficulty staying asleep or waking up too early (Average number of hours your are sleeping per night? _____)
☐	☐	Sleeping too much (Average number of hours your are sleeping per night? _____)
☐	☐	Increased appetite/Weight gain (lbs._____)
☐	☐	Decreased appetite/Weight loss (lbs._____)
☐	☐	Fatigue/Poor energy level
☐	☐	Decreased activity (School, work, hobbies, social, physical)
☐	☐	Poor concentration or slowed thinking
☐	☐	Thoughts of suicide
☐	☐	Excessive feelings of guilt or worthlessness
☐	☐	Crying spells

3) Any of the following indicating a pattern of hyperactivity or attention problems (beginning no later than age seven):

Recent	Past	
☐	☐	Difficulty sustaining attention during tasks or during play activities
☐	☐	Not seeming to listen to what's being said
☐	☐	Not following instructions and failing to finish schoolwork or chores
☐	☐	Difficulty organizing tasks or activities
☐	☐	Getting easily distracted away from an activity by even minor interruptions
☐	☐	Frequent forgetfulness in daily activities
☐	☐	Frequent fidgeting or squirming in seat
☐	☐	Difficulty staying seated even when expected to remain in seat (e.g. school)
☐	☐	Often running about or climbing on things excessively (or, in older children, feeling restless)
☐	☐	Difficulty playing or doing tasks quietly
☐	☐	Often blurting out answers before the question is completed
☐	☐	Difficulty waiting for your turn in group activities

4) Any of the following indicating a pattern of behavior in which the basic rights of others or major societal rules are violated:

Recent	Past	
☐	☐	Frequent bullying, threatening or intimidation of others
☐	☐	Frequently initiating physical fights
☐	☐	Ever stolen items of significant value
☐	☐	Ever been physically cruel to people or animals
☐	☐	Frequently staying out late at night despite parental prohibitions
☐	☐	Frequent lies or breaking promises to obtain favors or to avoid obligations (i.e. "conning" others)
☐	☐	Ever set fires with the intention of causing serious damage
☐	☐	Destroyed others property
☐	☐	Running away from home (at least overnight)
☐	☐	Truancy from school
☐	☐	Ever breaking into someone else's house, car or building

5) A pattern of negative, hostile or defiant behavior occurring both at home and outside the home:

Recent	Past	
☐	☐	Often loses temper
☐	☐	Often argues with adults
☐	☐	Often actively defies adults requests or rules
☐	☐	Often deliberately does things that annoy other people
☐	☐	Often blames others for his/her own mistakes or misbehavior
☐	☐	Is often touchy or easily annoyed
☐	☐	Is often angry or resentful
☐	☐	Is often spiteful or vindictive

6) Check any of the following relating to your alcohol or drug use:

Recent	Past	
☐	☐	I've felt alcohol or drugs were causing a problem for me
☐	☐	I have frequently used alcohol or drugs
☐	☐	I have felt guilty about my use
☐	☐	Others have worried about my use
☐	☐	I've had a desire or tried unsuccessfully to control my use or cut down
☐	☐	I've used alcohol or drugs more often or in larger amounts than I meant to
☐	☐	I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I've stopped using; or I've had to use in order to relieve withdrawal

7) Any of the following symptoms for most of the day, nearly every day, for longer than two or three days at a time:

Recent	Past	
☐	☐	Euphoric or "high" mood
☐	☐	Irritable mood
☐	☐	Decreased need for sleep without feeling tired
☐	☐	Increased energy level
☐	☐	Increased activity (work, social, physical, sexual)
☐	☐	Thoughts speeded up or racing thoughts
☐	☐	Much increased talkativeness or being much more socially outgoing
☐	☐	Making decisions too impulsively
☐	☐	Going on spending sprees

8) Any of the following disturbances in eating or maintaining normal weight:

Recent	Past	
☐	☐	Insistence on maintaining body weight below expected for age and height
☐	☐	Intense fear of gaining weight or becoming fat even though underweight
☐	☐	I feel "fat" even when others see me as underweight
☐	☐	Eating binges
☐	☐	Feeling of lack of control of eating during eating binges
☐	☐	Vomiting or using laxatives to prevent weight gain
☐	☐	Being overconcerned about body weight and shape

9) Panic attacks with any of the following:

Recent	Past	
☐	☐	Heart pounding or racing heart
☐	☐	Trembling or shaking
☐	☐	Nausea or stomach problems
☐	☐	Shortness of breath or choking
☐	☐	Fear of dying
☐	☐	Chest pain or discomfort
☐	☐	Dizziness, unsteady feelings or faintness
☐	☐	Avoiding situations or places that may cause panic or severe anxiety

10) Check any of the following that apply:

Recent	Past	
☐	☐	I tend to do things on impulse which end up being damaging to me or others
☐	☐	I have tried to commit suicide
☐	☐	I have made cuts, burns or other injuries to myself without wanting to kill myself

11) Any of the following at any time:

Recent	Past	
☐	☐	Hearing voices that are not actually there
☐	☐	Vivid voices in my head that do not seem like my ideas
☐	☐	Feeling that others might be putting thoughts in my head
☐	☐	Feeling others might be able to read my thoughts
☐	☐	Others saying I'm suspicious or paranoid
☐	☐	Feeling others might be talking about me

12) Any of the following problems relating to a past severe trauma or stress:

Recent	Past	
☐	☐	History of relatives hurting me physically or touching me in sexual areas
☐	☐	History of unwanted sexual contact
☐	☐	I have memories or dreams of a stressful event that I have trouble putting out of my head
☐	☐	I sometimes have flashbacks of past events; or I act or feel as though I am re-living a stressful event from the past
☐	☐	I try to avoid situations or people that remind me of a severely stressful event in the past

13) Any of the following obsessions or compulsions:

Recent	Past	
☐	☐	Excessive doubting; or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my mind
☐	☐	Urges to check things, wash things, or count repeatedly
☐	☐	Excessive concern about coming into contact with germs or dirt
☐	☐	Excessive concern with right/wrong or morality
☐	☐	Excessive need for things to be exact or symmetrical