Joy Piccolino, PsyD
Licensed Psychologist

Client Registration

Date_____

1. Client Information

Client Name_____Date of Birth_____
Last Name First Name Initial

Address_____Home Phone_____

City_____State_____Zip_____ Cell Phone_____

Employer_____Occupation_____ Work Phone_____

Email address_____

2. Please indicate how you would like to pay for services by initialing one of the following:

_____ I give Joy Piccolino, PsyD, LP permission to bill my insurance company for services. I will be responsible for co-pays, deductibles, and fees that are not covered by my insurance.

_____ I will pay Joy Piccolino, PsyD, LP directly for services and give permission to bill my insurance company for possible out-of-network benefits that will be paid to me.

_____ I will pay Joy Piccolino, PsyD, LP directly for services and do not wish to involve insurance companies.

3. Primary Insurance

Primary Insurance Company_____

ID#_____Group #_____

Policy Holder Information (If the client is not the employee/policy holder):

Name_____Relationship_____
Last Name First Name Initial

Address_____City_____State_____Zip_____

Date of Birth _____ Employer_____

4. Secondary Insurance

Secondary Insurance Company_____

ID#_____Group #_____

Policy Holder Information (If the client is not the employee/policy holder):

Name_____Relationship_____
Last Name First Name Initial

Address_____City_____State_____Zip_____

Date of Birth _____ Employer_____

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Client Services Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. We can discuss any questions you have about these documents at the first appointment. Please note that the first appointment is an assessment meeting where we both will evaluate whether I can provide services to you on an ongoing basis. When you sign this document, it will represent an agreement between us.

PSYCHOTHERAPY

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Results and experiences vary from person to person.

Our first few sessions will involve an evaluation of your needs. Next, if you decide to continue with therapy, we will develop treatment goals together. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional for a second opinion.

PROFESSIONAL FEES

My hourly fee is $260 for the initial diagnostic session, $215 for subsequent 60-minute therapy sessions, and $170 for 45-minute sessions. In addition to weekly appointments, I charge $215 for other professional services you may need, though I will break down the hourly cost into 15-minute increments if I work for periods of less than one hour. Other services include report/letter writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Fees are occasionally updated.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $430 per hour for preparation and attendance (portal to portal) at any legal proceeding, with a minimum of 2 hours.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. I accept cash, checks, Visa and MasterCard. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. Accounts are due 45 days after the date of service. Overdue accounts may be charged interest at a rate of 1.5% per month.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

There are many different insurance plans and reimbursement options, and I am not able to keep track of them all. It is your responsibility to know your level of coverage for services with me. I recommend all clients contact their insurance company to ask about plan coverage, co-pays, co-insurance, and deductibles, referencing Joy Piccolino, PsyD, LP as your provider.

If you elect to use your health insurance coverage, you should be aware that most insurance companies require that I provide them with your clinical diagnosis and dates of services for billing purposes. Sometimes, insurance companies request additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire records (in rare cases). Although all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. You understand that, by using your insurance, you authorize me to release necessary information to your insurance company. I will try to keep that information limited to the minimum necessary.

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24-hours notice, you will be billed directly according to the scheduled fee or according to the rules of your insurance plan. Your insurance plan does not cover payment for missed appointments; therefore, you are responsible for payment in full. Repeated cancellations and missed appointments may result in termination of the therapeutic relationship. A letter reflecting termination will be mailed to you should this occur.

LIMIT ON UNPAID BALANCE

I may terminate treatment and refer a client elsewhere for continued care if the unpaid balance exceeds $500.00.

RETURNED CHECKS

Payments made by check that are not honored by the bank will incur a returned check fee equal to fees charged by my bank, not to exceed $30 per check. Repeated returned checks will result in your account being designated as a “cash only” account for non-insurance related payments.

AVAILABILITY AND CRISIS COVERAGE

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by confidential voicemail. If you are experiencing distress when I am not available, in the metro area, please call **CRISIS (274747) from a mobile phone, text MN to 741741, or go to the nearest emergency room. If you are not in a crisis, but would like to receive support or information from a peer, you can contact the Minnesota Warmline at (651) 288-0400 or (877) 404-3190, Monday - Saturday from 5 - 10 PM. For a life-threatening emergency, please call 911.

Other resources include these county crisis lines:

Dakota County 24-hour Crisis Line: 952-891-7171
Carver-Scott Mental Health Crisis Program 24-hour phone: 952-442-7601
Ramsey County Crisis Line: 651-266-7900
Hennepin County Crisis Services for Adults (COPE): 612-596-1223

You may contact me by email at **DrJoy@DrJoyPiccolino.com**. Please keep in mind that email technology is not secure and I may not be able to respond immediately. I do not check my email according to a planned schedule, so emergencies

or situations requiring my rapid attention should definitely not be sent by email. Email messages are best kept to requests for me to contact you and to work out scheduling, with information about how and when I can reach you.

WEB SEARCHES

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age, there is an incredible amount of information available about individuals on the Internet, much of which may actually be known to that person and some of which may be inaccurate and/or unknown. It has also become common for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions.

If you encounter any information about me through web searches, or in any other fashion, please discuss this with me during our time together so that we can deal with it and its potential impact on our work. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

SOCIAL MEDIA

I honor your privacy and value our therapeutic relationship. In order to preserve the integrity of our work, I will not seek or accept invitations to be connected with you via social media.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I routinely consult other mental health professionals about cases in order to provide the best care to clients. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

- In the event of my death or incapacitation, access to your records will be given to executors of my professional will for the purpose of notifying you and for maintenance of your file until such time as your records may be destroyed.

There are some situations where I am permitted or required to disclose information ***without*** either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order from a judge. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency, pursuant to their lawful authority, is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a workers compensation claim, I must, upon appropriate request, disclose information related to the claim to appropriate individuals, which may include the patient's employer, the insurer or the Department of Labor and Industry.

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission, but there are a few exceptions based on governing entities such as state laws and ethics codes. Situations in which I may be required to discuss information without your consent include:

- Reports of recent child abuse or neglect
- Maltreatment of vulnerable adults
- Imminent threats to self or others
- Use of illicit chemical or alcohol during pregnancy
- Court order
- Information regarding sexual contact with another health care provider

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if they determine that the issues demand it, and I must comply with that court order. There are some situations in which I am legally obligated to take action to protect others from harm even if I have to reveal some information about your treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I am required to make a report to the appropriate state agency.

If I believe that you are threatening serious bodily harm to another person, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you. If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PATIENT RIGHTS

HIPAA provides you with rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MISCELLANEOUS

If we meet in another setting, I will acknowledge you only if you acknowledge me first. In these situations, confidentiality and your comfort are my guides.

CLIENT'S BILL OF RIGHTS

As a consumer of psychological services offered by a psychologist licensed by the state of Minnesota, you have the right:

A. to expect that the provider has met the minimum qualifications of education, training, and experience required by state law for licensure;

B. to examine public records maintained by the Board of Psychology that contain the credentials of the provider;

C. to report complaints to the Minnesota Board of Psychology;

Phone: (612)617-2230; Hearing/Speech Relay: (800)627-3529
Fax: (612)617-2240
www.psychologyboard.state.mn.us

D. to be informed of the cost of professional services before receiving the services;

E. to privacy as defined and limited by rule and law;

F. to be free from being the object of unlawful discrimination while receiving psychological services;

G. to have access to their records as provided in Minnesota Statutes, sections 144.291 to 144.298, except as otherwise provided by law or a prior written agreement;

H. to be free from exploitation for the benefit or advantage of the provider;

I. to terminate services at any time, except as otherwise provided by law or court order;

J. to know the intended recipients of psychological assessment results;

K. to withdraw consent to release assessment results, unless that right is prohibited by law or court order or is waived by prior written agreement;

L. to a nontechnical description of assessment procedures; and

M. to a nontechnical explanation and interpretation of assessment results, unless that right is prohibited by law or court order or is waived by prior written agreement.

Joy Piccolino, PsyD
Licensed Psychologist

Acknowledgement Form

Client Name _____ DOB _____

CONSENT FOR TREATMENT: I consent to treatment and agree to abide by the policies and agreements with Joy Piccolino, PsyD, LP, as stated in the Client Services Agreement.

ACKNOWLEDGEMENTS

- CLIENT RIGHTS AND DATA PRIVACY: I have received and read the Client Services Agreement and HIPAA Notice form.

- ASSIGNMENT OF INSURANCE BENEFITS: I the undersigned, certify that I have insurance coverage as noted in the Client Registration and assign directly to Joy Piccolino, PsyD, LP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Joy Piccolino, PsyD, LP to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

- CANCELLED/MISSED APPOINTMENTS: I understand that if an appointment is missed or cancelled with less than 24-hours notice, I will be billed directly according to the scheduled fee or according to the rules of my insurance plan. Repeated cancellations and missed appointments may result in termination of the therapeutic relationship. A letter reflecting termination will be mailed to you should this occur.

- AUTHORIZATION FOR COMMUNICATIONS VIA TEXT OR EMAIL AND ACKNOWLEDGMENT: Per HIPAA regulations, you have the right to receive communications via text message and/or non-secured email from Joy Piccolino, PsyD, LP, if you choose. These messages will be used for scheduling, logistics, and administrative purposes only. Before considering using non-secured email or text communication be advised that text messaging and nonsecure email messaging is an unencrypted conversation that has the potential to be read by a third party. Your cell service carrier rates will apply to communications via your cell phone. Joy Piccolino, PsyD, LP is not responsible for any charges you may incur. Please initial one:

  I DO consent_____ Email address:_____

  I DO NOT consent_____

- COURT COSTS: I understand that if Joy Piccolino, PsyD, LP is required, by subpoena or other means of summoning, to appear in court on my behalf that I will be responsible for a fee for all time and costs associated, including but not limited to deposition time, attorney meetings and calls, travel time, preparation time, research, costs for copying records, time in court, etc. Because of the difficulty of legal involvement, I charge $430/hour (portal to portal), with a minimum of 2 hours.

- EMERGENCY CONTACT: In case of emergency, Joy Piccolino, PsyD, LP is authorized to contact the following person for the purpose of assessing client safety or whereabouts or obtaining other emergency information. Clinical information will not be released unless necessary to confirm or assess safety.

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

By signing below, I consent to treatment and understand and agree to the policies and terms outlined above and in the Client Services Agreement. This document is subject to regular updates.

Client Signature: _____ Date: _____

Printed Name: _____

Joy Piccolino, PsyD
Licensed Psychologist

Credit Card Authorization

Client Name: _____

I have implemented a policy which enables you to maintain your credit card information securely on file with Joy Piccolino, Psy.D., LP. In providing me with your credit card information, you are giving Joy Piccolino, Psy.D., LP permission to automatically charge your credit card on file for your outstanding balances on your account, including co-pays, deductibles, co-insurance, and late cancellations or missed appointments, unless other arrangements have been made.

Co-pays/Co-insurance: Co-pays and co-insurance are generally due at the time of session and may be paid using cash, check, or credit card. They are not automatically charged to the card on file at the time of service, unless requested.

Outstanding Balance: If your insurance provider has paid their portion of your bill and there is still an outstanding balance owed, Joy Piccolino, Psy.D., LP will notify you in session and/or via mailed billing statement. **If the balance is not paid in full within 15 days of the notice, at that time any balance owed will be charged to your credit card.** A copy of the charge will be e-mailed to you.

This agreement will expire on termination of services and settlement of final balance. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if there is an unpaid balance.

Type of Card: ____ Visa ____ MasterCard

Credit card #: _____

Security Code: _____ Expiration Date:_____

Name on Card (if different): _____

Billing Address for Credit Card Statements (if different):

_____
Street Address *Zip Code*

Signature: _____ Date:_____

Joy Piccolino, PsyD
Licensed Psychologist

Telehealth Services Informed Consent Form

I _____ consent to engaging in telehealth with Joy Piccolino, PsyD, LP. Telehealth will occur primarily through Doxy.me, a HIPAA-compliant telehealth platform, and less often via telephone. I agree to originate my appointment from a non-public location that allows privacy and minimizes the ability of the appointment being overheard.

I understand I have the following rights with respect to telehealth sessions:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. The laws that protect the confidentiality of my personal information, as outlined in the Client Services Agreement, also apply to telehealth.

3. I understand there are risks to telehealth including but not limited to the possibility, despite reasonable efforts on the part of Joy Piccolino, PsyD, LP, that the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

4. In addition, I understand that telehealth-based services and care may not be as complete as in-person services.

5. By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis, I should immediately call 911, a local county crisis agency or the National Suicide Hotline at 988, or go to the nearest hospital or crisis facility.

Records

The telehealth sessions shall not be recorded in any way by either participant unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

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

My signature below indicates that I have read this Agreement and agree to its terms.

Client Signature:_____ Date:_____

Joy Piccolino, PsyD
Licensed Psychologist

HIPAA Notice Form

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Patient's Health Information

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse/Neglect**
- **Vulnerable Adult Abuse/Neglect**
- **Health Oversight Activities:** The Minnesota Board of Psychology may subpoena records from me if they are relevant to an investigation it is conducting.
- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order.
- **Serious Threat to Health or Safety**: If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.
- **Worker's Compensation**: If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide written Notice to you at our next session or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Department of Health & Human Services 175 5th St E, St. Paul, MN 55101 (651) 290-3861.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on November 15, 2004.

Joy Piccolino, PsyD
Licensed Psychologist

Client History Form

Name: _____ Date: _____

Current living situation: _____ Marital status: _____

Briefly describe the problems or concerns that prompted you to seek therapy now: _____

How long has it been a problem?: _____

What are your goals for our work together?:_____

MENTAL HEALTH & MEDICAL HISTORY

Primary care provider/clinic: _____ Date of last physical:_____

Have you previously been treated for mental health issues? ____No ____Yes - therapy ____Yes - medication

If yes, where and when were you treated? Was it helpful?: _____

Previous hospitalizations (incl psychiatric):_____

Previous surgeries: _____

Medical/health concerns:_____

History of concussions/head injuries, dates:_____

List all current prescribed medications, dosages, and reasons for taking:_____

Symptom Checklist: Please check all symptoms that you are currently experiencing.

⬜ Intimate relationship problems ⬜ Parental stress ⬜ Family relationship problems ⬜ Work-related problems ⬜ Grief/death ⬜ Loss of relationship ⬜ Other losses ⬜ Social difficulties ⬜ School problems ⬜ Financial difficulties ⬜ Life transitions ⬜ Chronic pain ⬜ Chronic health problems ⬜ Depressed mood ⬜ Irritable mood ⬜ Fatigue ⬜ Difficulty enjoying life ⬜ Social isolation ⬜ Decreased appetite ⬜ Increased appetite ⬜ Difficulty falling asleep ⬜ Difficulty staying asleep ⬜ Early awakening ⬜ Sleeping too much ⬜ Unable to sleep ⬜ Poor concentration ⬜ Excessive guilt ⬜ Low self-esteem ⬜ Negative self-talk ⬜ Hopelessness ⬜ Moving or speaking slowly ⬜ Low sex drive ⬜ Overactive sex drive	⬜ Anxious mood ⬜ Restlessness ⬜ Worries ⬜ Racing thoughts ⬜ Panic attacks ⬜ Muscle tension ⬜ Obsessive thoughts ⬜ Repetitive rituals/behaviors ⬜ Social phobia/anxiety ⬜ Phobia of animals or objects ⬜ Trouble leaving safe environment ⬜ Experienced or witnessed traumatic event ⬜ Recurrent distressing dreams or memories related to traumatic event ⬜ Reliving traumatic experience ⬜ Avoidance of talking or thinking about traumatic event ⬜ Avoidance of people/places/ objects that remind you of traumatic event ⬜ Trouble recalling important aspects of traumatic event ⬜ Changes in belief about self, others, or the world ⬜ Loss of interest in things once enjoyed before trauma ⬜ Feeling detached from others ⬜ Hypervigilance ⬜ Exaggerated startle response ⬜ Difficulty imagining the future	⬜ Suicidal thoughts ⬜ Previous suicide attempt ⬜ Self-harm behavior ⬜ Thoughts of harming others ⬜ Anger outbursts ⬜ Mood swings ⬜ Impulsive behavior ⬜ Excessive alcohol use ⬜ Drug use ⬜ Overspending ⬜ Binge eating ⬜ Purging ⬜ Restricting food intake ⬜ Obsession with Internet ⬜ Chronic feeling of emptiness ⬜ Fear of abandonment ⬜ Intense or unstable relationship ⬜ Unstable sense of self ⬜ Reactive and sudden mood shift ⬜ Visual hallucinations ⬜ Auditory hallucinations ⬜ Fear that others people are out to get you ⬜ Belief that thoughts or ideas are inserted into your head

FAMILY/SOCIAL HISTORY

Are your parents: ____alive____ deceased____ married____ divorced____other (please specify)_____

Do you have siblings? Yes / No If yes, where do you fall in birth order?_____

Family history of mental health and substance abuse:_____

Have you had legal problems? Yes / No If yes, please describe:_____

Are you involved in current litigation or a legal situation? Yes / No If yes, please describe:_____

EDUCATION/EMPLOYMENT INFORMATION

Highest grade completed:_____ Occupation:_____

Current school/employment status:_____

Military service (date and branch):_____

CAGE/CAGE-AID

Preliminary Questions:
1. Do you drink alcohol? Yes/No
2. Have you ever experimented with drugs? Yes/No

If you answered yes to either of the above questions, please answer the questions below.

1. In the last three months, have you felt you should cut down or stop drinking or using drugs? Yes/No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? Yes/No
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs? Yes/No
4. In the last three months, have you been waking up wanting to have a drink or use drugs? Yes/No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**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 fidgety 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 in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over 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's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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