Adult MH/SA Registration

Dear Perspective Client,
Please complete all sections of the Registration Document enclosed in preparation for your initial assessment with Bethany Johnson, LCSW.
The information requested includes Protected Health Information and will be included in patient chart. The following forms are specific to **Adults seeking a pre-bariatric mental health assessment.**

Name: _____ Referral Source: _____

Guardian: _____ Spouse/Partner: _____

DOB: _____ Gender: _____

Address: _____ Phone: _____

_____ Alt Phone: _____

Email:_____

Appointment Reminder Preference: ☐ Text ☐ Email

Please note, in order to receive text reminders you must sign Non-Secure Communication/Transmission form, clients are able to indicate reminder preferences when scheduling online.

Marrital Status ☐Single ☐Married ☐Never Married ☐Divorced ☐Separated

Employment Status: ☐Full-time ☐Part-time ☐Seasonal ☐Homemaker
☐Student ☐Retired ☐Disabled ☐Military

Current Employer: _____ Length of Employment: _____

Primary Health Insurance: _____
Subscriber Name: _____
Subscriber DOB: _____ Member ID: _____
Group Number: _____

Secondary Health Insurance: _____
Subscriber Name: _____
Subscriber DOB:_____ Member ID: _____
Group Number: _____

Employee Assistance Program
Agency/Group: _____
Confirmation Number: _____ Approved Number of Visits: _____

Primary Problem:

_____
_____
_____
_____
_____
_____

Assessment Type:

☐Mental Health ☐Substance Use ☐Risk ☐Other: _____

Current Symptoms:

☐Depression
☐Conflict
☐Work Issues
☐Grief
☐Hallucinations
☐Memory
☐Weight Loss
☐Anxiety
☐Sleep Issues
☐Eating Issues
☐Infidelity
☐Drug Abuse DUI
☐Violent Thoughts
☐Panic
☐Sadness
☐Trauma
☐Pain
☐Nightmares
☐Spacing Out
☐Anger outburst
☐Hopelessness
☐Worthlessness
☐Confusion
☐Chronic Illness
☐Forgetfulness
☐Thoughts of Suicide/Not wanting to live

Other Symptoms:

_____

_____

Previous/Current Diagnosis:

☐Migraine
☐Chronic UTI's
☐Seizures
☐Brain Injury
☐Cancer
☐sleep disorder
☐Diabetes
☐Sleep disorders
☐Chronic Strep
☐Intellectual Disorders
☐Hormonal Issues
☐Obesity
☐Hyperthyroidism
☐Developmental Disorders

Primary Care Provider: _____

Neurologist/Psychiatrist: _____

Please provide a List of medications, dosages, and frequency:

_____

_____

_____

_____

Release and Request of Patient Health Information
Bethany Johnson, LCSW

PATIENT INFORMATION

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip _____ Phone _____

Information to be released from

Name (person and/or organization) Bethany Johnson, LCSW B Johnson LLC
Address 606 E Main Street, STE 2
City: Madison State Indiana Zip 47250
Phone: 234-444-5055 Alt. Phone: 812-265-4151 Fax: 812-265-5028

Information to be released to

(Where do you want the information sent? Who may have the information?)

Name (persons and/or organization): Dr David Schumacher, Norton Kings Daughters Hospital, General/ Bariatric Surgery
Address 1373 E State Rd 62
City: Madison State Indiana Zip 47250
Phone Number 812-801-8840 Fax Number 812-801-0767

Informati on tobe Released

(What do you want sent or released? Check the appropriate box.)

☐ Patient/Client requests that an exchange of information permitted between the above identified entities

☐ Patient/Client requests that information be release to the designated individual/agencies above in the event of a mental health or physical health crisis.

☐ Patient/Client request that release remain on file for ongoing and/or future identified use for an extent of 1 year or upon patient discharges from treatment revocation of release.

☐ Patient/ Client request to terminate prior standing release of information to the above persons/ agency.

Date(s) of Service: From ___/___/___ To ___/___/___

Only record types checked below:

☐ Attendance/compliance ☐ Progress notes
☐ Written/Telephone Communication
☐ Discharge Summary ☐ Billing Information ☐ Appointment Reminders
☐ Psychotherapy ☐ Behavioral Health Assessment Summary ☐ Appointment Scheduling
☐ Recommendations ☐ Behavioral Health Treatment Plan ☐ Trauma History
☐ Other records Specify record types(s) _____

Special Authorization Section

(Per IC-16-39-2 this specialauthorization is valid for 180 days.)

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse & Treatment	☐ Yes	☐ No
HIV/ STI Testing and Results	☐ Yes	☐ No
Mental Health/ Psychiatric Diagnosis	☐ Yes	☐ No
Psychotherapy Records	☐ Yes	☐ No
Genetic Records	☐ Yes	☐ No

Release Instructions:

(How and when do you want the information released?)

Release Method/Format requested: (check one) ☐ Electronic Access
E-mail address _____
All Email communication will be completed via an encrypted email requiring a password and accessible for a limited time
☐ Paper ☐ Fax (patient care only) ☐ Mail ☐ Verbal
Frequency of release: _____
Date information is needed _____ NOTE: Please allow 30 days for processing

Purpose of Release:

(Why is it needed?)

☐ Personal use* ☐ Multidisciplinary Treatment ☐ Social Security appeal
☐ Continuing Care ☐ Insurance payment/claim ☐ Social Security Disability Determination*
☐ Transfer of care ☐ Litigation/legal/Attorney
☐ Other* _____

*Fees may be charged in accordance with IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to theabove-named authorized entity. The revocation will not apply to information that has already been released in response to this authorization.

I understand that I am not required to sign this Authorization in order to receive health care treatment.

Records may include records that it received from other organizations, other collateral information shared and stored within record will not be released as a part of release of records

B Johnson, LLC or Bethany Johnson, LCSW cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered bystate and federal privacy protections after it is released. By signing this authorization, you release B Johnson, LLC or Bethany Johnson, LCSW from any and all liability resulting from a redisclosure by the recipient.

Your signature indicates that you have read and understand this form, and you authorizerelease of your information as described above.

Patient/Legal Guardian Signature _____ _____

Parent Legal Guardian Printed Name: _____ Date

_____
Authority to act on behalf of patient (Attach documentation)

Eating Disorder Examination Questionnaire (EDE-Q 6)

Instructions: The following questions are concerned with the past four weeks (28 days) only.
Please read each question carefully, and please answer all of the questions.

Questions 1-12: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days) only.

On How Many Days of the Past 28 days…	Zero Days	1-5 Days	6- 12 Days	13-15 Days	16-22 Days	23- 27 Days	Every day
1. Have you been deliberately trying to limit the amount of food you eat in order to influence your shape or weight (whether of not you have succeeded) ?	0	1	2	3	4	5	6
2. Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?	0	1	2	3	4	5	6
3. Have you tried to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
4. Have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
5. Have you had a definite desire to have an empty stomach with the aim of influencing your weight or shape?	0	1	2	3	4	5	6
6. Have you had a definite desire to have a totally flat stomach?	0	1	2	3	4	5	6
7. Has thinking about food, eating, or calories made it very difficult to concentrate on things you are interested in (for example, working, following conversation, or reading)?	0	1	2	3	4	5	6
8. Has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working following conversation, or reading)?	0	1	2	3	4	5	6
9. Have your had a definite fear of losing control over eating?	0	1	2	3	4	5	6
10. Have you had a definite fear that you might gain weight?	0	1	2	3	4	5	6
11. Have you felt fat?	0	1	2	3	4	5	6
12. Have you had a strong desire to lose weight?	0	1	2	3	4	5	6

Please continue on the next page.

Eating Disorder Examination questionnaire (EDE-Q 6) Continued

Questions 13-18: Please fill in the appropriate number in the boxes on the right. Remember the Questions only refer to the past four weeks (28 days).

Over the past 28 days….	**Number of Times/ Days**
13. Over the past 28 days, how many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)?	
14. On how many of these times did you have a sense of having lost control over your eating (at the time you were eating)?	
15. Over the past 28 days, on how many days have such episodes of overeating occurred (ie. You have eaten an unusually large amount of food and have had a sense of loss of control at the time)?	
16. Over the past 28 days, how many times have your made yourself sick (vomiting) as a means of controlling your shape or weight?	
17. Over the past 28 days, how many times have you taken laxatives as a of means of controlling your shape or weight?	
18. Over the past 28 days, how many times have you exercised in a "driven" or "compulsive" way as a means of controlling your weight, shape or amount of fat, or to burn calories?	

Questions 19-21: Please circle the appropriate number.
Please note: for the purpose of these questions "binge eating" means eating what others would regard as an unusually large amount of food for the circumstances, accompanied by a sense of having loss control over eating.

	No Days	**1-5 days**	**6-12 days**	**13-15 days**	**16-22 days**	**23-27 days**	**Every day**
19. Over the past 28 days, on how many days have you eaten in secret (ie furtively)? … do not count episodes of binge eating.	0	1	2	3	4	5	6
	None of the times	A few of the times	Less than half	Half of the times	More than half	Most of the time	Every time
20. On what portion of the times that you have eaten have you felt guilty (felt that you have done wrong) because of the effect on your shape or weight? … Do not count episodes of binge eating.	0	1	2	3	4	5	6
	Not at all	Slightly		Moderately		Markedly	
21. Over the past 28 days, how concerned have you been about other people seeing you eat? … Do not count episodes of binge eating.	0	1	2	3	4	5	6

Please continue to the next page.

Name:_____ Date: _____

Eating Disorder Examination Questionnaire EDE-Q Continued

Questions 22-28: Please circle the appropriate number on the right.
Remember that the questions only refer to the past four weeks (28 days).

On how many of the past 28 days…	Not at All	Sightly		Moderately		Markedly	
22. Has your weight influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
23. Has your shape influenced how you think about (judge) yourself as person?	0	1	2	3	4	5	6
24. How much would to have upset your if you had been asked to weigh yourself once a week (no more, no less often) for the next four weeks?	0	1	2	3	4	5	6
25. How dissatisfied have you been with your weight	0	1	2	3	4	5	6
26. How dissatisfied have you been with your shape?	0	1	2	3	4	5	6
27. How uncomfortable have you felt seeing your body (for example, seeing your body in the mirror, in a shop window reflection, while undressing or taking a bath/shower)?	0	1	2	3	4	5	6
28. How uncomfortable have you felt about others seeing your shape or figure (for example, in communal changing rooms, when swimming, or wearing tight clothes)?	0	1	2	3	4	5	6

What is your weight at present? (Best estimate): _____
If attempting to lose weight, what is your goal weight and/or size? _____lbs Size:____

What is your height? (Best estimate): _____

Do you take any diet or weight loss medication/ supplements? Yes____ No ____

If so, are they being prescribed by a physician? Yes____ No ____

If Female:

Over the past 3-4 months have you missed any menstrual Periods?

Yes ____ No____

If so, How Many: _____

Have you, or are you currently taking birth control? Yes ____ No____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

LEVEL 2—Depression—Adult*

*PROMIS Emotional Distress—Depression—Short Form

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt worthless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt that I had nothing to look forward to.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt helpless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt like a failure.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt depressed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt unhappy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	I felt hopeless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Anxiety—Adult*

*PROMIS Emotional Distress—Anxiety—Short Form

If the measure is being completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____hours/week

Instructions to patient: The questions below ask about these feelings in more detail and especially how often you (individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt fearful.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt anxious.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt worried.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I found it hard to focus on anything other than my anxiety.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt nervous.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt uneasy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt tense.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Sleep Disturbance—Adult*

*PROMIS—Sleep Disturbance—Short Form

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions to patient: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "problems with sleep that affected your sleep quality over all" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

In the past SEVEN (7) DAYS....						
	Not at all	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**	
1. My sleep was restless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2. I was satisfied with my sleep.	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1	
3. My sleep was refreshing.	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1	
4. I had difficulty falling asleep.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
In the past SEVEN (7) DAYS....						
	Never	**Rarely**	**Sometimes**	**Often**	**Always**	
5. I had trouble staying asleep.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6. I had trouble sleeping.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7. I got enough sleep.	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1	
In the past SEVEN (7) DAYS....						
	Very Poor	**Poor**	**Fair**	**Good**	**Very good**	
8. My sleep quality was...	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1	
Clinician Use					**Total/Partial Raw Score:**	
					Prorated Total Raw Score:	
					T-Score:	

LEVEL 2—Substance Use—Adult*

*Adapted from the NIDA-Modified ASSIST

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5-TR Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "using medicines on your own without a doctor's prescription, or in greater amounts or longer than prescribed, and/or using drugs like marijuana, cocaine or crack, and/or other drugs" at a slight or greater level of severity. The questions below ask how often you (the individual receiving care) have used these medicines and/or substances **during the past 2 weeks. Please respond to each item by marking (✓ or x) one box per row.**

During the past **TWO (2) WEEKS**, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed?							
		Not at all	**One or two days**	**Several days**	**More than half the days**	**Nearly every day**	**Item Score**
a.	Painkillers (like Vicodin)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
b.	Stimulants (like Ritalin, Adderall)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
Or drugs like:							
d.	Marijuana	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
e.	Cocaine or crack	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
f.	Club drugs (like ecstasy)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
g.	Hallucinogens (like LSD)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
h.	Heroin	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
i.	Inhalants or solvents (like glue)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
j.	Methamphetamine (like speed)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Clinician Use Total Score:	

Severity of Acute Stress Symptoms—Adult*

*National Stressful Events Survey Acute Stress Disorder Short Scale (NSESSS)

Please list the traumatic event that you experienced: _____

Date of the traumatic event: _____

Instructions: People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? **Please respond to each item by marking (✓ or x) one box per row.**

		Not at all	A little bit	Moderately	Quite a bit	Extremely	Item score
1.	Having "flashbacks," that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	Being "super alert," on guard, or constantly on the lookout for danger?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	Feeling jumpy or easily startled when you hear an unexpected noise?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
Clinician Use						**Total/Partial Raw Score:**	
						Prorated Total Raw Score: (if 1 item left unanswered)	
						Average Total Score:	

Severity of Dissociative Symptoms—Adult*

*Brief Dissociative Experiences Scale (DES-B)—Modified

Instructions: For each statement below, please check (✓) the box that best answers each question to show how much each thing has happened to you in the past SEVEN (7) DAYS.

		Not at all	Once or twice	Almost every day	About once a day	More than once a day	**Item score**
1.	I find myself staring into space and thinking of nothing.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	People, objects, or the world around me seem strange or unreal.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	I find that I did things that I do not remember doing.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	When I am alone, I talk out loud to myself.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	I feel as though I were looking at the world through a fog so that people and things seem far away or unclear.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	I am able to ignore pain.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	I act so differently from one situation to another that it is almost as if I were two different people.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
8.	I can do things very easily that would usually be hard for me.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
Clinician Use						**Total/Partial Raw Score:**	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

DES-B (Dalenberg C, Carlson E, 2010) modified for DSM-5 by C. Dalenberg and E. Carlson.

The Personality Inventory for DSM-5—Brief Form (PID-5-BF)—Adult

Name: _____ **Date:**_____

Instructions: This is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no right or wrong answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.						
		Very False or Often False	**Sometimes or Somewhat False**	**Sometimes or Somewhat True**	**Very True or Often True**	**Item score**
1	People would describe me as reckless.	0 ☐	1 ☐	2 ☐	3 ☐	
2	I feel like I act totally on impulse.	0 ☐	1 ☐	2 ☐	3 ☐	
3	Even though I know better, I can't stop making rash decisions.	0 ☐	1 ☐	2 ☐	3 ☐	
4	I often feel like nothing I do really matters.	0 ☐	1 ☐	2 ☐	3 ☐	
5	Others see me as irresponsible.	0 ☐	1 ☐	2 ☐	3 ☐	
6	I'm not good at planning ahead.	0 ☐	1 ☐	2 ☐	3 ☐	
7	My thoughts often don't make sense to others.	0 ☐	1 ☐	2 ☐	3 ☐	
8	I worry about almost everything.	0 ☐	1 ☐	2 ☐	3 ☐	
9	I get emotional easily, often for very little reason.	0 ☐	1 ☐	2 ☐	3 ☐	
10	I fear being alone in life more than anything else.	0 ☐	1 ☐	2 ☐	3 ☐	
11	I get stuck on one way of doing things, even when it's clear it won't work.	0 ☐	1 ☐	2 ☐	3 ☐	
12	I have seen things that weren't really there.	0 ☐	1 ☐	2 ☐	3 ☐	
13	I steer clear of romantic relationships.	0 ☐	1 ☐	2 ☐	3 ☐	
14	I'm not interested in making friends.	0 ☐	1 ☐	2 ☐	3 ☐	
15	I get irritated easily by all sorts of things.	0 ☐	1 ☐	2 ☐	3 ☐	
16	I don't like to get too close to people.	0 ☐	1 ☐	2 ☐	3 ☐	
17	It's no big deal if I hurt other peoples' feelings.	0 ☐	1 ☐	2 ☐	3 ☐	
18	I rarely get enthusiastic about anything.	0 ☐	1 ☐	2 ☐	3 ☐	
19	I crave attention.	0 ☐	1 ☐	2 ☐	3 ☐	
20	I often have to deal with people who are less important than me.	0 ☐	1 ☐	2 ☐	3 ☐	
21	I often have thoughts that make sense to me but that other people say are strange.	0 ☐	1 ☐	2 ☐	3 ☐	
22	I use people to get what I want.	0 ☐	1 ☐	2 ☐	3 ☐	
23	I often "zone out" and then suddenly come to and realize that a lot of time has passed.	0 ☐	1 ☐	2 ☐	3 ☐	
24	Things around me often feel unreal, or more real than usual.	0 ☐	1 ☐	2 ☐	3 ☐	
25	It is easy for me to take advantage of others.	0 ☐	1 ☐	2 ☐	3 ☐	
	Clinician Use only				Total/Partial Raw Score:	
					Prorated Total Score: (if 1-6 items left unanswered)	
					Average Total Score:	