Dedicated Outpatient Therapy Services, LLC

906 E. 1st Street Chandler, OK 74834
Phone: 405-258-3033 Fax: 405-258-3011

Client Information:

Last Name:_____ First Name:_____ MI_____

SSN:____-___-_____ DOB:___/____/_____ Age:_____ Sex: _____M ____F Grade:_____

Ethnicity: ___ White ___Asian ____American Indian ____Pacific Islander ____African American

____Hispanic/Latino _____ Non Hispanic/Latino

Marital Status: ___Single ___Married ___Separated ___Divorced ___ Widowed

Address:_____ City:_____ State: _____ Zip:_____

Primary Phone:_____ Preferred Contact: ___Text ____Call ___ Email

Email:_____

Emergency Contact:

Please list someone who does not live in the home

Last Name:_____ First Name:_____

Primary Phone:_____ Relationship_____

Current Living Situation:

I live (check one): ___Alone ___W/significant other ___Family/ Biological ___ Non Relative/Foster

Number of Persons in the home: _____

Persons living in the home (Please list everyone in home/use back if needed:

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Family History:

Have any members of your extended family suffered or dealt with the following (check all that apply)

___ Alcoholism (Who?_____)

___ Drug Addiction (Who?_____)

___ Sex Addiction (Who?_____)

___ Gambling (Who?_____)

___ Eating Disorder (Who?_____)

___ Depression (Who?_____)

___Chronic Pain (Who?_____)

___ Chronic Medical Condition (Who?_____)

___ Anxiety (Who?_____)

___ Hospitalized for Mental Health (Who?_____)

Chief Concerns For Seeking Treatment:

____Mood ___Anxiety ___Relationships ___Employment ___Memory

____Concentration ____Substance Abuse ____ Medical Issues ____ Recent Event

Reported Mood(on the day you are completing paperwork):

____Euphoric ____Elated ___Anxious ____Depressed ____Worried ___Hopeless

____Calm ____Suicidal ___Irritable ____ Panicky ____Angry

Recent Stressors:

____Divorce ____Housing ____Conflict ____Work/School ____Losses/Death

____Medical ____Transitions ____Legal ____Other:_____

How many times a week do you exercise: _____ What kind of exercise:_____

Are you having problems sleeping: ___ No ___ Yes ___Sleeping to much ____Sleeping to little

Any Difficult with appetite or eating habits: ___ No ___Yes ___Eating More ____ Eating Less

Currently Suicidal: ____ No ____Yes Previously Suicidal: ____No ____Yes

Do you have thoughts of self harm or harming others? ____ No _____Yes

Have you received counseling services before? ____No ____Yes Where? _____

Advance Directive:

Identification of someone who can be authorized to make decisions for you if you are unable to make those decisions as they apply to mental health/substance abuse services. Do you have some identified to make decisions for you regarding mental health/substance abuse services, if you are unable to make those decisions? ____No ____Yes

If so who: _____ Relationship: _____

Third Party Billing Authorization:

I authorize D.O.T.S, LLC to bill me, bill my insurance and/or the individual listed below:

1) For each service at the time of service according to the rate and schedule of:
    a. Individual $150.00 an hour
    b. Family $150.00 an hour
    c. Group $125.00 an hour
2) For a missed session at the regular session rate if I cancel less than 48 hours before my appointment.
3) A monthly late fee of 10% if and when my payment balance becomes past due.
4) For court appearances according to the rate and schedule of:
    a. $100.00 an hour at a 4-hour minimum

I acknowledge that I will receive a receipt for the payment and the appropriate information needed to submit to my insurance company, other party listed, and/or for tax purposes of all payments.

Insurance Company: _____ **Policy Number:** _____

Policy Holder: _____ **DOB:** _____

Client Signature: _____

Legal Guardian/Parent: _____

Provider Signature: _____

Medical Marijuana:

Please provide a copy of your card

_____User _____Non User How Often:_____

Medications:

___Over Use ____As prescribed _____Forgetful _____Inconsistent _____Discontinued

Tobacco:

____Nonuser _____No Longer Using _____User Type:_____

Alcohol:

____Non Drinker ____ Social _____ Drinker How Often:_____

Please describe a brief description of your alcohol use in the space below:

_____

Street Drugs:

_____Non User _____ User Type:_____

Hobbies/Sports:

_____ _____

_____ _____

Medical History:

Name of Physician: _____ Date of last physical:_____

Current Medications: _____

How would describe your health: ___ Poor ____Good ___Excellent

Oklahoma Department of Mental Health and Substance Abuse Services

CONSUMER RIGHTS

Each consumer has the right to be treated with respect and dignity.

Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.

No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.

Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each consumer shall have the right to the following:

Allow other individuals of the consumer's choice participate in the consumer's treatment and with the consumer's consent;

To be free from unnecessary, inappropriate, or excessive treatment; To participate in consumer's own treatment planning;

To receive treatment for co-occurring disorders if present;
To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and To not be discharged for displaying symptoms of the consumer's disorder.
Every consumer's record shall be treated in a confidential manner.

No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.

A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.

No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

ODMHSAS: Office of Consumer Advocacy, E-Mail: AdvocacyDivision@odmhsas. org

Local: (405) 521-4256 Toll Free: (866) 699-6605 Reachout Hotline (800) 522-9054

Dedicated Outpatient Therapy Services, LLC

NOTICE OF CLIENTS RIGHTS

Clients shall retain all rights, benefits, and privileges guaranteed to by the law of the Constitution of the State of Oklahoma and the United States of America, except those specifically lost through due process of law.

You have the right to be treated with dignity and respect.

You have the right to receive services in an environment that provides privacy, promotes dignity, and provides the opportunity for you to improve you level of functioning. You have the right to receive services in a human psychological environment protecting you from any harm, abuse, or neglect without regard to your race, religion, gender, sexual orientation/gender identity, language, ethnic/national origin, age, degree of disability/handicap condition, legal status or any other characteristic protected under federal laws, local laws. COPY:OACT 450:1525 EFFECTIVE 07/01/2013

You have the right not to be neglected, sexually, physically verbally, or otherwise abused. You have the right to be provided with competent, appropriate treatment services, and individualized treatment plan. You will be afforded the opportunity to participate in your treatment and treatment planning. You may agree or refuse to agree to the proposed treatment plan. If you allow your family/and or significant other can be involved in treatment planning and treatment.

You have the right to assent grievance with respect an alleged infringement on his/her rights.

Your records will be treated in a confidential manner.

You have the right to not be required to participate in any research, project, medical experiment without his/her informed consent as defined by law. Refusal to participate shall not affect the services available to the client. You have the right to request the opinion of an outside medical or psychiatric consult at your expense, or right to internal construction upon request at no expense.

You have the right to file a grievance if you believe any of these or other right are violated. You will never be retaliated against or be subject to any adverse conditions or treatments for assenting your rights.

LIMITS OF CONFIDENTIALITY: General, without written consent our office will not say to anyone outside our agency that you receive services here. THERE ARE SOME EXCEPTIONS: 1.) If you say you have knowledge of or are partaking in child or elder abuse or neglect. 2.) You say you are going to harm yourself or someone else. 3.) You commit a crime or threaten to commit a crime against this agency or anyone who is associate with the agency. 4.) Release of information is requested by a special court order.

APPOINTMENT EXPECTATIONS: Your counselor will make every effort to begin and end sessions on time. If you are more than 15 minutes late for your session, your counselor may not be available. Clients/Guardians are responsible for remembering appointments. If you miss an appointment and do not contact your counselor within 14 days, they will consider it your desire to terminate counseling.

AT ANY TIME, YOU MAY CALL:
ODMHSAS Consumer Advocacy: 1-866-699-6605 or 405-521-4256
ODMHSAS Office of Inspector General: 1-877-426-4058 or 405-522-4058

By signing this notice, I acknowledge that I have read and provided a copy of the Notice of Clients Rights. Any questions I had were explained to me to my satisfaction.

Client Signature:_____ Date:_____

Parent/Guardian:_____ Date:_____

Provider:_____ Date:_____

D.O.T.S, LLC
906 E. 1st Street Chandler, OK 74834

Informed Consent for Electronic Communication

It is strongly encouraged that matters of concern be discussed during therapy sessions. However, there are times in which a client may elect to utilize email/electronic communication. Please be advised that use of email communication has risks regarding protection of your private health care information. Risks of using email/text include, but are not limited to:

- Communication can be intercepted by someone who is not the intended recipient and can be stored and/or printed
- Your identity can be determined from knowing your email/electronic communication address.
- Receipt of email/electronic communication sometimes are not noticed and are not responded to in a timely manner.
- Can be circulated, forwarded and stored in numerous paper and electronic files.
- Senders can easily type in the wrong email address or phone number.
- Is easier to falsify than handwritten or signed documents.
- Backup copies may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect e-mails transmitted through their systems.
- Can be used as evidence in court.

If you choose to use emails/electronic communication as a way of communicating with your therapist, please read and sign below.

- I understand that I am not required to participate in email/electronic communication. I understand that I may withdraw this consent at any time or limit what information I do not want sent via electronic communication by notifying my therapist in writing.
- I understand that emails/electronic communication should ***never*** be used to communicate emergency, urgent, or other time-sensitive information. *We do not provide electronic counseling. If you need a timely response, please contact your clinician via phone. If an urgent matter arises, please call: Edwin Fair Crisis hotline at 405.372.1250 or go to the emergency room at your nearest hospital.*
- I understand that all text messaging and e-mail to or from a client can be printed out and become a part of the file in the same way that therapy notes become part of the file.
- I understand that electronic communication should be limited to business material ***only***. Examples of these include: scheduling, receipt of Superbill, and other non-detailed forms. I understand that any other matters of concern need to be discussed during scheduled sessions.

If you choose to engage in electronic communication, your provider will:

- Utilize a HIPAA compliant platform for emailing diagnostic and billing information. However, please be advised that some emails such as those containing attachments such as the "Release of Information Form" may not be compatible with this platform. In these cases, standard email servers will be utilized.
- Send text appointment reminders via a HIPAA compliant platform.
- Utilize a HIPAA compliant text messaging application (Such as "OhMD") for any other type of scheduling related messages. If you would like the option of text messaging for scheduling related purposes, please provide your phone number below and your therapist will send you an "invitation" to connect via a HIPAA compliant messaging application. Please be advised that it is your responsibility to read their privacy policy in order to ensure your understanding of their adherence to HIPAA.

If you choose to use Telemedicine:

- Understand that telemedicine includes the practice health care delivery, diagnosis, consultation, treatment for medical data, and education using interactive audio, video or data communications.
- Telemedicine also involves the communication of my medical behavioral health information, both orally and visually, to health care providers within our agency.

I give my informed consent to participate in email and electronic communication. I understand the risks and benefits of utilizing email/electronic communication and do so at my own risk.

Client signature:_____ DATE:_____

Legal Guardian/Parent Signature:_____ DATE:_____

Legal Guardian/Parent Signature:_____ DATE:_____

Provider signature_____ DATE:_____

Dedicated Outpatient Therapy Services, LLC
906 E. 1st Street Chandler, OK 74834
Phone: 405-258-3033 Fax: 405-258-3011

I give the staff members of D.O.T.S, LLC permission to transport my child _____ as needed for counseling appointments.

I authorize my child _____ to be seen by their assigned counselor from D.O.T.S,LLC with them being mindful of working around core class schedule.

If you have any questions, please feel free to contact us at the above number. Thank you for making these accommodations for us.

Parent/Guardian Signature:_____

Date:_____

Dedicated Outpatient Therapy Services, LLC

906 E. 1st Street Chandler, OK 74834
Phone: 405-258-3033 Fax: 405-258-3011

Mental Health

Within the last 90 days (3 months) have you had a significant period in which you have experienced:

1. Serious Depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)?: ☐ Yes ☐ No ☐ Not Provided
2. Serious anxiety or tension (felt uptight, worried, unable to relax)?: ☐ Yes ☐ No ☐ Not Provided
3. Being prescribed medication for psychological/emotional problem?: ☐ Yes ☐ No ☐ Not Provided
4. Thoughts of harming yourself?: ☐ Yes ☐ No ☐ Not Provided
5. Hallucinations (heard/seen things others don't hear or see)?: ☐ Yes ☐ No ☐ Not Provided
6. An attempted suicide?: ☐ Yes ☐ No ☐ Not Provided

Substance Abuse

During the past 12 months have you:

1. Been preoccupied with drinking alcohol and/or using other drugs?: ☐ Yes ☐ No ☐ Not Provided
2. Tried to stop drinking alchohol and/or using other drugs, but couldn't?: ☐ Yes ☐ No ☐ Not Provided
3. Had problems caused by drinking/using drugs, and you kept using?: ☐ Yes ☐ No ☐ Not Provided
4. Need to drink and/or use more to get the same effect you used to?: ☐ Yes ☐ No ☐ Not Provided
5. Drunk alcohol and/or used other drugs more than you intended?: ☐ Yes ☐ No ☐ Not Provided
6. Experienced periods of time where your thinking speeds up and you have trouble keeping up with your thoughts?: ☐ Yes ☐ No ☐ Not Provided
7. Drunk alcohol and/or used other drugs to alter the way you feel?: ☐ Yes ☐ No ☐ Not Provided

Trauma

During the past year (12 months) have you:

1. Experienced a traumatic event, natural disaster, war, accident, injury, loss of a loved one?: ☐ Yes ☐ No ☐ Not Provided
2. Had periods of time where you felt that you could not trust family or friends?: ☐ Yes ☐ No ☐ Not Provided
3. Ever been afraid of your partner and/or family member? ☐ Yes ☐ No ☐ Not Provided
4. Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened?: ☐ Yes ☐ No ☐ Not Provided

Gambling

During the past year (12 months) have you:

1. Felt the need to bet more and more money?: ☐ Yes ☐ No ☐ Not Provided
2. Had to lie to people important to you about how much you gamble? ☐ Yes ☐ No ☐ Not Provided

Child/Adolescent Section

1. Are you feeling mad, sad, hopeless, nervous, or have you had a change in your sleeping, eating, or school performance?: ☐ Yes ☐ No ☐ NP
2. Are you spending less time with friends, care less about your appearance, or feel alone?: ☐ Yes ☐ No ☐ NP
3. Get into trouble for acting up, fighting, setting fires, hurting animals or tearing up stuff?: ☐ Yes ☐ No ☐ NP
4. Have you ever experienced a very bad thing or person (traumatic event) where you continued to feel scared, worried, or nervous or even had nightmares that bothered you after it was all over?: ☐ Yes ☐ No ☐ NP
5. Are you using alcohol and/or illegal drugs including inhalants?: ☐ Yes ☐ No ☐ NP
6. Are you misusing any prescription medication or over the counter products?: ☐ Yes ☐ No ☐ NP

Client Name:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so 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 ☐

FOR OFFICE CODING 0 + _____ + _____ + _____

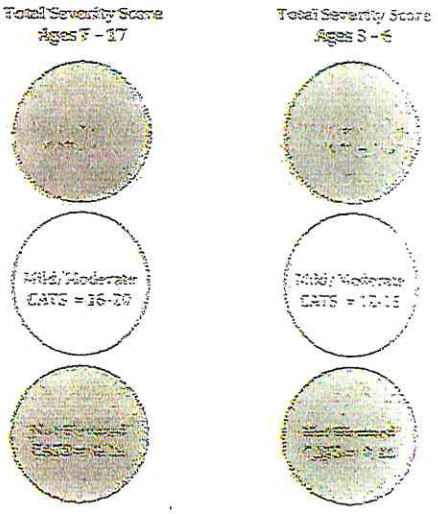
=Total Score: 0

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

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

Staff Signature & Date:_____

Child and Adolescent Trauma Screen (CATS) Scoring



Child's Name: _____

Caregiver's Name: _____

Provider's Name: _____

Assessment Date: _____

CAREGIVER Report

Trauma Exposure: _____

_____

Total PTSD Severity Score: _____ *Add ALL items, 1-20*

Criteria	# of Symptoms (Only count items rated 2 or 3)	# Symptoms Required	DSM-5 Criteria Met?	
Re-experiencing Items 1-5		1+	☐ Yes	☐ No
Avoidance Items 6-7		1+	☐ Yes	☐ No
Negative Mood/ Cognitions Items 8-14		2+	☐ Yes	☐ No
Arousal Items 15-20		2+	☐ Yes	☐ No
Functional Impairment Set of 1-5 Yes/No Questions		1+	☐ Yes	☐ No

*Age 6 & Under - Only need 1 symptom of avoidance OR negative mood/cognitions

CHILD Report

Trauma Exposure: _____

Total PTSD Severity Score: _____ *Add ALL items, 1-20*

Criteria	# of Symptoms (Only count items rated 2 or 3)	# Symptoms Required	DSM-5 Criteria Met?	
Re-experiencing Items 1-5		1+	☐ Yes	☐ No
Avoidance Items 6-7		1+	☐ Yes	☐ No
Negative Mood/ Cognitions Items 8-14		2+	☐ Yes	☐ No
Arousal Items 15-20		2+	☐ Yes	☐ No
Functional Impairment Set of 1-5 Yes/No Questions		1+	☐ Yes	☐ No

Child and Adolescent Trauma Screen (CATS) - Caregiver Report (Ages 7-17 years)

Child's Name: _____ Date: _____

Caregiver Name: _____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark No if it didn't happen to the child.

1.	Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes	☐ No
2.	Serious accident or injury like a car/bike crash, dog bite, sports injury.	☐ Yes	☐ No
3.	Robbed by threat, force or weapon.	☐ Yes	☐ No
4.	Slapped, punched, or beat up in the family.	☐ Yes	☐ No
5.	Slapped, punched, or beat up by someone not in the family.	☐ Yes	☐ No
6.	Seeing someone in the family get slapped, punched or beat up.	☐ Yes	☐ No
7.	Seeing someone in the community get slapped, punched or beat up.	☐ Yes	☐ No
8.	Someone older touching his/her private parts when they shouldn't.	☐ Yes	☐ No
9.	Someone forcing or pressuring sex, or when s/he couldn't say no.	☐ Yes	☐ No
10.	Someone close to the child dying suddenly or violently.	☐ Yes	☐ No
11.	Attacked, stabbed, shot at or hurt badly.	☐ Yes	☐ No
12.	Seeing someone attacked, stabbed, shot at, hurt badly or killed.	☐ Yes	☐ No
13.	Stressful or scary medical procedure.	☐ Yes	☐ No
14.	Being around war.	☐ Yes	☐ No
15.	Other stressful or scary event?	☐ Yes	☐ No

Describe: _____

Which one is bothering the child most now? _____

If you marked "YES" to any stressful or scary events for the child, then turn the page and answer the next questions.

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks:

0 Never / 1 Once in a while / 2 Half the time / 3 Almost always

1. Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	0	1	2	3
2. Bad dreams related to a stressful event.	0	1	2	3
3. Acting, playing or feeling as if a stressful event is happening right now.	0	1	2	3
4. Feeling very emotionally upset when reminded of a stressful event.	0	1	2	3
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	0	1	2	3
6. Trying not to remember, talk about or have feelings about a stressful event.	0	1	2	3
7. Avoiding activities, people, places or things that are reminders of a stressful event.	0	1	2	3
8. Not being able to remember an important part of a stressful event.	0	1	2	3
9. Negative changes in how s/he thinks about self, others or the world after a stressful event.	0	1	2	3
10. Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it.	0	1	2	3
11. Having very negative emotional states (afraid, angry, guilty, ashamed).	0	1	2	3
12. Losing interest in activities s/he enjoyed before a stressful event. Including not playing as much.	0	1	2	3
13. Feeling distant or cut off from people around her/him.	0	1	2	3
14. Not showing or reduced positive feelings (being happy, having loving feelings).	0	1	2	3
15. Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	0	1	2	3
16. Risky behavior or behavior that could be harmful.	0	1	2	3
17. Being overly alert or on guard.	0	1	2	3
18. Being jumpy or easily startled.	0	1	2	3
19. Problems with concentration.	0	1	2	3
20. Trouble falling or staying asleep.	0	1	2	3

Total Score____
Clinical = 15+

Please mark "YES" or "NO" if the problems you marked interfered with:

1. Getting along with others	☐ Yes	☐ No	4. Family relationships	☐ Yes	☐ No
2. Hobbies/Fun	☐ Yes	☐ No	5. General happiness	☐ Yes	☐ No
3. School or work	☐ Yes	☐ No			

Child and Adolescent Trauma Screen (CATS) - Youth Report

Name: _____ Date: _____

Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark No if it didn't happen to you.

1.	Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes	☐ No
2.	Serious accident or injury like a car/bike crash, dog bite, sports injury.	☐ Yes	☐ No
3.	Robbed by threat, force or weapon.	☐ Yes	☐ No
4.	Slapped, punched, or beat up in your family.	☐ Yes	☐ No
5.	Slapped, punched, or beat up by someone not in your family.	☐ Yes	☐ No
6.	Seeing someone in your family get slapped, punched or beat up.	☐ Yes	☐ No
7.	Seeing someone in the community get slapped, punched or beat up.	☐ Yes	☐ No
8.	Someone older touching your private parts when they shouldn't.	☐ Yes	☐ No
9.	Someone forcing or pressuring sex, or when you couldn't say no.	☐ Yes	☐ No
10.	Someone close to you dying suddenly or violently.	☐ Yes	☐ No
11.	Attacked, stabbed, shot at or hurt badly.	☐ Yes	☐ No
12.	Seeing someone attacked, stabbed, shot at, hurt badly or killed.	☐ Yes	☐ No
13.	Stressful or scary medical procedure.	☐ Yes	☐ No
14.	Being around war.	☐ Yes	☐ No
15.	Other stressful or scary event?	☐ Yes	☐ No

Describe: _____

Which one is bothering you the most now? _____

If you marked "YES" to any stressful or scary events, then turn the page and answer the next questions.

Mark 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks:

0 Never / 1 Once in a while / 2 Half the time / 3 Almost always

1.	Upsetting thoughts or pictures about what happened that pop into your head.	0	1	2	3
2.	Bad dreams reminding you of what happened.	0	1	2	3
3.	Feeling as if what happened is happening all over again.	0	1	2	3
4.	Feeling very upset when you are reminded of what happened.	0	1	2	3
5.	Strong feelings in your body when you are reminded of what happened (sweating, heart beating fast, upset stomach).	0	1	2	3
6.	Trying not to think about or talk about what happened. Or to not have feelings about it.	0	1	2	3
7.	Staying away from people, places, things, or situations that remind you of what happened.	0	1	2	3
8.	Not being able to remember part of what happened.	0	1	2	3
9.	Negative thoughts about yourself or others. Thoughts like I won't have a good life, no one can be trusted, the whole world is unsafe.	0	1	2	3
10.	Blaming yourself for what happened, or blaming someone else when it isn't their fault.	0	1	2	3
11.	Bad feelings (afraid, angry, guilty, ashamed) a lot of the time.	0	1	2	3
12.	Not wanting to do things you used to do.	0	1	2	3
13.	Not feeling close to people.	0	1	2	3
14.	Not being able to have good or happy feelings.	0	1	2	3
15.	Feeling mad. Having fits of anger and taking it out on others.	0	1	2	3
16.	Doing unsafe things.	0	1	2	3
17.	Being overly careful or on guard (checking to see who is around you).	0	1	2	3
18.	Being jumpy.	0	1	2	3
19.	Problems paying attention.	0	1	2	3
20.	Trouble falling or staying asleep.	0	1	2	3

Total Score____
Clinical = 15+

Please mark "YES" or "NO" if the problems you marked interfered with:

1. Getting along with others	☐ Yes	☐ No	4. Family relationships	☐ Yes	☐ No
2. Hobbies/Fun	☐ Yes	☐ No	5. General happiness	☐ Yes	☐ No
3. School or work	☐ Yes	☐ No			