RISE + SHINE
COUNSELING

TEEN INTAKE PACKET

Parent/Guardian needs to complete this form

It is the policy of Rise and Shine Counseling to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability. No person shall be excluded from participation in, be denied the benefits of any service, or be subjected to discrimination because of race, color, nationality, religion, sex, sexual preference, age or disability.

race, color, nationality, religion, sex, sexual preference, age or disability.

Client Information	Employer Status
Client Name: _____ Address/Addresses: _____ _____ City/State: _____Zip: _____ Date of Birth: ____ / ____ / _____ Sex: □ Male □ Female □ Intersex □ Nonbinary □ LGBTQ Parents/Guardians Names: _____ _____ Home #: _____ Cell #: _____	Parent/Guardian filling out this form is: □ Employed □ Single □ Self-employed □ Married □ Retired □ Divorced □ Unemployed □ Widowed □ Student Occupation: _____ Company: _____ City/State/ZIP: _____ How many people live in your household? ___ Children Names/Ages: _____ _____ _____

At which number may we leave a **confidential** message? (regarding scheduling, therapy information, billing, etc.) □ Home □ Cell How did you hear about Rise and Shine Counseling? _____	Spouse/Partner Name: _____ Spouse/Partner Occupation: _____ Email Address: _____ _____

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____

Preferred Hospital: _____

Relationship to Client: _____

INVOLVEMENT IN CARE

I hereby request the following person(s) to be allowed to participate in my care and/or payment decision-making process. I understand these persons(s) may be given health or payment information about me.

NAME	RELATIONSHIP	PHONE NUMBER	TYPE OF INFO (Billing, Scheduling, Clinical, All)

Rise and Shine Counseling will make a reasonable effort to provide only the necessary information for the person(s) to make an informed decision or to receive printed/verbal protected health information.

PAYMENT INFO

Out of Pocket/Private Pay: Rise and Shine Counseling is Private Pay. All fees are due at the time of service. Our billing staff is not authorized to split payments or to run a specific dollar amount

on certain days of the month. We accept cash, major credit cards, debit cards and health saving cards. We will also provide invoices and superbills, as some insurance companies reimburse for out of network providers.

CANCELLATION POLICY

Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is cancelled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the waiting list, or a client with a clinical emergency. **For these reasons, we kindly ask for at least 24-hour cancellation notice by phone, directly to your therapist. If you cancel or no show after the 24-hour period, (and do not use an alternative option below) you will be charged a missed flat rate fee of $100.00.** The missed fee is your responsibility.

You can avoid a cancellation/missed session fee by considering one of the following options:

• Have a Telehealth session instead - this is where a counselor provides psychological counseling and support over video conferencing or a telephone call. This is especially beneficial during inclement weather, transportation issues, sick kids, etc. This is not our preferred method of therapy, however within good reason, can be approved by a supervisor. Please note: Internet, a computer or mobile device, an integrated or external microphone and camera are required for video conferencing.

• If you can reschedule in the same week at a time your therapist has open, we will waive the missed fee.

ADDITIONAL INFO

Are you required by a court of law to receive counseling as part of a legal proceeding? Yes / No

Have you ever received counseling services from Rise and Shine Counseling or any other organization? Yes / No

If yes, where/when?

_____

Do we have your permission to send calendar invites for sessions indicating time of session and location? Yes / No

At which email would you like to receive these calendar invitations?

_____

This electronic communication will only relate to scheduling and will not, under any circumstances relate to therapy itself. Please be aware this is considered an unsecure form of communication and there is a potential chance that a third party may be able to intercept these messages. Please Note: You are not able to cancel replying to this text message. All cancellations must be done by phone directly to your therapist.

The information I have given is true and correct. I have read all the above policies and by signing below agree to its terms and conditions. I also agree to notify Rise and Shine Counseling staff if address, insurance, or any other changes occur during my therapy.

Parent/Guardian/Spouse Signature: _____ Date: _____

(If applicable)

Parent/Guardian/Spouse Signature: _____Date:_____

RISE + SHINE
COUNSELING

Consent for Treatment

We are committed to providing you with the best possible care.

Please read and initial each item:

_____1. Therapy

I understand there are no guarantees made to me regarding therapy treatment. My decision is voluntary, and I understand that I may terminate these services at any time. I understand that during treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

_____ 2. Compliance with Treatment Plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may force Rise and Shine Counseling to transfer my care to a different counseling practice.

_____ 3. Payment

I understand all fees are due at the time of session.

_____ 4. Confidentiality

All information shared in session is confidential except in circumstances governed by Federal and State law, including 1) to warn others of life-threatening concerns should it become necessary, 2) to notify appropriate state agencies of any suspicion of child or dependent adult abuse and 3) to provide information in legal cases when under court order. _____

5. Release of Information

I authorize the release of any medical or other information necessary to collect payment on my account. All other medical records request requires a separate signed authorization document and records cannot be released until we receive that form.

_____ 6. Minor Children

We require at least one parent signature to authorize treatment for a minor. (Missouri law states those under the age of 18 is considered a minor). Please be aware additional signatures/authorizations may be required depending on custody or other legal disputes. I agree to read the Parental Agreement document provided and bring a signed copy to my first session.

_____ 7. No Harm Agreement

I agree that I will not engage in self harm and/or harm to others. I agree I will take the following actions if I violate this agreement/if I am the parent or guardian of a minor client. 1) I will call 911 if I believe that I am in immediate danger of harming myself/ or others. 2) I will call any or all 24-hour suicide prevention lines (1-800-SUICIDE) and I will continue talking on Client Name Page 5 of 14 the phone for as long as necessary until the suicidal thoughts have subsided. For non-life-threatening, clinical emergencies, please call 816-246-4465 and leave a message on your therapist voicemail box.

_____ 8. Services NOT provided

Rise and Shine Counseling therapists are not qualified as legal experts in court cases. Rise and Shine Counseling does not provide custody evaluations, sexual abuse investigations, or anything related to such matters. A fee of $2000.00 per day will be incurred if Rise and Shine Counseling therapist would subpoenaed and required to appear in a court of law. A fee of $100.00 per hour will be incurred if gathering documentation is required by an attorney or court of law. These expenses are the responsibility of parents/guardians or clients if a minor client, or client themselves, if an adult.

_____ 9. Privacy Practices

A list of patient rights and responsibilities are available upon request to all patients. They are also posted in our waiting room.

_____

Print Client Name Date of Birth

_____

Client/Parent/Guardian Signature Date

_____

Parent/Guardian Signature Date (Both signatures are required for divorced parents who have joint custody)

_____

Therapist Signature Date

RISE + SHINE
COUNSELING

If client is 13 years old or older, please have THEM fill out the below symptoms assessment.

So we can better serve you, please give us an accurate account of what your symptoms are. If you have any questions or concerns, we invite you to discuss them with your therapist.

(✓your concerns)

I AM EXPERIENCING	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: sweating, trembling, shortness of breath, heart palpitations					
Nightmares about traumatic experience					

I AM FEELING…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or feelings of loss					
Changes in sleep (too much or too little)					
Normal daily tasks require more effort					

Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
I am angry, irritable, hostile					
I feel euphoric, energized, and highly optimistic					
I have racing thoughts					
I need more sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I HAVE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					
Been hearing voices when alone					
Problems with my speech					
Risk taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concerns for consequence					
Been physically harming myself					

Been violent toward others					
Been hearing voices when alone					

I USE THE FOLLOWING…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Alcohol					
Marijuana					
Nicotine (Cigarettes)					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

MY EATING INVOLVES…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Restriction of food consumption					
Bingeing and purging					
Binge eating					
A lot of weight loss or gain					

I HAVE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Concerns about my sexual function					
Questions about my sexual orientation					

Presenting Problem: Please describe the problem(s) that prompted you to seek help for your child/family:

_____
_____
_____
_____

When did these symptoms/problems begin? (Approximate date):

_____

Please describe any changes or events that might have contributed to the problems' development:

_____
_____
_____
_____

Therapy Goals:

_____
_____
_____
_____

I verify that I have completed this form to the best of my knowledge.

_____ _____

Client Signature Date

RISE + SHINE
COUNSELING

RISE AND SHINE COUNSELING CHILD EVALUATION

Parents/Guardians, please complete this child evaluation and give it to their therapist at the time of your first appointment. This information will help your child's therapist identify problem areas and provide the best treatment possible.

Childs Name _____ Date _____

Are the parents of this child: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

What are the custody arrangements? N/A Joint Sole Other

If joint custody exists, are both parents aware of the child's involvement in counseling? ☐Yes ☐No

Was this child adopted? ☐ Yes ☐ No

If yes, please describe when/why:

_____

Where is the child living at this time? _____

Please check (✓) below

FEELINGS RELATED TO PARENTING	NEVER	SOMEWHAT	OFTEN	ALWAYS
I am worried about my child.				
I am confident in childrearing.				
I have conflict with others related to how I discipline my child.				

FAMILY HISTORY

Does anyone in the family, (immediate or extended), have or exhibit the following:

Psychiatric Problems ☐ Yes ☐ No

If yes, whom (parent, sibling, aunt, etc.)

_____

Depression or Anxiety □ Yes □ No

If yes, whom

_____

Abuse of alcohol or drugs □ Yes □ No

If yes, whom_____

Suicidal behavior □ Yes □ No

If yes, whom _____

Physical violence □ Yes □ No

If yes, whom _____

Health conditions (or deceased) □ Yes □ No

If yes, when _____

DEVELOPMENT HISTORY

Did this child's biological mother use alcohol or drugs during her pregnancy? □ Yes □ No □ Unsure If yes, what substances: _____

Did the biological mother experience unusual stress or health complications during this child's pregnancy? □ Yes □ No If yes, describe:

_____

Did the child experience any trauma at birth (anoxia, etc.)? □ Yes □ No □ Unsure If yes, explain:

_____

Were the child's developmental milestones (walk, talk, toilet training, etc.) within normal limits? □ Yes □ No If no, explain:

_____

EMOTIONAL AND BEHAVIORAL HISTORY

Has your child ever seen a counselor/therapist before? □ Yes □ No

Has your child ever been hospitalized for emotional/behavioral reasons? □ Yes □ No

Has your child taken medications for emotional or behavior problems? □ Yes □ No If yes, specify drug name: _____

Has your child ever received Psychological Testing (WISC-III, etc.)? □ Yes □ No If yes, please describe: _____

Has your child ever witnessed violence (domestic, homicide)? □ Yes □ No □ Unsure

If yes, please describe: _____

Has your child ever suffered from physical abuse or neglect? □ Yes □ No □ Unsure

If yes, please describe: _____

Has your child ever been a victim of sexual abuse? □ Yes □ No □ Unsure

If yes, please describe: _____

MEDICAL HISTORY

Please list all prescription and over the counter medications/supplements your child is currently taking (include doctor's name who prescribed):

_____

Please check (✓) below all the health problems that apply to your child.

HEALTH PROBLEMS	NONE	HAD IN PAST	CURRENT
Allergies			
Asthma			
Headaches			
Seizures			
Head Injury			

HEALTH PROBLEMS	NONE	HAD IN PAST	CURRENT
Cancer			
Heart problems			

Sinus Problems			
Hearing Problems			
Vision Problems			

HEALTH PROBLEMS	NONE	HAD IN PAST	CURRENT
Meningitis			
Encephalitis			
Unconsciousness			
Concussion			

Other serious illnesses not listed:

_____

SCHOOL FUNCTIONING

If your child is school age, please state the grade and school your child attends:

_____

Does your child appear motivated for school? □ Yes □ No

Has your child ever been suspended or expelled from school? □ Yes □ No

If yes, describe:

_____

Has your child ever been diagnosed with a learning disability or attention deficit? □ Yes □ No

If yes, describe:

_____

Does your child have difficulty making friends or getting along with peers? □ Yes □ No □ Unsure

CURRENT SYMPTOMS

Please rate all symptoms that apply to your child currently. If not applicable, please leave blank.
Sometimes = (1-2 days/week) **Often** = (3-4 days/week) **Most days** = (5-6 days/week) **Always** = (7 days/week)

CURRENT SYMPTOMS	SOMETIMES	OFTEN	MOST DAYS	ALWAYS
Very Unhappy				
Fearful				
Peer Conflict				
Animal Cruelty				
Soiled Pants				
Suicide Talk				
Insomnia				
Irritable				
Phobic/Fearful				
Disobedient				
Cutting Self				
Stomachaches				
Failing Grades				
Temper Tantrums				
Sluggish				
Argumentative				
Sibling Violence				
Head Banging				
Hallucinations				
School Refusal				
Poor Appetite				
Withdrawn				
Distractible				
Regressed				
Overactive				
Daydreaming				
Destructive				
Bed Wetting				
Legal Trouble				
Impulsive				
Rocking Self				
Mute				
Drug Use				

Victim of Bullying				
Stealing				
Initiates Bullying				
Alcohol Use				

Presenting Problem: Please describe the problem(s) that prompted you to seek help for your child/family:

_____
_____
_____
_____

When did these symptoms/problems begin? (Approximate date):

_____

Please describe any changes or events that might have contributed to the problems' development:

_____
_____
_____
_____

Therapy Goals:

_____
_____
_____
_____

I verify that I have completed this form to the best of my knowledge.

_____ _____

Parent Signature Date

RISE + SHINE
COUNSELING

CONSENT FOR TELEHEALTH

This Informed Consent for Telehealth contains important information focusing on doing psychotherapy using the phone or the video conferencing through the Internet. Please read this carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telehealth

Telehealth refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the client and clinician can engage in services without being in the same physical location. This can be helpful if bad weather is expected, if the client or clinician moves to a different location, has transportation issues, or is otherwise unable to meet in person. It can also be more convenient and takes less time. Telehealth, however, requires technical competence on both parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person psychotherapy and telehealth, as well as some risks. For example:

Risks to confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telehealth. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology

There are many ways that technology issues might impact telehealth. If the session is interrupted for any reason and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telehealth platform on which we

agreed to conduct therapy. If you do not receive an attempt to reconnect within two (2) minutes, then call me using the telephone. If a technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

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. Your signature below indicates you understand the risk of telehealth and agree to engage in therapy through the means of video conferencing or telephone.

_____ _____

Client Signature Date

_____ _____

Therapist Date

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COUNSELING

Agreement for Parents and Guardians

Effective: October 1, 2019

Psychotherapy can be an important resource for children. A therapeutic relationship can be beneficial by:

• Facilitating an open and appropriate expression of the strong feelings which routinely accompany emotional and mental difficulties, including guilt, grief, sadness and anger.

• Providing an emotionally neutral setting in which children can explore these feelings.

• Helping children understand and accept their emotional and mental health needs and how to appropriately communicate these needs to the important people in their lives such as their parents, siblings, family, friends, etc.

• Offering feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities.

Who can authorize treatment for a Minor:

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child.

• If you are married, only one parent needs to consent for treatment for your child.

• If you have joint legal custody of your child – both parents must consent for treatment and a copy of the divorce decree needs to be provided.

• If you are separated but still legally married, only one parent needs to consent for treatment, however, please be aware that it is our policy to notify the other parent we are meeting with your child. We believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

Confidentiality:

In some situations, we are required by law or by the guidelines of our profession to disclose information, whether we have you or your child's permission. Confidentiality cannot be maintained when:

• Child patients tells us they plan to cause serious harm or death to themselves, or others, and we believe they have the intent and ability to carry out this threat in the very near future. We must take steps to inform a parent or guardian or others of what the child has told us and how serious we believe this threat to be and to try to prevent the occurrence of such harm.

• Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, we will need to use professional judgment to decide whether a parent or guardian should be informed.

• Child patients tell us, or we otherwise learn, that it appears that a child is being neglected or abused-- physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, we are required by law to report the alleged abuse to the appropriate state child protective agency.

• We are ordered by a court to disclose information.

Divorce, Custody or other Legal Disputes:

In the cases of separation and divorce, we ask parents to remember that this decision was not initiated or made by the child, but he or she must find a way to deal with and come to terms with this change in their family. The usefulness of such therapy is extremely limited when the therapy itself becomes simply another matter of dispute between parents. With this in mind, and in order to best help your child, we strongly recommend that each of the child's caregivers mutually accept the following as requisites for the child's participation in therapy.

• It is our primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers, psychologists, social workers, etc.). In some cases, this may include a recommendation that you consult with a physician, should matters of your child's physical health be relevant to this therapy.

• We ask that all caregivers remain in frequent communication regarding this child's welfare and emotional wellbeing. Open communication about his or her emotional state and behavior is critical. In this regard, we invite each of you to initiate frequent and open exchange with their therapist.

• Over the course of treatment, we may meet with the child's parents/guardians either separately or together. Please be aware, however, at all times, our patient will always be your child – not the parents/guardian, siblings or other family members of that child. We recommend that parties who are disputing custody strongly consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than try to settle a custody dispute in court. **We make it clear to the families we work with that we do not make custody evaluations or recommendations for court.** There are two key reasons for this position. The first is that we see it as a conflict of interest. If the child or family we are engaged in therapy with knows we may be making a custody recommendation, they may come in with a hidden agenda that will interfere with the therapy's effectiveness. Secondly, we see custody evaluation as a specialized area that requires additional training past a standard mental health degree. We have chosen not to specialize in this area and therefore do not practice in this area. It is crucial for us to set and maintain firm boundaries on this issue because there is often still important work to be done post-divorce. Your understanding of this may not prevent a judge from requiring our testimony, even though we will not do so unless legally compelled. If we are required to testify, we are ethically bound not to give our opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, we will provide information as needed, if appropriate releases are signed or a court order is provided, **but we will not make any recommendation about the final decision(s).** Furthermore, if we are required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse their therapist at the rate of $300 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Appointments:

Please make every effort to get your child to their appointment on time. We do ask that you give us a minimum of 24-hour notice if you need to cancel/reschedule your appointment. This allows us time to fill that spot with someone else. If no cancel notice is given and you're not able to reschedule within the same week or have a telehealth session, you will be charged a $100 missed session fee.

We strive to provide a safe and peaceful environment for all our clients. As such, we ask that you not leave unattended minors at the clinic at any time. It is likely that your child's therapist has sessions before and after your scheduled time and cannot be responsible for your child after the session has ended. We encourage you to stay at the office for the length of your child's session but understand that unexpected situations may require that you briefly leave our location. Should these situations arise, we ask you to inform your therapist at the start of the session, so that they are aware of your absence. We also ask that you return 15 minutes prior to the end of your child's therapy session. This ensures that your child's therapist can update

you (if needed) and schedule upcoming sessions. Additionally, we ask that you come into the building to pick up your child at the end of the appointment time.

Payment:

Payment for our services is due, in full, at the time of service. Who pays for this service is not for us to determine. If you are divorced and the court has issued both parents pay 50/50 for counseling, the two of you will have to settle that outside of our office. We will not split, divide or partial bill each parent.

Your understanding of these points and agreement in advance of starting this therapy may resolve difficulties that would otherwise arise and will help make this therapy successful. Your signature, below, signifies that you have read and accept these points.

_____ _____ _____

Child's Name Date of birth Age

_____ _____

Caregiver's Signature Date

_____ _____

Printed Name / Relationship to Child

_____ _____

Caregiver's Signature Date

_____

Printed Name / Relationship to Child

_____ _____

Therapist's Signature Date

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

PLEASE READ AND SIGN BELOW

By signing below, I authorize Rise and Shine Counseling billing department to charge my credit/debit card account for any outstanding balances, including, but not limited to: private pay fees; missed appointment or late cancellation fees; along with any other outstanding balances. I acknowledge that Rise and Shine Counseling does not need any further

authorization, such as phone calls or emails, prior to charging my card. All information entered on this form will be kept strictly confidential by Rise and Shine Counseling. If you have any further questions, please feel free to contact our billing staff at 816-878-1455.Cardholder Signature _____

*Please be assured this information will be kept strictly confidential and will stored in HIPPA Compliant software

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If client is 13 years old or older, please have THEM fill out the below symptoms assessment.

So we can better serve you, please give us an accurate account of what your symptoms are. If you have any questions or concerns, we invite you to discuss them with your therapist.

(✓your concerns)

I AM EXPERIENCING	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: sweating, trembling, shortness of breath, heart palpitations					
Nightmares about traumatic experience					

I AM FEELING…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or feelings of loss					
Changes in sleep (too much or too little)					
Normal daily tasks require more effort					

Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
I am angry, irritable, hostile					
I feel euphoric, energized, and highly optimistic					
I have racing thoughts					
I need more sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I HAVE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					
Been hearing voices when alone					
Problems with my speech					
Risk taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concerns for consequence					
Been physically harming myself					

Been violent toward others					
Been hearing voices when alone					

I USE THE FOLLOWING…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Alcohol					
Marijuana					
Nicotine (Cigarettes)					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

MY EATING INVOLVES…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Restriction of food consumption					
Bingeing and purging					
Binge eating					
A lot of weight loss or gain					

I HAVE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Concerns about my sexual function					
Questions about my sexual orientation					