Adult Intake Form

Intake Date: _____ **Referred by**: _____

Self (Adult)

Name: _____
Last First Middle
D.O.B. _____ Age _____
Address _____
City, State _____ Zip _____
Mobile # _____ lve msg? Y N
Home phone # _____ lve msg? Y N
Work phone # _____ lve msg? Y N
Email address _____
Employer _____
Social Security # _____
Emergency contact & # _____

Marriage/Relationship History

Current marital status _____
Name of spouse/partner _____
Date of marriage/relationship _____ Age _____
Length of relationship _____
Name of children
_____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

Previous spouse/partner _____
Date of marriage/relationship _____ Age _____
Length of relationship _____
Name of children
_____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

Previous spouse/partner _____
Date of marriage/relationship _____ Age _____
Length of relationship _____
Name of children
_____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

Spouse/Partner/Guardian

Name: _____
Last First Middle
D.O.B. _____ Age _____
Address _____
City, State _____ Zip _____
Mobile # _____ lve msg? Y N
Home phone # _____ lve msg? Y N
Work phone # _____ lve msg? Y N
Email address _____
Employer _____
Social Security # _____
Emergency contact & # _____

Marriage/Relationship History

Current marital status _____
Name of spouse/partner _____
Date of marriage/relationship _____ Age _____
Length of relationship _____
Name of children
_____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

Previous spouse/partner _____
Date of marriage/relationship _____ Age _____
Length of relationship _____
Name of children
_____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

Previous spouse/partner _____
Date of marriage/relationship _____ Age _____
Length of relationship _____
Name of children
_____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

Date _____

Child/Adolescent Intake Form

Child's Name _____
(First) (Middle) (Last)

Age _____ DOB _____ Grade _____

School _____ School Phone # _____

School Address _____ Teacher _____

Child's Insurance _____

Father _____ DOB _____
(First) (Middle) (Last)

Address _____

Home Phone # _____ Work Phone # _____

Place of Employment _____

Does father carry insurance on this child? _____ Type _____

Mother _____ DOB _____
(First) (Middle) (Last)

Address _____

Home Phone # _____ Work Phone # _____

Place of Employment _____

Does mother carry insurance on this child? _____ Type _____

Siblings

First Name	Last Name	Age	DOB
1.			
2.			
3.			
4.			
5.			
6.			

Adult, Child & Family Counseling Inc.
6700 W. Central, Suite 106 • Wichita, KS 67212
Tel: 316.945.5200/Fax: 316.945.5549

Consent for Treatment of a Minor Child

I, (we) _____
(Name)

of City _____ County _____ State_____

do hereby affirm that I am (we are) the parent(s)/legal guardian(s) of /have power of attorney for

of _____
(Name of child)

a minor, age _____ born _____ who resides with
(Age of Child) (Date of Birth)

me (us) at _____
(Home Address)

I, (we) authorize our child, _____ to be seen for psychotherapy by
(Name of Child)

_____ at Adult, Child and Family Counseling,
(Name of Therapist)

6700 W. Central, Suite 106, Wichita, KS, 67212.

I authorize use of this form from _____ day of _____
(Date of the month) (Month and Year)

Until I revoke this consent in writing.

Signature of parent or guardian _____ date _____

Signature of parent or guardian _____ date _____

Client Bill of Rights

1. You have the right to choose when to begin and when to terminate therapy.

2. You have the right to request a referral to another therapist or agency.

3. You have the right to receive information regarding fees for services and "late cancel" and "no-show" fees. (see financial agreement)

4. You have the right to receive respectful treatment in a safe environment free from sexual, physical, and emotional abuse or illegal behaviors. You have the right to have your cultural, spiritual, and personal values respected.

5. You have the right to request information regarding your therapist's qualifications, licensure, education, training, experience, and limits of practice.

6. You have the right to share only the information that you wish to disclose.
    a. Your signed informed consent must be given before audio or video recording.
    b. Your therapist may consult with the other clinicians regarding details of your treatment as a normal part of best practice, but none of your identifying information will be revealed without your written consent.
    c. If you are court-ordered to be evaluated or to attend therapy, there may be legal consequences for your refusal to cooperate and insurance may not cover the cost of "court-ordered" counseling.

7. You have the right to know your diagnosis, your treatment goals, and your progress if you request that information from your therapist.

8. You have the right to keep what you tell your therapist private and confidential unless you give permission to share the information with others. However, there are some situations in which your therapist is required by law to report with or without your permission, such as:
    a. If you threaten to hurt another person, your therapist must warn that person and the authorities.
    b. If there is physical or sexual abuse to a minor or disabled individual, your therapist must report it to the proper authorities.
    c. If you are suicidal or at risk of hurting yourself, your therapist must report to the police department or emergency contact so they can check on you.
    d. If your therapist receives a court order subpoenaing case records or testimony.

9. You may review your therapist's code of ethics and request a copy. We encourage you to report any concerns to our office manager, Joann Harder.

_____ _____

client signature date

_____

client's printed name

Financial Agreement

We base our fees on the amount of time you are with your therapist. You are responsible for any fees not covered by insurance.

There will be a $35 charge for a returned check.

Fees for writing Court reports will be $150/hour, and fees for depositions and testifying in court will be $200/hour which includes travel time to and from the office. You may also be charged for any time your therapist is preparing for court appearances related to your case. These fees cannot be billed to your insurance.

You must give at least 24 hour notice to cancel an appointment so the appointment time can be given to someone else. You may be charged for appointments that are not canceled or rescheduled at least 24 hours in advance.

- You will receive a warning letter after your first “no show” or “late cancellation.”
- Your second “no show” or “late cancellation” may result in a twenty-five ($25) fee which cannot be billed to insurance.
- Your third “no show” or “late cancellation”may result in a one hundred ($100) charge which cannot be billed to insurance.
- When available, recurring weekly or biweekly appointments are made available for clients seeking regular access to treatment at a predictable time. Missed appointments or cancellations can result in the loss of your “standing” appointments.

I understand and agree that payment for service is my responsibility and that copays and deductibles are due at the time of service.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment of insurance claims. I authorize payment of insurance benefits for service provided to be made directly to my therapist. In the event that I am paid by my insurance company, I agree to promptly pay my therapist.

My Signature confirms that I agree to this financial agreement.

_____ _____

client signature date

_____

client’s printed name

Client Authorization to Reciprocal Release of Information to Physician/Waiver of Physician Consult

I understand that my records are protected under the applicable state law governing confidentiality of client/therapist relationship and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke the consent at any time except to the extent that action has been taken in reliance on it.

In accordance with Kansas statute: *When a client has symptoms of a mental disorder, a licensed [marriage and family therapist/professional counselor/social worker] shall consult with the client's primary care physician or psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to the client's symptoms of a mental disorder. A client may request in writing that such consultation be waived and such request be made part of the client's record.*

I, _____ DOB _____ hereby authorize
(please print client's name) (client's date of birth)

_____ and Adult, Child and Family Counseling to act on the following:
(therapist's name)

Please initial one:

_____ I consent to reciprocal release of information with my physician.

or

_____ I do not consent to reciprocal release information to my physician and waive the physician consult.

Physician's name and office address:

_____

_____

_____
(client's printed name)

_____ _____
(client's signature) (date)

or

_____
(guardian's printed name and relationship)

_____ _____
(guardian's signature) (date)

Adult, Child & Family Counseling Inc.
6700 W. Central, Suite 106
Wichita, KS 67212
Tel: 316.945.5200/Fax: 316.945.5549

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: August 01, 2016

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received a copy of the Notice of Privacy Practices of Adult, Child and Family Counseling with the effective date of August 01, 2016.

_____ _____

(signature of client/client representative) (date)

_____

(relationship to client)

Documentation of Good Faith Efforts

Client Name _____ Date _____

The client presented to the facility on the state and was provided with a copy of the Notice of Privacy Practices of Adult, Child and Family Counseling. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, subject knowledge meant was not obtained because:

- ☐ Client refused to sign.
- ☐ Client was unable to sign or initial because: _____
- ☐ Client had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other: _____

Signature of employee completing form _____

Original to be maintained in client's permanent medical record

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

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

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	

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

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…	**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.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes		❑ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes		❑ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes		❑ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	❑ Yes		❑ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	❑ Yes		❑ No			
	25.	Have you EVER tried to kill yourself?	❑ Yes		❑ No			

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Relationship with the child: _____

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

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			