Client Name:
SoonerCare ID:

BYTE & ASSOCIATES, LLC

CLIENT CONFIDENTIALITY STATEMENT

All client information will be entered into the client's chart for use by direct care providers. Client charts are the property of Byte & Associates, LLC, and will not be removed from Byte & Associates' premises, nor photocopied or shown to anyone unless specifically authorized by an officer of Byte & Associates, LLC.

I understand that any illegal, unnecessary and/or inappropriate release of confidential client information will not be tolerated and is cause for immediate termination and prosecution.

EXCEPTIONS TO CONFIDENTIALITY

Client records are considered confidential and will not be released to other individuals or agencies without each client's expressed written consent except: upon receipt of a legitimate subpoena; in the event of a valid medical emergency; to meet the requirements of state law that child/elderly abuse to be reported, or; in the event that the client presents an imminent danger to themselves or others.

Since part of the cost of treatment may be paid by federal, state or local sources, these sources have the right to review client files on a periodic basis to verify that such services have been delivered appropriately. Also, insurance companies may need to review parts of files to verify diagnoses and treatment procedures, so as to process claims payment. Others having access to client files are Byte & Associates, LLC's staff, contractors, consultants, and accountants. In each of these cases client information may be released only by designated staff with administrative approval.

All staff must have a general knowledge of the provisions of public law 99-401, which amends the federal confidentiality laws to remove any restriction on compliance with state laws mandating the reporting of child abuse or neglect. This statute requires that cases involving suspected, actual, or imminent harm to children must be reported to child protection agencies and therefore are not covered by confidentiality requirements. This provision applies only to initial reports of child abuse or neglect and not to requests for additional information or records. Thus, court orders are still required before records may be used to initiate or substantiate any criminal charge against a client or to conduct any investigation of a client.

I have received, read and understand the above statement regarding exceptions to confidentiality.

Client Signature: _____ Guardian Signature: _____ Date: _____

Sooner Care #:_____

Therapist Signature: _____ Date: _____

Client Name:
SoonerCare ID:

Byte and Associates, LLC Counseling Services

***Individual Consent* - Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations**

I understand that as a part of my health care, Byte & Associates, LLC, receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examinations, and test results, diagnoses, treatment, treatment plans, and billing and health information. I understand that Byte & Associates, LLC, and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my psychiatric/psychological condition
- Plan my care and treatment
- Communicate with other health professionals concerning my care
- Document services for payment/reimbursement
- Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

I have been provided a *Notice of Information Practices* that fully explains the uses and disclosures that Byte & Associates, LLC will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent**.** Byte & Associates, LLC has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also understand that Byte & Associates, LLC cannot use or disclose my individually identifiable information other than as specified on the *Notice*. I also understand, however, that Byte & Associates, LLC reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised *Notice* to the address that I have provided.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, Byte & Associates, LLC may refuse to provide me health care services unless applicable state or federal law requires Byte & Associates, LLC to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that Byte & Associates, LLC is not required to agree to the requested restrictions but that, if it does agree, it must honor the restriction unless I request that it stop doing so or Byte & Associates, LLC notifies me that it is no longer going to honor the request.

I request the following restrictions on the use or disclosure of my individually identifiable health information: _____

I understand that I have the right to request restriction as to the method of communication to me. For example, I might request that all behavioral health information be mailed to a certain post office box rather than to my home. I further understand that Byte & Associates, LLC must honor this request if the *method of communication* would harm me if I want an alternate method of communication.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for facility directories and to family members. I object to uses and disclosures as follows:

_____

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Byte & Associates, LLC has already taken action in reliance on my earlier effective consent.

The information you authorize to release may include records that may indicate the presence of a communicable or venereal disease, which may include, but are limited to, disease such as hepatitis, syphilis, gonorrhea, tuberculosis, and the human immunodeficiency virus (HIV) also known as Acquired Immune Deficiency Syndrome (AIDS).

_____ _____ _____
Signature of Patient or Legal Representative Signature of Witness Date

Sooner Care #:_____

Client Name:
SoonerCare ID:

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

PLACE "X" UNDER YOUR ANSWER	NEVER	SOMETIMES	OFTEN
1. Complains of aches and pains			
2. Spends more time alone			
3. Tires easily, has little energy			
4. Fidgety, unable to sit still			
5. Has trouble with teacher			
6. Less interested in school			
7. Acts as if driven by a motor			
8. Daydreams too much			
9. Distracted easily			
10. Is afraid of new situations			
11. Feels sad, unhappy			
12. Is irritable, angry			
13. Feels Hopeless			
14. Has trouble concentrating			
15. Lees interested in friends			
16. Fights with other children			
17. Absent from school			
18. School grades dropping			
19. Is down on him or herself			
20. Visits the doctor with doctor finding nothing wrong			
21. Has trouble sleeping			
22. Worries a lot			
23. Wants to be with you more than before			
24. Feel he or she is bad			
25. Takes unnecessary risks			
26. Gets hurt frequently			
27. Seems to be having less fun			
28. Acts younger that children his or her age			
29. Does not listen to rules			
30. Does not show feelings			
31. Does not understand other people's feelings			
32. Teases others			
33. Blames other for his or her troubles			
34. Takes things that do not belong to him or her			
35. Refuses to share			

Total score: _____

Does your child have any emotional or behavioral problems for which she or he needs help? Are there any services that you would like your child to receive for these problems?

If Yes, What services? _____

Client Name:
SoonerCare ID:

CAREGIVER PERSPECTIVE OF CHILD

Child & Adolescent Trauma Screen (CATS) (Page 1)

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.**

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

If you marked "YES" to any stressful event for the child, proceed to the next page and answer the questions.

Client Name:
SoonerCare ID:

CAREGIVER PERSPECTIVE OF CHILD

Child & Adolescent Trauma Screen (CATS) (Page 2)

0 NEVER / 1 Once in a while / 2 Half the time / 3 Almost Always

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

TOTAL SCORE: ___

Mark "YES" or "NO" if the problem you marked interfered with:

PLACE "X" UNDER YOUR ANSWER	YES	NO
21. Getting along with others		
22. Hobbies/ Fun		
23. School or Work		
24. Family Relationships		
25. General Happiness		

Client Name:
SoonerCare ID:

CHILD Perspective of self AGE 3 – 17 (Skip if it does not apply)

Child & Adolescent Trauma Screen (CATS) (Page 1)

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.

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

If you marked "YES" to any stressful event for the child, proceed to the next page and answer the questions.

Client Name:
SoonerCare ID:

CHILD AGE 7 – 17 PERSPECTIVE (Skip if it does not apply)

Child & Adolescent Trauma Screen (CATS) (Page 2)

0 NEVER / 1 Once in a while / 2 Half the time / 3 Almost Always

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

TOTAL SCORE:___

Mark "YES" or "NO" if the problem you marked interfered with:

PLACE "X" UNDER YOUR ANSWER	YES	NO
21. Getting along with others		
22. Hobbies/ Fun		
23. School or Work		
24. Family Relationships		
25. General Happiness		

Client Name:
SoonerCare ID:

ACE Score

While child was growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…

Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____

7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 _____

10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

Client Name:
SoonerCare ID:

DASS-Y: Depression Anxiety Stress Scale
(Answer ABOUT the child)

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:
0 If the statement was NOT TRUE (in the past week)
1 If the statement was A LITTLE TRUE
2 If the statement was FAIRLY TRUE
3 If the statement was VERY TRUE

PLACE "X" UNDER YOUR ANSWER	0	1	2	3	
1. I got upset about little things					S
2. I felt dizzy, like I was about to faint					A
3. I did not enjoy anything					D
4. I had trouble breathing (e.g. fast breathing), even though I wasn't exercising and I was not sick.					A
5. I hated my life					D
6. I found myself overreacting to situations					S
7. My hands felt shaky					A
8. I was stressing about lots of things					S
9. I felt terrified					A
10. There was nothing nice I could look forward to					D
11. I was easily irritated					S
12. I found it difficult to relax					S
13. I could not stop feeling sad					D
14. I got annoyed when people interrupted me					S
15. I felt like I was about to panic					A
16. I hated myself					D
17. I felt like I was no good					D
18. I was easily annoyed					S
19. I could feel my heart beating really fast, even though I hadn't done any hard exercise					A
20. I felt scared for no good reason					A
21. I felt that life was terrible					D

Sx2_____ Ax2_____ Dx2_____

Client Name:
SoonerCare ID:

DAST- 10 Questionnaire
Drug Abuse Screening Test

Initial here if this does not apply____

You are going to read a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

PLACE "X" UNDER YOUR ANSWER	NO	Score	YES	Score
1. Have you used drugs other that those requires for medical reasons?		0		1
2. Do you abuse more than one drug at a time?		0		1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes."		1		0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?		0		1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."		0		1
6. Does your spouse (or parents) ever complain about your involvement with drugs?		0		1
7. Have you neglected your family because of your use of drugs?		0		1
8. Have you engaged in illegal activities in order to obtain drugs?		0		1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		0		1
10. Have you has medical problems as a result of your drug use (eg. memory loss, hepatitis, conclusions, bleeding, etc.)?		0		1

DO NOT GO BEYOND THIS PAGE.

Client Name:
SoonerCare ID:

DAST-10 SCORING

In these statements, the term "drug abuse" refers to the use of medications at a level that exceeds the instructions, and/or any non-medical use of drugs. Patients receive 1 point for every "yes" answer with the exception of question #3, for which a "no" answer receives 1 point. DAST-10 Score Degree of Problems Related to Drug Abuse Suggested Action.

DAST-10 Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

CATS SCORING

CHILD REPORT

Trauma Exposure:

Total PTSD Severity Score: (Add ALL items 1-20): _____

Criteria	# of Symptoms (Only count items rated 2 or 3)	# of Symptoms Required	DSM-5 Citeria Met? (Type Yes or NO)
Re-experiencing Items 1-5		1+	
Avoidance Items 6-7		1+	
Negative Mood/ Cognitions Items 8-14		2+	
Arousal Items 14-20		2+	
Functional Impairment Items 21-25		1+	

CAREGIVER REPORT

Trauma Exposure:

Total PTSD Severity Score: (Add ALL items: 1-20 for ages 7-17 and 1-16 for ages 3-6): _____

Criteria	# of Symptoms (Only count items rated 2 or 3)	# of Symptoms Required	DSM-5 Citeria Met? (Type Yes or NO)
Re-experiencing Items 1-5 (all ages)		1+	
Avoidance* Items 6-7 (all ages)		1+	
Negative Mood/ Cognitions* Items 8-11 (ages 3-6) Items 8-14- (ages 7-17)		2+	
Arousal Items 12-16 (ages 3-6) Items 15-20 (ages 7-17)		2+	
Functional Impairment Items 17-21 (ages 3-6) Items 21-25 (ages 7-17)		1+	

*** Ages 3-6 only need 1 symptom of avoidance OR negative mood/cognitions**

AGES 7-17	AGES 3-6
Score: 0-14 = Normal, not clinically elevated.	Score: 0-11 = Normal, not clinically elevated.
Score: 15-20 = Mild/Moderate trauma-related distress	Score: 12-15 = Mild/Moderate trauma-related distress
Score 21+ = Probable PTSD	Score 16+ = Probable PTSD

Client Name:
SoonerCare ID:

SCORING CHECKLIST

_____PED. SYMPTOM
_____CATS
_____ACE
_____DASS
_____DAST10