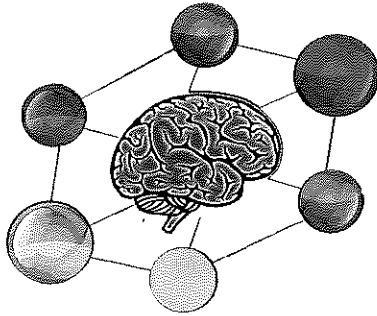


NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Today's Date:______________________ Referred by: ____________________________________

Patient's Name (first, mi, Last) ____

Date of Birth:________________________ Social Security(optional) _________________________

Cell Phone:______________________________Home Phone: _________________________________

May we leave a voicemail Circle: Yes or No Email:____________________________________

Home Address: ____

City:___________________________State:___________Zipcode:_____________________________

Emergency Contact: Name:______________________________Phone:_______________________

Relationship: _________________________________

Emergency Contact (2): Name:______________________________Phone:_______________________

Relationship: _________________________________

Primary Care Doctor:_________________________________Phone Number: ___________________

Current Therapist:___________________________________Phone Number: ___________________

Preferred Pharmacy:_________________________________Zipcode:___________________________

Phone Number: _____________________________________

Primary Insurance

Insurance Provider:___________________________________Member ID #: _________________________

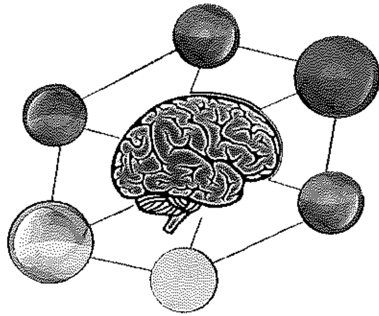
Primary Insurance Holder:________________________________Holder's DOB: _______________________

Secondary Insurance

Insurance Provider:___________________________________Member ID #: _________________________

Primary Insurance Holder:________________________________Holder's DOB: _______________________

I certify that the above information is correct and that I give Norkris Services Inc permission to render services to me and to release information about me to insurance carrier(s) for payment and medication authorization.



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

HIPPA "Summary of Privacy Practices"

A federal regulation called HIPPA requires that you be given information about how your personal health information is handled.

Your Records & Confidentiality

Norkris Services Inc Will not send your medical information out, or provide information about you to someone else, without your **Written Consent** (which you can revoke at any time). Norkris Services can receive information about you from others, though we are not allowed to confirm that you are a patient of ours. We must take care to not reveal information about you in the process of listening to others. Examples of us receiving information about you include receiving a voicemail about you from a family member.

Consent for Assessment & Treatment

I understand that as a patient of Norkris Services, I may receive a range of mental health and wellness services. The type and extent of services that I receive be will determined following an initial assessment. The goal of the assessment is to determine the best course of treatment for me.

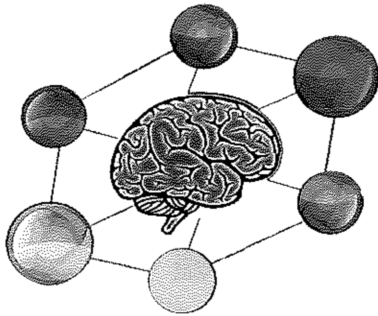
I consent to participate in the evaluation and treatment offered to me by Norkris Services. Treatment may be conducted via VSee, a HIPPA compliant telehealth server, if needs be and I consent. I understand that either Norkris Services or I may discontinue treatment at any time.

Though my provider will do her/his best to fully advise me on the pros and cons of treatment options, I understand that it is also my responsibility to speak up and ask questions if I am confused about any of the recommended therapies. I acknowledge that there is no guarantee that I will be cured, or that a given treatment will be effective for me personally. I intend that this consent form is to cover the entire course of treatment for my present condition and any future conditions for which I am seeking treatment.

Your Information Your Rights our Responsibilities

Your Rights:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a Complaint if you believe your privacy rights have been violated

Your Choices:

- Tell Family and friends about your condition
- Provide disaster relief
- Include you in a hospital Directory
- Provide Mental Health Care
- Market our services and sell your information
- Raise Funds

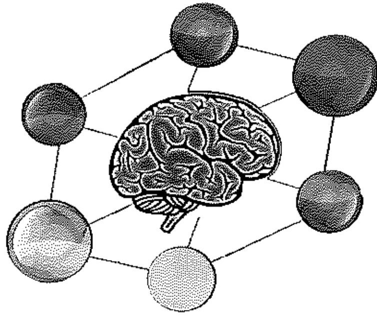
Our Use and Disclosures:

- Treat you
- Run our organization
- Bill for your services
- Help with Public Health and Safety Issues
- Do research
- Comply with the law
- Address worker's compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions

The patient represents that he/she is giving his/her consent knowingly and voluntarily without any elements of force, deceit duress or other form of constraint or coercion, with a general knowledge of the medical and psychiatric procedures outlined above, is aware of the circumstances and is physically and mentally competent to give consent.

- Patient's Signature____Date: ____________

- Patient's Parent/ Guardian Signature: ____



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Mental Health Insurance

Norkris Services Inc provides in network services for a wide variety of insurance providers. We also provide documentation of billing services if you prefer out of network coverage.

Please note that mental health coverage is frequently very different from medical coverage. We strongly encourage you contact your insurance provider or benefits administrator to verify the specific mental health services allowed by your insurance plan.

Copayments: Costs are often a percentage of the charges incurred instead of a fixed dollar amount. All copays and deductibles must be paid at the time of service.

Proof of Insurance: We must obtain a copy of your driver's license / and or your current ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claim Submission: We will submit your claims and assist you in any way reasonably, to help get your claims paid. If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance does not pay your claim in 45 days, the balance will automatically be billed to you.

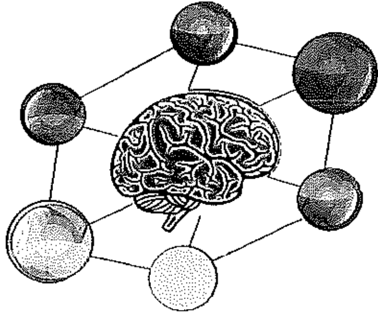
Our Practice is committed to providing the best treatments for our patients. Our prices are representative of the customary charges for our area

- To get the most out of your treatment, it is important to make it a top priority. You must try to keep all appointments that you schedule.
- IF I need to cancel a visit, I must call within 24 hours prior to my appointment. There is a $50 no call no show fee.
- If I miss three (3) visits, and I do not call to cancel Norkris Services INC may stop providing me services.
- Please sign below for your medical record giving us the authorization to bill your insurance provider and or health organization.

I understand that I am responsible for contacting my insurance for actual coverage for outpatient services and an office visit can range from $150-$250 and is determined by both time and complexity of the visit.

____

Patient Name / Authorized Representative Signature　　　　　　　　Date



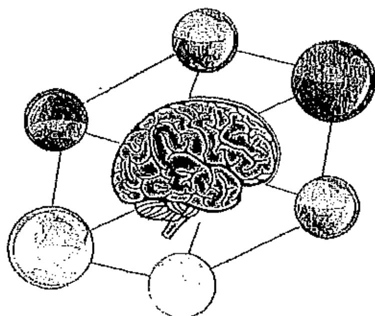
NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Prescription Refills

Please allow us **ATLEAST** **72 hours** for medication refills.

_________ (Patient/Authorized Representative Initials) I acknowledge that a copy of Notice of Privacy Practices is available to me at the time I am signing the document.



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Authorization to Release Medical Information

To:____

____

____

You are authorized to release any and all medical records related to my medical condition and treatment that I may have had during the following time period listed immediately below.

From: _____________________ to ______________________

To the following person(s), company, or government institution:

Name: ____

Address: ____

City, State & Zipcode: _____________________________________

____ My initials here indicate authorization to release all medical records requested.

I have executed this document on the ____ day of _______________ 20__

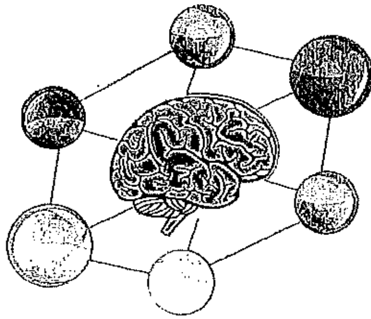
This Authorization is Valid for 1 year from the date of execution.

Name of Patient: ____

Signature of Patient / Parent/ Guardian: _____________________________________

Phone Number: ____

Date of Birth (of patient) ____



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Authorization to Release Medical Information

To:_______________________________________

____

____

You are authorized to release any and all medical records related to my medical condition and treatment that I may have had during the following time period listed immediately below.

From: ____________________ to ____________________

To the following person(s), company, or government institution:

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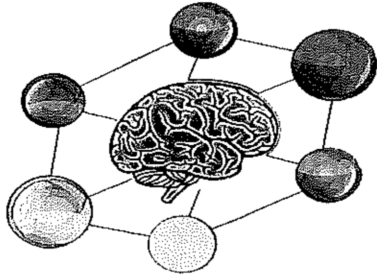


NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Credit Card Authorization Form

Your completion of this authorization form helps us to protect you, our valued patients, from credit card fraud. Norkris Services Inc, PC will keep all information entered on this form strictly.
NOTE: We will not charge your credit card without your explicit consent.

Patient to Sign Below:

If the name on the credit card is different from my own (e.g. if the below credit card belongs to my parent or spouse), I do hereby grant permission for Norkris Services Inc to disclose information regarding appointment dates kept and missed to the credit-card holder as necessary in order to collect payment.
Patient's Signature & Date: ____

Cardholder to Complete:

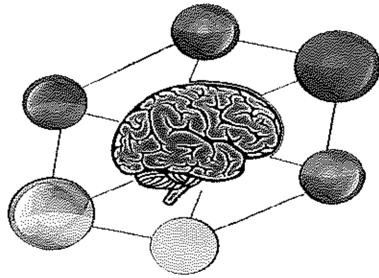
Name on Card: ______________________________
Relationship to patient (e.g. parent) ____________________
I,__________________________, hereby authorize Norkris Services Inc, PC, to charge my credit card for the amounts invoiced.

Type of Card: AMERICAN EXPRESS/VISA/MASTERCARD/OTHER
If other, please specify: ______________________________
Credit Card Number: ______________________________
Expiration Date: ______________________________
CVC Code: ______________________________

Credit Card Billing Address:
Street:______________________________
City:________________State:________________Zipcode: __________

As a credit card holder, I also authorize Norkris Services Inc , PC to charge my credit card for future services, communication(e.g. phone & email) fees, and also for late cancellations of failed appointments. Any dispute that I have regarding charges will be addressed directly with Norkris Services Inc. I will not dispute the charges to my credit card company.

______________________________ ______________
Cardholder's Signature Date



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

ELECTRONIC COMMUNICATIONS RELEASE

E-MAIL

E-mail can offer an easy and convenient way for patients and doctors to communicate. If you decide to e-mail us, here are things for you to know.

- E-mail is not confidential. My staff may read your emails to handle routine, non-clinical matters. You Should also know that if sending e-mails from work, your employer has a legal right to read your email if he or she chooses.
- E-mail communications become part of your medical record and will likely be printed and placed in your chart.
- E-mails may be forwarded to my staff for handling, if appropriate.
- E-mail should be limited to a brief question, requiring one sentence response.
- If you have any questions about changing your medication regimen (stopping, starting or changing dose), you will need to schedule an appointment, since email communication will not be adequate to fully inform you of the risks and benefits.
- E-mail is never, ever, appropriate for urgent or emergency problems! In an emergency, please call "911", or go to the nearest Emergency Room.
- If you agree to the option of communication via E-mail:
  We may not spam you
  You can have automatically- generated reminders e-mailed to you (which you can opt-out of)

PLEASE CHECK ONE:

- o I DO want to communicate with my provider (Norkris Services INC) electronically. I have read the above information and understand the limitations of security on information transmitted.
  - ■ E-Mail Address: ____________________
- o I do NOT want to communicate with any provider electronically. However, if I DO email my provider or Norkris Services, I am automatically authorizing them to email me in return.
- o I consent to Telehealth Services
- o I do not consent to Telehealth Services

- o Patient Signature:____________________ Date:__________

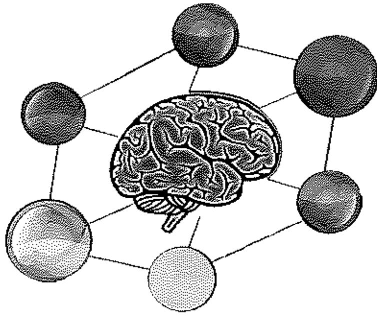
Text Messaging

You may choose to receive appointment reminders as a text message to your mobile phone. This option is for your convenience. Be advised that text messages – like emails- are not encrypted to HIPPA-compliant standards.

PLEASE CHECK ONE:

- o I DO want to receive appointment reminders via text message
- o I do NOT want to receive appointment reminders via text messaging.

Patient Signature: ____________________ **Date:** ____________________



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Intake Form

What are the problem(s) for which you are seeking help?

1. ____________________
2. ____________________
3. ____________________

Current symptoms Checklist: (Check once for any symptoms)

( ) Depressed Mood ( ) Racing Thoughts ( ) Excessive Worrying ( ) Unable to enjoy activities
( ) Impulsivity ( ) Anxiety Attacks ( ) Sleep pattern disturbance ( ) Increase risky behavior
( ) Avoidance ( ) Loss of Interest ( ) Crying Spells ( ) Increased Libido ( ) Hallucinations
( ) Concentration / forgetfulness ( ) Decrease need for sleep ( ) Decreased Libido ( )Fatigue
( ) Change in Appetite ( ) Excessive Energy ( ) Suspiciousness ( ) Excessive guilt ( ) Increased irritability

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No
If **Yes**, please answer the following. If **NO** please skip to the next section
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts?

____

When was the last time you had thoughts of dying?

____

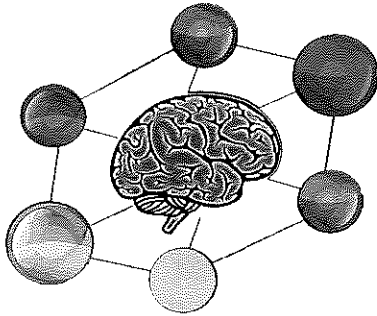
Has anything happened recently to make you feel this way?

____

Would anything make it better ?

____

Do you feel hopeless and/ or worthless? ( ) Yes ( ) No
Have you ever tried to kill or harm yourself before? ( ) Yes ( ) No



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect ( ) Yes ( ) No

Educational History:

Highest Grade Completed?_______Where? ____
Did you attend college? ( ) Yes ( ) No
What is your highest educational level or degree obtained? __________________________

Relationship History and Current Family:
Are you currently? ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed
How Long? _________
If not married, are you currently in a relationship? ( ) Yes ( ) No

How would you identify your sexual orientation?
( ) Straight/Heterosexual ( ) Lesbian/gay/homosexual ( ) Bisexual ( ) transsexual
( ) unsure/ questioning

Do you have any children? ( ) Yes ( ) No

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for:
Bipolar Disorder ( ) Schizophrenia ( ) Depression ( ) Anxiety ( )
Post-traumatic stress ( ) Alcohol Abuse ( ) Anger ( ) Suicide ( )
Violence ( ) other substance Abuse ( )
If yes, who had each problem?

____

____

Has any family member been treated with psychiatric medication? ( ) Yes ( ) No if yes, who was treated, what medications did they take, and how effective was the treatment?

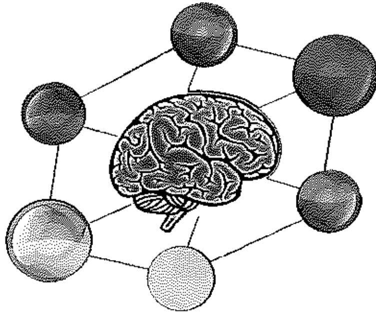
____

____

Is there any additional personal or family medical history? ( ) Yes ( ) No if yes please explain:

____

____



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom and nature of treatment.

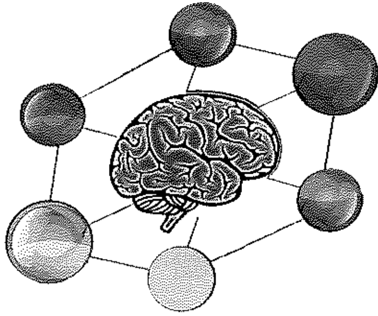
Reason	Dates Treated	By Whom

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reasons, when and where.

Reason	Dates Hospitalized	Where

Substance Use:

Have you ever been treated for Alcohol or drug use or abuse ( ) Yes ( ) No
If yes, for which substances? ______________________________
How many days per week do you drink any alcohol? ______________________________
What is the least amount of drinks you will drink in a day? ______________________________
What is the greatest number of drinks you will drink in a day? ______________________________
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you ever used any street drugs in the past 3 month? ( ) Yes ( ) No
Have you ever abused prescription medication? ( ) Yes ( ) No



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For Children and Families Mental Wellbeing

Check if you have ever tried the following:

Methamphetamine ( ) Yes ( ) No

Cocaine ( ) Yes ( ) No

LSD or Hallucinogens ( ) Yes ( ) No

Pain Killers (not as prescribed) ( ) Yes ( ) No

Tranquilizer/ sleeping pills ( ) Yes ( ) No

Ecstasy ( ) Yes ( ) No

Stimulants (pills) ( ) Yes ( ) No

Heroin ( ) Yes ( ) No

Marijuana ( ) Yes ( ) No

Methadone ( ) Yes ( ) No

Alcohol ( ) Yes ( ) No

Other ( ) Yes ( ) No

How many caffeinated beverages do you drink a day? Coffee________Sodas__________Tea ________

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No How many packs per day on average?____________How many years? _ In the past? ( ) Yes ( ) No How many years did you smoke?_________When did you quit? _________

Pipe, Cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No
What kind?__________________How often per day on average?___________How many years? ______

Legal History:
Have you ever been arrested? ( ) Yes ( ) No
Do you have any pending legal problems? ( ) Yes ( ) No

Is there anything else you would like us to know?

____
____
____
____
____
____
____
____

PATIENT NAME:______________________ DATE: ____________

PHQ-9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	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
		PHQ9 total score:			

Q6 CORE10	I made plans to end my life in the last 2 weeks	NO	YES

GAD-7

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score:			

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

PCL-5 with Criterion A

ID #:
Date:

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so): **_____I don't feel comfortable describing the worst event.**

____

____

____

____

How long ago did it happen?______________________________(please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

_____ Yes

_____ No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe ____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____ Accident or violence

_____ Natural causes

_____ Not applicable (the event did not involve the death of a close family member or close friend)

Second, below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	**Not at all**	**A little bit**	**Moderatel y**	**Quit e a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Mood Disorder Questionnaire

Patient Name ______________________ Date of Visit __________

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
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The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answerswill remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

OCI-R

The following statements refer to experiences that many people have in their everyday lives. Circle the number that best describes **HOW MUCH** that experience has **DISTRESSED or BOTHERED you during the PAST MONTH.** The numbers refer to the following verbal labels:

0 Not at all	1 A little	2 Moderately	3 A lot	4 Extremely

1.	I have saved up so many things that they get in the way.	0 1 2 3 4
2.	I check things more often than necessary.	0 1 2 3 4
3.	I get upset if objects are not arranged properly.	0 1 2 3 4
4.	I feel compelled to count while I am doing things.	0 1 2 3 4
5.	I find it difficult to touch an object when I know it has been touched by strangers or certain people.	0 1 2 3 4
6.	I find it difficult to control my own thoughts.	0 1 2 3 4
7.	I collect things I don't need.	0 1 2 3 4
8.	I repeatedly check doors, windows, drawers, etc.	0 1 2 3 4
9.	I get upset if others change the way I have arranged things.	0 1 2 3 4
10.	I feel I have to repeat certain numbers.	0 1 2 3 4
11.	I sometimes have to wash or clean myself simply because I feel contaminated.	0 1 2 3 4
12.	I am upset by unpleasant thoughts that come into my mind against my will.	0 1 2 3 4
13.	I avoid throwing things away because I am afraid I might need them later.	0 1 2 3 4
14.	I repeatedly check gas and water taps and light switches after turning them off.	0 1 2 3 4
15.	I need things to be arranged in a particular way.	0 1 2 3 4
16.	I feel that there are good and bad numbers.	0 1 2 3 4
17.	I wash my hands more often and longer than necessary.	0 1 2 3 4
18.	I frequently get nasty thoughts and have difficulty in getting rid of them.	0 1 2 3 4

COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

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PainEDU.org

Improving Pain Treatment Through Education

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O

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IMPROVING PAIN TREATMENT THROUGH EDUCATION

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

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IMPROVING PAIN TREATMENT THROUGH EDUCATION

Date ______________________________

Patient Name ______________________________

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk $\geq$ 8

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), 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 alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		Circle	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		**Score:**	

Interpretation of Score		
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

Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation.)

NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Past Medical History:

Allergies:

____

____

Current Over the Counter Medications:

____

____

____

Current Medical Problems:

____

____

List of all Current prescription medications and how often you take them (if none, write none)

Medication	Total Daily Dosage	Estimated Start Date