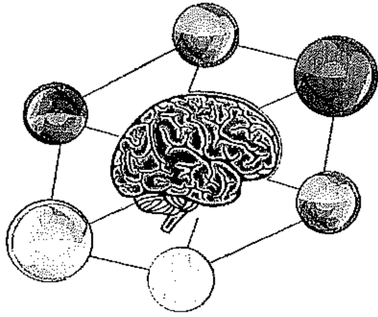


NORKRIS SERVICES, INC.

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 #: _________________________

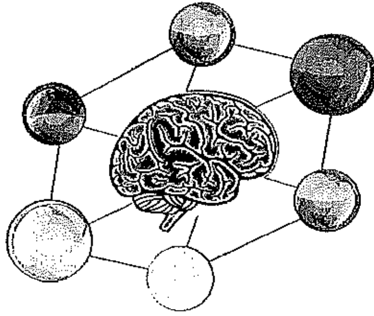
Primary Insurance Holder: ________________________________ Holder's DOB: _______________________

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** (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.

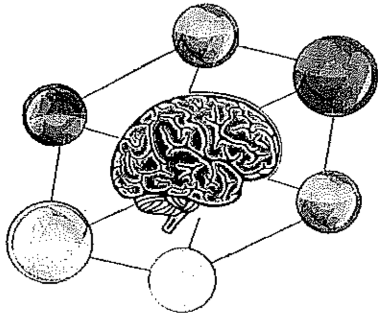
I consent to participate in the evaluation and treatment offered to me by Norkris Services. I understand that either Norkris Services or I may discontinue treatment at any time.

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

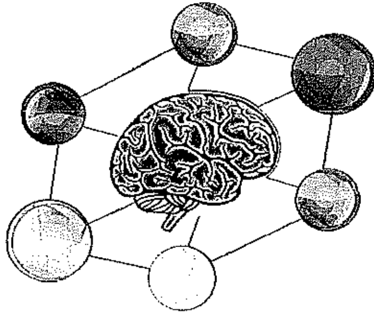
Our Use and Disclosures:

- 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.

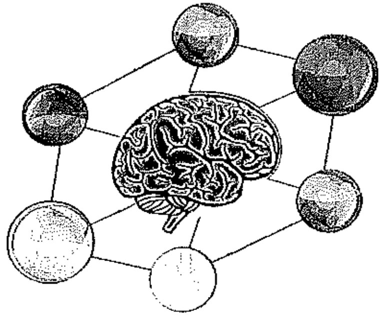
Our Practice is committed to providing the best treatments for our patients. Our prices are representative of the customary charges for our area

- 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



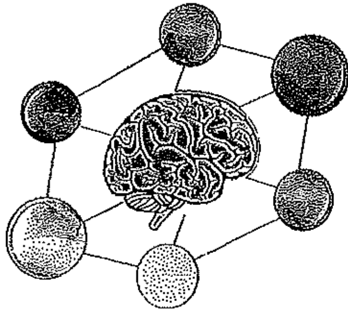
NORKRIS SERVICES, INC.

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 FOUNDATION

Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellness

Inform Consent to Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint custody of your child. If you are separated or divorced from the other parent of the child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe that it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic process. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me to have a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with the Therapist

In the course of my treatment of your child, I may meet with the child's parent/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child-not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those records will be available to any person or entity that had legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

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

- Child patients tell me they plan to cause serious harm or death to someone else, and I believe that they have the intent and ability to carry this threat out in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police]

Disclosure of Minor's Treatment Records to Parents

Although the laws of [this State] may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meeting with me, and you agree not to request access to your child's written treatment records.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature*______________________________**Date**__________________

*For very young children, the Childs's signature is not necessary

Parent/Guardian of Minor Patient:

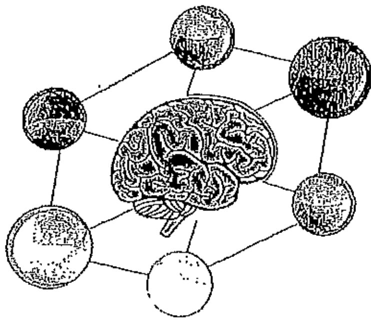
Please initial after each line and sign below, indicating your agreement to respect you child's privacy:

I will refrain from requesting detailed information about therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. ________ ________

Although I have the legal right to request written record/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment. ________ ________

Parent/Guardian Signature________________________**Date**____________________

Parent/Guardian Signature________________________**Date**____________________



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__

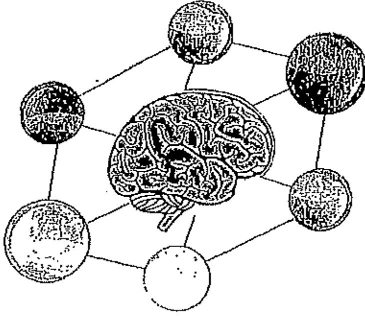
This Authorization is Valid for 1 year from the date of execution.

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:

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__

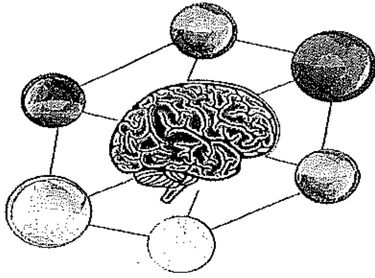
This Authorization is Valid for 1 year from the date of execution.

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

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:

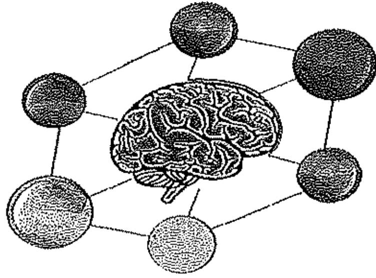
Name on Card: ______________________________
Relationship to patient (e.g. parent) ____________________
I, ______________________________, hereby authorize Norkris Services Inc, PC, to charge my credit card for the amounts invoiced.

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-M AIL

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:__________

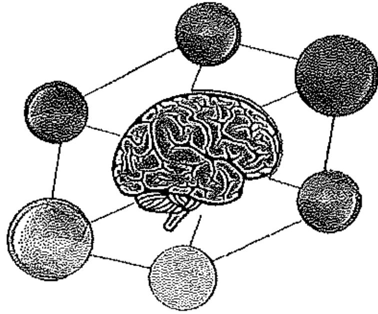
Text Messaging

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?

____

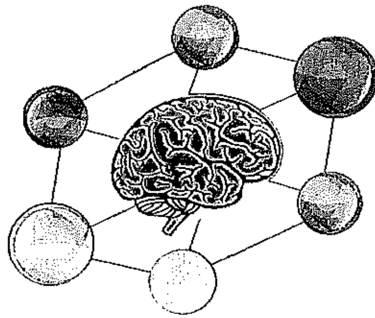
Has anything happened recently to make you feel this way?

____

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.

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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?

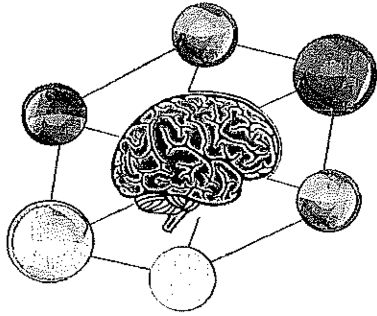
____

____

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

____

____



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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

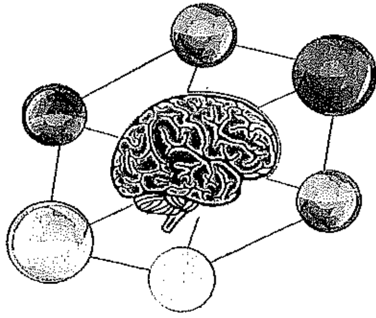
____

____

____

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



NORKRIS SERVICES, INC.

Attentive Therapeutic Expressive Minds Working
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?

____
____
____
____
____
____
____
____

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ____________ Child's Name: ______________________________ Date of Birth: ____________

Parent's Name: ______________________________ Parent's Phone Number: ______________________________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ___________ Child's Name: ______________________________ Date of Birth: ___________

Parent's Name: ______________________________ Parent's Phone Number: ______________________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ____________

Total number of questions scored 2 or 3 in questions 10–18: ____________

Total Symptom Score for questions 1–18: ____________

Total number of questions scored 2 or 3 in questions 19–26: ____________

Total number of questions scored 2 or 3 in questions 27–40: ____________

Total number of questions scored 2 or 3 in questions 41–47: ____________

Total number of questions scored 4 or 5 in questions 48–55: ____________

Average Performance Score: ____________

Patient Health Questionnaire-Modified for Teens

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, irritable or hopeless?	0	1	2	3
3. Trouble falling asleep, 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, weight loss, 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 like school work, reading, or watching TV?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: ____0____ + ________ + ________ + ________

= Total Score ________

10. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐
11. In the ***past year***, have you felt depressed or sad most days, even if you felt OK sometimes?	Yes ☐	No ☐		
12. Has there been a time in the ***past month*** when you have had serious thoughts about ending your life?	Yes ☐	No ☐		
13. Have you ***ever, in your whole life***, tried to kill yourself or made a suicide attempt?	Yes ☐	No ☐		

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by 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

Column totals _____ + _____ + _____ + _____ =

Total score _______

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

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

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	Moderately	Quite 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.
Permission for use granted by RMA Hirschfeld, MD

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 answers will 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

Name... Date.................... initial/ rebaseline/ mid/ end/ follow up

The following statements refer to experiences which many people have in their everyday lives. In the column labelled DISTRESS, please **CIRCLE** the number that best describes **HOW MUCH** that experience has **DISTRESSED** or **BOTHERED YOU DURING THE PAST MONTH**. The numbers in this column refer to the following labels: 0 = Not at all 1 = A little 2 = Moderately 3 = A lot 4 = Extremely

		DISTRESS				
1.	Unpleasant thoughts come into my mind against my will and I cannot get rid of them	0	1	2	3	4
2.	I think contact with bodily secretions (perspiration, saliva, blood, urine, etc) may contaminate my clothes or somehow harm me.	0	1	2	3	4
3.	I ask people to repeat things to me several times, even though I understood them the first time.	0	1	2	3	4
4.	I wash and clean obsessively.	0	1	2	3	4
5.	I have to review mentally past events, conversations and actions to make sure that I didn't do something wrong.	0	1	2	3	4
6.	I have saved up so many things that they get in the way.	0	1	2	3	4
7.	I check things more often than necessary	0	1	2	3	4
8.	I avoid using public toilets because I am afraid of disease or contamination.	0	1	2	3	4
9.	I repeatedly check doors, windows, drawers etc.	0	1	2	3	4
10.	I repeatedly check gas and water taps and light switches after turning them off.	0	1	2	3	4
11.	I collect things I don't need.	0	1	2	3	4
12.	I have thoughts of having hurt someone without knowing it.	0	1	2	3	4
13.	I have thoughts that I might want to harm myself or others.	0	1	2	3	4
14.	I get upset if objects are not arranged properly.	0	1	2	3	4
15.	I feel obliged to follow a particular order in dressing, undressing and washing myself.	0	1	2	3	4
16.	I feel compelled to count while I am doing things	0	1	2	3	4
17.	I am afraid of impulsively doing embarrassing or harmful things.	0	1	2	3	4
18.	I need to pray to cancel bad thoughts or feelings.	0	1	2	3	4
19.	I keep on checking forms or other things I have written.	0	1	2	3	4
20.	I get upset at the sight of knives, scissors and other sharp objects in case I lose control with them.	0	1	2	3	4
21.	I am excessively concerned about cleanliness.	0	1	2	3	4
22.	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

	DISTRESS				
24. I get behind in my work because I repeat things over and over again.	0	1	2	3	4
25. I feel I have to repeat certain numbers.	0	1	2	3	4
26. After doing something carefully, I still have the impression I have not finished it.	0	1	2	3	4
27. I find it difficult to touch garbage or dirty things.	0	1	2	3	4
28. I find it difficult to control my own thoughts.	0	1	2	3	4
29. I have to do things over and over again until it feels right.	0	1	2	3	4
30. I am upset by unpleasant thoughts that come into my mind against my will.	0	1	2	3	4
31. Before going to sleep I have to do certain things in a certain way.	0	1	2	3	4
32. I go back to places to make sure that I have not harmed anyone.	0	1	2	3	4
33. I frequently get nasty thoughts and have difficulty in getting rid of them.	0	1	2	3	4
34. I avoid throwing things away because I am afraid I might need them later.	0	1	2	3	4
35. I get upset if others change the way I have arranged my things.	0	1	2	3	4
36. I feel that I must repeat certain words or phrases in my mind in order to wipe out bad thoughts, feelings or actions.	0	1	2	3	4
37. After I have done things, I have persistent doubts about whether I really did them.	0	1	2	3	4
38. I sometimes have to wash or clean myself simply because I feel contaminated.	0	1	2	3	4
39. I feel that there are good and bad numbers.	0	1	2	3	4
40. I repeatedly check anything which might cause a fire.	0	1	2	3	4
41. Even when I do something very carefully I feel that it is not quite right.	0	1	2	3	4
42. I wash my hands more often or longer than necessary.	0	1	2	3	4

For therapist use:

Washing	
Checking	
Doubting	
Ordering	
Obsessions	
Hoarding	
Neutralising	
Total	

Family History Questionnaire

Clinician Use Only
Patient ________
Interview Date________
WMDC Consult

1) **Have any of your blood relatives been diagnosed with a mental illness?** ☐Yes ☐No *If yes, please indicate their sex, relationship to you, and if known, diagnosis and treatment:*

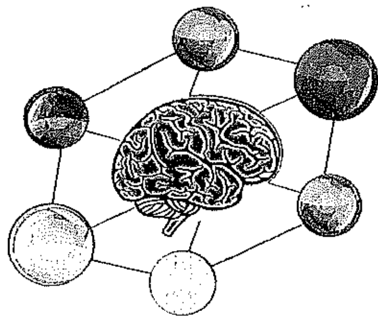
Relationship to you	Sex	Diagnosis (check all that apply)	Treatment (check all that apply if known)
	☐ Male ☐ Female	☐ Major depression ☐ Other:__________ ☐ Bipolar disorder ☐ Anxiety disorder	☐ therapy/counseling ☐ medication ☐ hospitalization
	☐ Male ☐ Female	☐ Major depression ☐ Other:__________ ☐ Bipolar disorder ☐ Anxiety disorder	☐ therapy/counseling ☐ medication ☐ hospitalization
	☐ Male ☐ Female	☐ Major depression ☐ Other:__________ ☐ Bipolar disorder ☐ Anxiety disorder	☐ therapy/counseling ☐ medication ☐ hospitalization
	☐ Male ☐ Female	☐ Major depression ☐ Other:__________ ☐ Bipolar disorder ☐ Anxiety disorder	☐ therapy/counseling ☐ medication ☐ hospitalization

2) **Have any of your female blood relatives suffered from mental illness within a year of giving birth?**☐Yes ☐No *If yes, please indicate below:*

Relationship to you	Diagnosis (check all that apply)
☐ Mother ☐ Sister ☐ Father's mother ☐ Mother's mother ☐ Cousin from mother's side ☐ Cousin from father's side ☐ Aunt from mother's side ☐ Aunt from father's side	☐ Major depression ☐ Bipolar disorder ☐ Anxiety disorder ☐ Other:
☐ Mother ☐ Sister ☐ Father's mother ☐ Mother's mother ☐ Cousin from mother's side ☐ Cousin from father's side ☐ Aunt from mother's side ☐ Aunt from father's side	☐ Major depression ☐ Bipolar disorder ☐ Anxiety disorder ☐ Other:
☐ Mother ☐ Sister ☐ Father's mother ☐ Mother's mother ☐ Cousin from mother's side ☐ Cousin from father's side ☐ Aunt from mother's side ☐ Aunt from father's side	☐ Major depression ☐ Bipolar disorder ☐ Anxiety disorder ☐ Other:

3) **Have any of your blood relatives committed suicide?** ☐Yes ☐No *If yes, please list their sex, relationship to you and age at suicide:*

Relationship to you	Sex	Age at suicide
	☐ Male ☐ Female	
	☐ Male ☐ Female	



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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