

DONNA MCLEMORE WATKINS, MEd, LPC, RPT
INFORMED WRITTEN CONSENT FOR TREATMENT POLICY STATEMENT FORM

Thank you for selecting me as your counselor. The intent of this statement is to inform you about the basic therapeutic relationship between counselor and client, to inform you of basic policies, and to help you understand our professional relationship.

Counseling Philosophy, Expectations of Clients

I believe in the capacity of people for self-efficacy. This means that you are able to personally create an improved quality of life and you are in charge of your goals and personal growth. I will work with you in achieving these personal goals. My approach to therapy involves mind, body, and spirit through the use of evidence-based practices. We will together examine issues related to your self-relationship and relationships with others.

Your decision to choose to enter counseling is a voluntary one and you may terminate at any time. If, in my professional opinion, it is in your best interest to refer you to another therapist, I will do so because of ethical standards. I will provide you with the contact information of the referral. Please note that it is impossible to guarantee any specific results regarding your counseling goals; however, we will work together to achieve the best possible results. At the end of the first session, we will decide if we want to enter into a counseling relationship. If we both agree, you will sign, date, and keep a copy of this informed consent.

Scope of Practice

I operate in an outpatient private practice consisting of traditional talk therapy, equine therapy, and other experiential therapies. I work with children, adolescents, and adults. I cannot and do not assume responsibility for client's daily functioning as an institution can. I am not an emergency facility for crisis management. I make every effort to return phone calls during office hours as quickly as possible but there may be unavoidable delays. I can be reached at 770-947-2311. IN THE EVENT OF AN EMERGENCY, you should call 911 or go to the emergency room.

Ethical Guidelines and Standards

I assure you that my services will be provided in a professional manner consistent with accepted ethical standards for licensed professional counselors.

Confidentiality

Please understand that I will keep confidential what you disclose, with the following exceptions:

1. You direct/allow me to tell someone by signing a release of information form.
2. I determine you are a danger to yourself or others.
3. I am ordered by a court to disclose information
4. You abuse a child or an elderly person.

Your signature indicates that you have reviewed this document, had your questions answered to your satisfaction and you agree to adhere to policies specified in this document.

Printed Name

Date

Client Signature

Guardian Signature for minor clients

Today's Date: _____

Red Clay Counseling, LLC
Patient Information and Financial Agreement
(Please Print Legibly)

PATIENT INFORMATION

Please use full legal name (no nicknames please)

Last _____ First _____ MI _____
DOB _____ Age _____ M/F _____ SSN _____
Physical Address _____
Mailing Address _____
City _____ State _____ Zip _____
County _____
Cell/Home Phone _____ E-Mail _____

PARENT/GUARDIAN (Person responsible for care and financial situations)

Last _____ First _____ MI _____
DOB _____ SSN _____ Occupation _____
Mailing Address _____
Primary Phone _____ Secondary _____
Employer _____ Work Phone _____
E-mail _____
Other parent/guardian _____ Phone _____

Are parents separated or divorced? Yes _____ No _____

If you are not a parent, are you the legal guardian? Yes _____ No _____

Best number to confirm your appointment? _____

YOU WILL NEED TO SHOW PROOF OF CUSTODY OR GUARDIANSHIP

ADDITIONAL INFORMATION

Referring Physician or Psychiatrist (Please provide doctors full name)

Phone# Diagnosis _____

If patient has seen other mental health professionals, please include psychians name and diagnosis _____

INSURANCE INFORMATION (Please fill out completely)

Primary Insurance name _____

Insurance ID# _____

Policy Holder's Name DOB _____

SSN _____ Relation to Patient _____

Group Number _____ Employer _____

Secondary Insurance Name _____ Insurance ID# _____

Policy Holder's Name _____ DOB _____

SSN _____ Relation to Patient _____

Group Number _____ Employer _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please Read and Initial=Init. each section)

Init. _____ I request that all insurance benefits be paid directly to Red Clay Counseling, LLC.

Init. _____ You are entitled to a clear understanding of your financial obligations before services are rendered. We participate with numerous managed care plans and to the best of our ability, certify your benefits prior to being seen. It is not possible for us to know all of the individual requirements of each plan. Your employer negotiates the benefits of your plan and we have no control over how claims may or may not be processed. Each plan is different in regards to what is covered, how often and where services may be rendered. Whether you have insurance or are self-pay, we maintain that you are ultimately responsible for all charges incurred.

Init. _____ We do not file indemnity plans, non-contracted or secondary insurance carriers. We try to assist you in getting services covered; but are not responsible if they are not covered under your contract and you will be billed. It is your responsibility to ensure that a referral and/or authorization has been obtained if necessary. If we do not have a referral on file, we are happy to see you as a self-pay patient. For a self-pay patient, full payment is required at the time of service.

Init. _____ If insurance cannot be verified by date of service, we expect payment in full. We accept cash, check and credit cards. If you do not have insurance, we expect payment in full, unless prior arrangements have been made with the business office.

***Co-pays are due at time of service; if it is not paid at the time of service, we will bill you with an additional administrative fee of 15% per visit.

***There is a per page fee for any written communication, to be paid at time of completion. Once requested, this fee will apply whether you choose to utilize it or not.

***Please make all checks payable to Red Clay Counseling, LLC.

*** We charge a \$35.00 returned check fee.

*****Cancellation fees and NO SHOW fees:** \$65.00 -individual therapy; \$70.00-family therapy, or amount equivalent to reserved time for cancellation with less than 24 hours notice.

***No-show fees are billed to you directly and are your responsibility. Insurance will not pay.

***Medical records can be obtained with signed release and applicable administrative fees at time of release. There is a fee incurred.

***This office practices Credit Bureau reporting for all delinquent balances.

*** **Court Appearance:** If Red Clay Counseling, LLC, Donna M. Watkins, M.Ed., LPC, testifies in court or is subpoenaed, client will pay \$150.00 per hour of time, including, but not limited to, preparation for court, testifying, and will include time at courthouse to appear. If to be paid by another entity besides client and entity does not pay, client is responsible for full amount.

Init. _____ I acknowledge understanding for above.

I have read, understand and accept the terms of this financial policy. I have been provided a copy of the Privacy Practices Notice.

Date _____

Responsible Party or Patient/Client Signature _____

Printed Name _____

Signature of Staff/Witness _____

Red Clay Counseling, LLC

Patient Confidentiality

We request all cell phones and electronic devices be turned off during sessions for further patient confidentiality. Absolutely no videotaping or recording allowed to insure patient confidentiality.

Patient confidentiality is a top priority at Red Clay Counseling, LLC. Therefore, it is important that you provide us with the following information to ensure that there is no violation of your privacy.

I acknowledge that I have been made aware of the "NOTICE OF PRIVACY PRACTICES" for Protected Health Information on the date set forth below.

In the event that I am unable to be reached, Red Clay Counseling, LLC may leave any appointment or account information in the following manner:

_____ You may leave messages on my mobile phone. Number: _____

_____ You may leave messages on my home answering machine. Number: _____

_____ You may call my work number and leave a message. Number: _____

_____ You may leave messages on my office voicemail. Number: _____

_____ You may share appointment/account information with my spouse. Number: _____

_____ You may share appointment information with my children. Number: _____

_____ You may share my appointment and account information with:

Name _____ Phone Number _____ Relationship to Patient _____

Name _____ Phone Number _____ Relationship to Patient _____

_____ In the event you are unable to reach me; Red Clay Counseling **may not** leave appointment information or account information with anyone but myself, including on voicemail, at the following phone number: _____

Proxy Permission Form: The following person(s) may make medical decisions and sign any appropriate documents related to my child's care in my absence.

Name of Proxy (Please print) Relationship

Signature of Client or Guardian Date Relationship to Client

Red Clay Counseling, LLC Medical Release

Date of Release _____

Name _____ DOB (mm/dd/yyyy) _____

Address _____

Phone Number () _____

I give Red Clay Counseling, LLC permission to contact the following person in case of a medical emergency:

Name _____

Phone Number () _____

Additionally, I give permission for Red Clay Counseling, LLC staff to contact 911 and/or emergency personnel to assist in the case of an emergency.

Please Note: Please take care when entering & exiting the property by driving slowly into the parking area, watching out for children, other cars or loose animals. Also, while taking the stairs up and down into the center, hold the hand rails and step carefully. Please hold on to small children and monitor them, while inside and outside the building to ensure that they do not exit. Parents/guardians will accompany all children under age of 10 to the downstairs restroom.

Signature of Client or Guardian: _____ Date: _____

Signature of Staff/Witness: _____ Date: _____

Red Clay Counseling, LLC
Donna M. Watkins, M.Ed., LPC

Welcome,

These are a few friendly reminders about OAKHILL and Red Clay Counseling, LLC:

- *Because parking is limited, please park in the marked parking area.
- *Since the waiting area is small, **please limit persons who accompany the patient being seen.**
- *This is a totally, non-smoking facility, including smoking in vehicles on the property.
- *Please do not bring food or drinks inside the building.
- *Please do not leave your children unattended.
- *Please assist little ones under the age of 6 going up and down the stairs.
- *Please accompany children under the age of 10 to the restroom, located downstairs.
- *Please do not wander the property without staff escort.
- *Please do not feed or touch the animals without staff guidance.
- *Please inform Red Clay Counseling, LLC of cancellations within 24 hours to avoid a No Show Charge.

We appreciate your understanding and respect for this sacred space.

Sincerely,

Donna M. Watkins, M.Ed., LPC

Red Clay Counseling, LLC

I, _____, have read, understand and accept the terms of the
(printed name of client or guardian if minor)

general rules and guidelines at Red Clay Counseling, LLC and Douglasville Psychotherapy Center at Oakhill, P.C. I
have been provided a copy of the Rules in the new client forms package.

Date: _____

Responsible Party or Patient/Client Signature: _____

Printed Name: _____

Signature of Staff/Witness: _____

HIPAA Notice of Privacy Practices Statement

Red Clay Counseling, LLC

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

All information describing your mental health treatment and related health care services (“mental health information”) is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy too. This Notice applies to your counselor, psychotherapist, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDS, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

For TREATMENT for example, we may give information about your psychological condition to other health care providers to facilitate your treatment, referrals or consultations.

For PAYMENT for example, we may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.

For APPOINTMENTS AND SERVICES to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.

WITH YOUR WRITTEN AUTHORIZATION we may use or disclose mental health information for purposes not described in this Notice only with your written authorization.

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION.

As REQUIRED BY LAW when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.

For HEALTH OVERSIGHT ACTIVITIES to governmental, licensing, auditing and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

In JUDICIAL PROCEEDINGS in response to court/ administrative orders, subpoenas, discovery requests or other legal process.

To PUBLIC HEALTH AUTHORITIES to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.

To LAW ENFORCEMENT for example, to assist in an involuntary hospitalization process.

To THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES for legislative investigations.

For RESEARCH PURPOSES subject to a special review process and the confidentiality requirements of state and federal law.

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.

To PROTECT CERTAIN ELECTIVE OFFICERS including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

To Receive a Copy of this Notice when you obtain care.

To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.

To Inspect and Request a Copy of Your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.

To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason of the request. We may deny your request for an amendment if the information

was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.

To Receive An Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.

To Request that We Contact you by Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for information we already have about you as well as any information we receive in the future.

CONTACT INFORMATION:

If you have questions about this Notice or believe your privacy rights have been violated, you may contact:

The Secretary of the Department of Health and Human Services
Contact the Office for Civil Rights
1-866-627-7748, 1-800-537-7697 (TTY)

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/>

Filing a complaint will not affect the services you receive at Red Clay Counseling, LLC.

By law, Red Clay Counseling, LLC is required to follow the terms in this privacy notice. Red Clay Counseling, LLC has the right to change the way your personal health information is used and given out. If Red Clay Counseling, LLC makes any changes to the way your personal health information is used and given out while you are a current client, you will get a new notice, directly or by mail, within 60 days of the change.

Red Clay Counseling, LLC

(For Caregiver to Complete)

ADOLESCENT PSYCHOSOCIAL (Ages 12-17 yrs.)

IDENTIFYING INFORMATION

Date of Initial Appointment _____

Name of child _____ Sex _____

Birthdate _____ Place of birth _____ Age _____

Address (number and street) _____

City _____ State _____ Zip _____

Telephone _____ Religion (optional) _____

Education (grade) _____ Present school _____

Referral Source _____

Adult completing form _____ Relationship _____

CHIEF COMPLAINT

Presenting Problems (check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Very unhappy | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Fire setting | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Stealing | <input type="checkbox"/> Temper outbursts | |
| <input type="checkbox"/> Disobedient | <input type="checkbox"/> Lying | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Infantile |
| <input type="checkbox"/> Sexual trouble | <input type="checkbox"/> Daydreaming | <input type="checkbox"/> Mean to others | |
| <input type="checkbox"/> School performance | <input type="checkbox"/> Fearful | <input type="checkbox"/> Destructive | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Trouble with the law | |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Running away | <input type="checkbox"/> Soiled pants | <input type="checkbox"/> Slow |
| <input type="checkbox"/> Self-mutilating | <input type="checkbox"/> Distractible | <input type="checkbox"/> Rocking | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Sickly | <input type="checkbox"/> Lacks initiative | <input type="checkbox"/> Shy | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Undependable | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Strange behavior | <input type="checkbox"/> Peer conflict |
| <input type="checkbox"/> Strange thoughts | <input type="checkbox"/> Suicide talk | <input type="checkbox"/> Aggressive towards others | |

How long have these problems occurred? (Number of weeks, months, years) _____

What happened that makes you seek help at this time? _____

Problems perceived to be: Very serious _____ Serious _____ Not serious _____

What are your expectations of your child? _____

What changes would you like to see in your child? _____

What changes would you like to see in yourself? _____

What changes would you like to see in your family? _____

PSYCHOSOCIAL HISTORY

Current Family Situation

Biological Mother's Name: _____ Age: _____

Stepmother's Name: _____ Age: _____

Adoptive Mother's Name: _____ Age: _____

Biological Father's Name: _____ Age: _____

Stepfather's Name: _____ Age: _____

Adoptive Father's Name: _____ Age: _____

MARITAL HISTORY OF PARENTS

Natural Parents: _____ Married When _____ Ages _____, _____

_____ Separated When _____

_____ Divorced When _____

_____ Deceased When _____ M or F _____

Step Parents _____ Married When _____

_____ Separated When _____

_____ Divorced When _____

If Child is Adopted:

Adoptive Source _____

Reason and circumstances _____

Age when child first came into home _____

Date of legal adoption _____

What has the child been told _____

LIVING ARRANGEMENTS

Number of moves in child's life _____

Places and Dates _____

Present Home (Renting or Buying) _____

Apartment or House _____

Does the child share a room with anyone else _____ If no, how long has child had own space _____

Was the child ever placed, boarded or lived away from the family _____

Explain _____

What are the major family stressors at the present time, if any _____

What are the sources of family income _____

List All Individuals Living In the Home:

Name	Relationship	Age	Sex	School Present grade	Living at home	Uses Drugs
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HEALTH OF FAMILY MEMBERS

List all other extended family members by their relationship to the patient and/if they have drug and/or alcohol problems (legal or illegal), history of depression self-destructive behavior or legal problems.

Name: _____ Relationship: _____ Type of Issue: _____

Name: _____ Relationship: _____ Type of Issue: _____

Name: _____ Relationship: _____ Type of Issue: _____

Does or did any member of the child's family have any problems with:

____ Reading ____ Spelling ____ Math ____ Speech

If yes, explain _____

Is there any history in the child's family of:

____ Mental retardation ____ Epilepsy ____ Birth defects ____ Schizophrenia

If yes, explain _____

CHILD HEALTH INFORMATION

Note all health problems the child has had or has now

Symptom	Age	Symptom	Age
____ High fever	_____	____ Dental problems	_____
____ Pneumonia	_____	____ Weight problems	_____
____ Flu	_____	____ Allergies	_____
____ Encephalitis	_____	____ Skin problems	_____
____ Meningitis	_____	____ Asthma	_____
____ Convulsions	_____	____ Headaches	_____
____ Unconsciousness	_____	____ Stomach problems	_____
____ Concussions	_____	____ Accident prone	_____
____ Head injury	_____	____ Anemia	_____
____ Fainting	_____	____ High or low blood pressure	_____
____ Dizziness	_____	____ Sinus problems	_____
____ Tonsils out	_____	____ Heart problems	_____
____ Vision problems	_____	____ Hyperactivity	_____
____ Hearing problems	_____	____ Earaches	_____
____ Other problems	_____		

Explain _____

Has the child ever been hospitalized? Yes ____ No ____

If yes, when and for how long _____

Has the child ever been seen by a medical specialist? Yes ____ No ____

If yes, explain _____

Has the child ever taken or is he/she currently taking any prescribed medications? Yes _____ No _____

If yes, explain _____

Name of Primary Care Physician _____

DEVELOPMENTAL HISTORY

Pregnancy/Child Wanted? Yes _____ No _____ Planned for? Yes _____ No _____

Normal pregnancy? Yes _____ No _____

Was mother ill during pregnancy? Yes _____ No _____ Explain _____

Length of pregnancy _____ Parental support and acceptance _____

BIRTH

Length of active labor _____ Easy _____ Difficult _____

Full term? Yes _____ No _____ If premature, how early _____

If overdue, how long _____

Birth weight _____ Type of delivery _____ Head first _____ Breech _____

Was is necessary to give the infant oxygen? Yes _____ No _____ For how long _____

Did the infant require blood transfusions? Yes _____ No _____

Did the infant require X-rays? Yes _____ No _____

Physical condition of infant at birth _____

Did the mother abuse alcohol/drugs during pregnancy? Yes _____ No _____ For how long _____

Did the mother use tobacco during pregnancy? Yes _____ No _____ For how long _____

NEWBORN PERIOD

Symptom	Yes	No
Irritability	_____	_____
Vomiting	_____	_____
Difficulty breathing	_____	_____
Difficulty sleeping	_____	_____
Convulsions/twitching	_____	_____
Colic	_____	_____
Normal weight gain	_____	_____
Was child breast fed	_____	_____

DEVELOPMENTAL MILESTONES

Age at which the child:

- Sat up _____
- Crawled _____
- Walked _____
- Spoke single words _____
- Sentences _____
- Bladder trained _____
- Bowel trained _____
- Weaned _____

Describe the manner in which toilet training was accomplished _____

EARLY SOCIAL DEVELOPMENT

Relationship to siblings and peers

- _____ Individual play
- _____ Group play
- _____ Competitive
- _____ Cooperative
- _____ Leadership role
- _____ A follower

Describe special habits, fears, or idiosyncrasies of the child _____

Educational History

	Name	City/State	Dates attended	Grade completed
Preschool	_____	_____	_____	_____
Elementary	_____	_____	_____	_____
Junior High	_____	_____	_____	_____
High School	_____	_____	_____	_____
Type of classes?	Regular _____	Learning Disability _____	Continuation _____	
	Emotionally Handicapped _____	Opportunity _____		
Did the child skip grades?	Yes _____	No _____	Which grade _____	
Did the child repeat a grade?	Yes _____	No _____	Which grade _____	
Does the child have specific learning disabilities?	_____			
Has the child ever had a tutor or other special help with school?	_____			
Does the child attend school on a regular basis?	Yes _____	No _____		
Does the child appear motivated for school?	Yes _____	No _____		
Has the child ever been suspended or expelled?	Yes _____	No _____		

RECREATIONAL:

How does your child spend his/her time?

What hobbies does your child enjoy?

How often does your child play:

By himself or herself? _____

With his/her friends? _____

With family? _____

What was the most fun your child has ever had?

When was your child happiest?

What type of physical activity is your child involved in?

What activities do you do with your child? _____

TREATMENT GOALS:

In looking at your child's current situation, in what areas would you like to see improvement? Please check all that apply and add more if needed.

- | | | |
|---|---|--|
| <input type="checkbox"/> Anger Control | <input type="checkbox"/> Stress Management | <input type="checkbox"/> Fair Fighting |
| <input type="checkbox"/> Communication Skills | <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Increasing Flexibility | <input type="checkbox"/> Assertiveness Skills | <input type="checkbox"/> Decision Making |
| <input type="checkbox"/> Socially Comfortable | <input type="checkbox"/> Financial Management | <input type="checkbox"/> Self Esteem |

Any additional treatment goals for your child:

ACADEMIC PERFORMANCE

Highest grade on last report card _____

Lowest grade on last report card _____

Favorite subject _____

Least favorite subject _____

Does child participate in extracurricular activities? Yes _____ No _____ Which ones _____

In school, how many friends does the child have? _____

What are the child's educational aspirations? _____

Has the child had special testing in school? Yes _____ No _____ Explain _____

List the child's special interests hobbies, skills

Has the child ever had difficulty with the police? Yes _____ No _____ When _____

Has the child ever appeared in juvenile court? Yes _____ No _____ When _____

Has the child ever been on probation? Yes _____ No _____ When and for how long _____

Has the child ever been employed? Yes _____ No _____ Where and for how long _____

CULTURAL CONSIDERATIONS

ADDITIONAL COMMENTS

Caregiver's Questionnaire

Date _____

Name of client _____ Age _____

Name of caregiver (filling out form) _____

Answer all of the questions by indicating the degree of the problem. Write "N" for Never, "S" for Sometimes, or "O" for Often in front of the number for each question.

Questions

- _____ 1. Picks at things (nails, fingers, hair, clothing)
- _____ 2. Talks back to authority figures (attitude)
- _____ 3. Has problems with making or keeping friends
- _____ 4. Excitable, impulsive
- _____ 5. Wants to run things
- _____ 6. Sucks or chews (thumbs, clothing, blankets, etc)
- _____ 7. Cries easily/often
- _____ 8. Emotionally reactive
- _____ 9. Has a chip on his/her shoulder
- _____ 10. Tendency to daydream
- _____ 11. Always squirming, restless, and moving around
- _____ 12. Difficulty learning
- _____ 13. Experiences fear and anxiety in new situations/meeting new people
- _____ 14. Breaks things/destructive
- _____ 15. Lies, makes up stories
- _____ 16. Does not follow the rules
- _____ 17. Gets into trouble more than peers
- _____ 18. Shy and does not assert self
- _____ 19. Has problems with speech (stuttering, hard to understand baby talk)
- _____ 20. Denies mistakes and is defensive
- _____ 21. Blames others for mistakes
- _____ 22. Steals
- _____ 23. Argumentative
- _____ 24. Disrespectful
- _____ 25. Pouts and sulks

- 26. Obeys rules but is resentful
- 27. When hurt or angered by someone, holds a grudge
- 28. Develops stomach-ache or head-ache when stressed
- 29. Worries unnecessarily
- 30. Does not finish tasks
- 31. Emotionally sensitive and easily hurt
- 32. Bullies others
- 33. Cruel and insensitive
- 34. Clingy and in need of constant reassurance
- 35. Easily distracted
- 36. Frequent head-aches or stomach-aches
- 37. Rapid mood changes
- 38. Fights a lot and creates conflicts
- 39. Power struggles with authority
- 40. Childish or immature and wants help when should be able to do it independently
- 41. Does not get along well with siblings
- 42. Easily frustrated
- 43. Perfectionism prevents trying new things
- 44. Problems with sleep
- 45. Problems with eating
- 46. Has bowel problems
- 47. Vomiting, nausea, or other complaints of pain or physical distress
- 48. Feeling he/she is treated differently in the family than siblings
- 49. Passive and gets pushed around
- 50. Self-centered, brags, little understanding of others

(For Teen to Complete, Independently and Confidentially)

The Mood Disorder Questionnaire

INSTRUCTIONS: Please answer each question as best you can.

YES N
 O

1. Has there ever been a period of time when you were not your usual self and...

... 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 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 much 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 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 into 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 able to work, having family, money or legal troubles, getting into arguments or fights?

_____ No problem _____ Minor problem _____ Moderate problem _____ Serious problem

4. Have any of your blood relatives (ie. Children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? _____

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? _____

(For Teen to Complete, Independently and Confidentially)

Anxiety Scale

Instructions: Indicate how much you have been bothered by each symptom during the past week, including today, by checking the column that most closely corresponds to how you've been feeling.

	Not at all	Mildly	Moderately	Severely
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of the worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding or racing	0	1	2	3
Unsteady	0	1	2	3
Terrified	0	1	2	3
Nervous	0	1	2	3
Feelings of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion or discomfort in abdomen	0	1	2	3
Faint	0	1	2	3
Face flushed	0	1	2	3
Sweating (not due to heat)	0	1	2	3

Total _____

(For Teen to Complete, Independently and Confidentially)

Depression Scale

Instructions: This questionnaire consists of seven groups of statements. Read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past 2 weeks, including today. Circle the number beside the statement you have picked. If several statements in one group seem to apply equally well, choose the statement with the highest number beside it.

Sadness	I do not feel sad	0
	I feel sad much of the time	1
	I am sad all the time	2
	I am so sad or unhappy that I can't stand it	3

Pessimism	I am not discouraged about my future	0
	I feel more discouraged about my future than I used to	1
	I do not expect things to work out for me	2
	I feel my future is hopeless and will only get worse	3

Past Failure	I do not feel like a failure	0
	I have failed more than I should have	1
	As I look back, I see a lot of failures	2
	I feel I am a total failure as a person	3

Self-Dislike	I feel the same about myself as ever	0
	I have lost confidence in myself	1
	I am disappointed in myself	2
	I dislike myself	3

Self-Criticism	I don't criticize or blame myself more than usual	0
	I am more critical of myself than I used to be	1
	I criticize myself for all of my faults	2
	I blame myself for everything bad that happens	3

Suicidal Thoughts	I don't have any thoughts of killing myself	0
	I have thoughts of killing myself, but I would not carry them out	1
	I would like to kill myself	2
	I would kill myself if I had the chance	3

Loss of Interest	I have not lost interest in other people or activities	0
	I am less interested in other people or things	1
	I have lost much of my interest in other people or things	2
	It's hard to get interested in anything	3

Total _____

(For Teen to Complete, Independently and Confidentially)

Self Esteem Inventory

Answer the questions below with True (T) or False (F)

1. I usually put my best foot forward _____
2. I rarely feel embarrassed _____
3. I feel I have above average intelligence _____
4. I am quite ambitious _____
5. I can be very active _____
6. I am tenacious in matters that count _____
7. I enjoy my own company _____
8. I have strong powers of concentration _____
9. I don't feel shy or ill-at-ease with new people _____
10. When situations beyond my control go wrong, I don't
blame myself _____
11. I enjoy being praised or complimented _____
12. I don't feel anxious when I have to address a group of
superiors _____
13. I have fantasies of doing something great _____
14. I don't feel humiliated or hurt if someone makes a joke
at my expense _____
15. I don't mind showing off my good points and getting
attention for it _____
16. In general, I have lots of energy _____
17. I enjoy taking calculated risks _____
18. I am psychologically "tough" _____
19. I have a great deal of self-confidence _____
20. I can remain cool in a crisis _____
21. I have considerable powers of discernment _____
22. I am quite self-sufficient _____
23. I feel I am a persuasive person _____
24. I feel I can hold my own in any group _____
25. I can give praise easily and with sincerity _____
26. I appreciate constructive criticism _____
27. I am accepted by most people I meet _____
28. I don't feel uncomfortable in a position of authority _____
29. I feel I have a strong personality _____
30. I react quickly and well to an unexpected situation _____

(Please have client fill out independently)

For Teens Age 12 and Older

Client Name _____

Sex _____ Age _____

Date _____

Complete these sentences to express your real feelings. Try to do every one.

1. I like _____

2. The happiest time _____

3. I want to know _____

4. Back home _____

5. I regret _____

6. At bedtime _____

7. Men _____

8. The best _____

9. What annoys me _____

10. People _____

11. A mother _____

12. I feel _____

13. My greatest fear _____

14. In school _____

15. I can't _____

16. Sports _____

17. When I was a child _____

18. My nerves _____

19. Other people _____

20. I suffer _____

21. I failed _____
22. Reading _____
23. My mind _____
24. The future _____
25. I need _____
26. Marriage _____
27. I am best when _____
28. Sometimes _____
29. What pains me _____
30. I hate _____
31. This place _____
32. I am very _____
33. The only trouble _____
34. I wish _____
35. My father _____
36. I secretly _____
37. I _____
38. Dancing _____
39. My greatest worry is _____
40. Most women _____