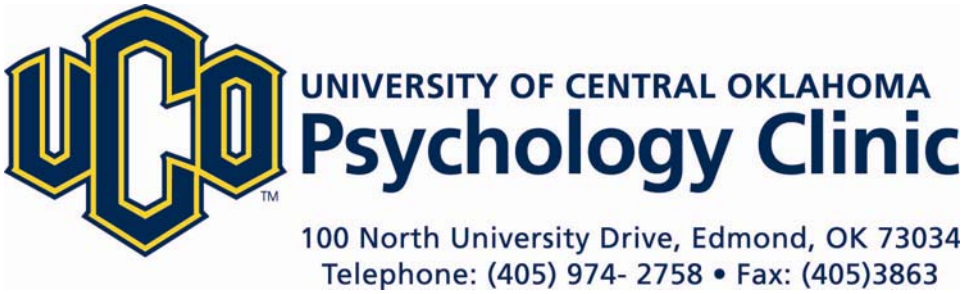

Folder Checklist

LEFT SIDE OF FOLDER:

_____ Counseling and Non-Counseling Contacts

_____ Informed Consent

_____ Notice of Privacy Practices

_____ Listing of Disclosures of Confidential Information

_____ Release/Obtain of Information Form

RIGHT SIDE OF FOLDER:

_____ Session Notes

_____ Initial Treatment Plan

_____ Intake Summary

_____ Confidential Intake Form

UNIVERSITY OF CENTRAL OKLAHOMA
Psychology Clinic
100 North University Drive, Edmond, OK 73034
Telephone: (405) 974- 2758 • Fax: (405)3863

COUNSELING AND NON-COUNSELING CONTACTS

Please keep an accurate, chronological record of contacts (other than counseling sessions) with the client on this form. For example, if the client misses an interview and you contact him/her by phone or letter, state that here. If you ask for or release information regarding a client, list that here, etc.

NOTE: Always date and CLEARLY print your name on the entry.

DATE	YOUR NAME	TIME CALLED	ACTION TAKEN

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Psychology Clinic
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AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

NAME:	DATE OF BIRTH:	DATE OF AUTHORIZATION:

Authorization is hereby voluntarily granted to the UCO Psychology Clinic by the below signee/guardian to exchange information with the following persons or organizations:

_____

Name of Persons or Organization

_____ _____ _____ _____ _____ _____

Street **City** **State** **Zip** **Telephone** **Fax**

INFORMATION TO BE RELEASED COVERS THE DATES OF: _____

METHOD FOR RELEASING: **(Check all that apply)** ☐ **Oral** ☐ **Written** ☐ **Fax (fax cover sheet required)** ☐ **E-mail**

_____

INFORMATION TYPE: **Please check all that apply**

☐ **Release** ☐ **Request** ☐ **Request/Release**
☐ **Psychological Testing/Assessments** ☐ **Summaries of Treatment**
☐ **Treatment/Service Plans** ☐ **Other (Please Specify):** _____

PUROSE OF INFORMATION:

☐ **Treatment/Service Coordination** ☐ **Evaluation** ☐ **Treatment/Service Planning**
☐ **Other (Please Specify):** _____

I understand that this authorization is subject to revocation at any time, except to the extent that the UCO Psychology Clinic has already taken action on its authorization. If not revoked earlier by written notice to the UCO Psychology Clinic, this authorization shall expire as follows:

☐ One year from date of authorizing signature.
☐ Upon reaching: (Specify date, event, or condition on which this consent for expires)

_____

Once the requested information is disclosed pursuant to this authorized consent form, UCO Psychology Clinic will no longer have control over the information, and there is a potential that it may be re-disclosed by the recipient and no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____ _____ _____

Student/Authorized Signature Date Clinician/Witness Signature Date

_____ _____

Parent/Guardian Signature (if needed) Date

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Listing of Disclosures of Confidential Information

_____ There were no applicable disclosures made of your protected health information for the period you specified.

_____ Disclosures of your protected health information were made by this office to:

Date of Disclosure	Person to Whom Client Information was Discussed	Agency and Address	Description of Information Disclosed	Purpose of Information Disclosed

We are temporarily unable to process the accounting for disclosures you have requested due to:

_____ A suspension required by law.

_____ Other, specify: _____

However, your request will be provided by _____
(Month/Day/Year)

If you have any questions concerning this accounting for disclosures, please contact:

_____ at 405/974-5707.
Printed Name of Counselor

_____ Date: _____
Counselor's Signature

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Psychology Clinic
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information
We, University of Central Oklahoma Psychology Clinic (UCO), are committed to protecting the privacy of patient personal and health information. Applicable Federal and State laws require us to maintain the privacy of our patients' personal and health information. This Notice explains our clinic's privacy practices, our legal duties, and your rights concerning your personal and health information. In this Notice, your personal health information (PHI) is referred to as "health information" and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income, or other financial information. We will follow the privacy practices described in this Notice while it is in effect. This Notice takes effect May 1, 2005 and will remain in effect until replaced.

How We Protect Your Health Information
We protect your health information by

- Treating all of your health information that we collect as confidential.
- Stating confidentiality policies and practices in our UCO staff handbooks, as well as disciplinary measures for privacy violations.
- Restricting access to your health information only to those UCO staff that need to know your health information in order to provide our services to you.
- Only disclosing your health information that is necessary for an outside service company to perform its function on the clinic's behalf; such companies have, by contract, agreed to protect and maintain the confidentiality of your health information.
- Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

Uses and Disclosures for Treatment, Payment, and Health Care Operations
UCO may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes, *as long as you consent to receive evaluation or treatment services from the clinic.* To help clarify these terms, here are some definitions.

"Treatment, Payment, and Health Care Operations"

- *Treatment* occurs when a Psychological Associate provides, coordinates, or manages your health care and other services related to your health care. An example of treatment: a Psychological Associate consults with another health care provider, such as your family physician.
- *Payment* occurs when a Psychological Associate obtains reimbursement for your healthcare.
- *Health Care Operations* activities relate to the performance and operation of the UCO. Examples of health care operations: quality assessment and improvement activities, business-related matters, such as audits and administrative services, case management and care coordination, conducting training and educational programs, or accreditation activities.

- *"Use"* applies only to activities within UCO, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside UCO, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization
UCO may use or disclose PHI for purposes outside treatment, payment, or healthcare operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when UCO is asked for information for purposes outside treatment, payment or healthcare operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization (1) to the extent that UCO has relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy

Uses and Disclosures with Neither Consent nor Authorization
The UCO may use or disclose PHI without your consent or authorization in the following circumstances.

- *Abuse* – If we have reason to believe that a minor child, elderly person or disabled person may have been abused, abandoned, or neglected, the UCO must report this concern or observations related to these conditions or circumstances to the appropriate authorities.
- *Health Oversight Activities* – If the Board of Examiners in Psychology, Council on Accreditation, or other oversight body, is investigating a Psychological Associate or UCO as part of a formal complaint you have filed, UCO may be required to disclose PHI regarding your case.
- *Judicial and Administrative Proceedings as Required* – If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof; we may be compelled to provide the information. Although courts have recognized a therapist-patient privilege, there may be circumstances in which a court would order UCO to disclose personal health or treatment information. UCO will not release information without your written authorization, or that of your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party (e.g., law enforcement agency, Social Security Administration) or when the evaluation is court ordered.
- *Serious Threat to Health or Safety* – If you communicate to UCO personnel an explicit threat of imminent serious physical harm or death to identifiable victim(s), and we believe you may act on the threat, we have a legal duty to take the appropriate measures to prevent harm to that person(s), including disclosing information to the police and warning the victim. If we have reason to believe that you present a serious risk of physical harm or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.
- *Worker's Compensation* – The UCO may disclose PHI regarding you as authorized by, and to the extent necessary, to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- *National Security* – We may be required to disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may be required to disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may be required to disclose health information to a correctional institution or law enforcement official having lawful custody of PHI of an inmate or patient under certain circumstances.
- *Research* – Under certain limited circumstances, we may use and disclose health information for research purposes. All research projects, however, are subject to scrutiny and approval by an institutional review board.

Patient's Rights and Clinician's Duties

Patient's Rights

- *Rights to Request Restrictions* – You have the right to request additional restrictions on certain uses and disclosures of PHI. UCO may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are being seen at UCO. On your request, UCO will send your bills to another address.
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of your clinic health records. A reasonable fee may be charged for copying or, if necessary, redacting the record(s). Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request, in writing, an amendment of your health information as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
- *Right to an Accounting* –You generally have the right to receive an accounting of disclosures of PHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
- *Electronic vs. Paper Copy* – If you received this notice electronically (e.g., accessing a website), you have the right to obtain a paper copy of the notice from the UCO upon request.

UCO Duties

UCO, and all associated persons, are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices. UCO reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, the UCO is required to abide by the terms currently in effect.

Other Restrictions

UCO must also conform to Federal regulations (42 CFR, Part 2) regarding the release of alcohol/drug treatment records and confidentiality standards related to such treatment.

Changes to this Notice

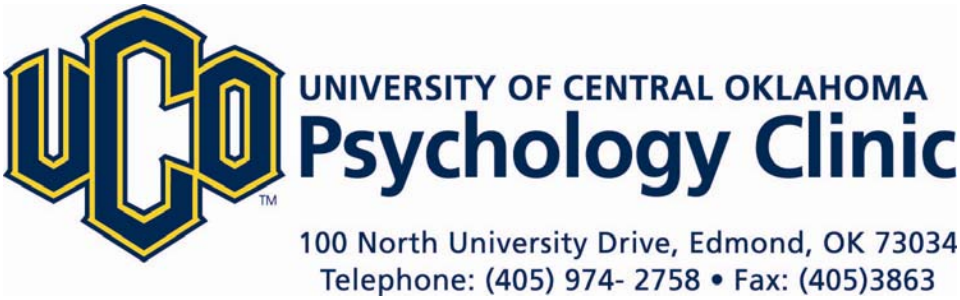
UCO reserves the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility. You may request a copy of the Notice at any time.

Questions and Complaints

For questions regarding this Notice or our privacy practices, please contact the UCO Director. If you are concerned that your privacy rights may have been violated, you may contact Caleb W. Lack, Ph.D. to make a complaint. You may also make a written complaint to the U.S. Department of Health and Human Services.

If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.

Department of Health and Human Services
Office for Civil Rights
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX
Toll free: 1-800-368-1019
http://www.hhs.gov/ocr/hipaa/



CLIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign this Acknowledgement)

I, _____, have received a copy of the Notice of Privacy Practices.

_____
Name (Print)

_____
Signature

_____
Date

For Office Use Only

University of Central Oklahoma Psychology Clinic has made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

_____ Patient/ Individual refused acknowledgement; Date of refusal: _____

_____ Communication barriers prohibited obtaining an acknowledgement

_____ Emergency situation prevented obtaining an acknowledgement

_____ Other _____

Attempt was made by: _____ Date: _____

Explanation: _____

Psychological Associate: or Clinician	_____ Name	_____ Signature
Supervisor: (if needed)	_____ Name	_____ Signature

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SERVICES CONSENT FORM

Client name: _____ Date: __ / __ / ____

I hereby voluntarily consent to utilize the services provided by University of Central Oklahoma Psychology Clinic (hereafter referred to as UCO). Possible services include: individual, group, marital, or family therapy, assessment and/or consultation. As a client utilizing the services of UCO, I understand that I have a right to ask any questions I may have about the process, methods, duration, and goals of my treatment and/or assessment; the right to discuss any concerns I may have about my progress in services provided; and the right to terminate services if I feel I am not making progress.

I have read and hereby certify that I understand the following:

UCO operates as both an independent facility and a training and research facility for the Master's program at UCO. This program requires supervision of all services provided by psychological associates. Supervision is provided by a licensed clinical psychology and faculty of the Psychology program.

There is a possibility that the clinician, psychological associate, and/or supervising faculty may change during the course of services.

For training or research purposes, services may be audio or video taped, and/or observed by supervisors or other psychological associates of UCO. All such individuals are bound by confidentiality.

Tapes, tests, and other information obtained during contacts with the clinic may be used for research and/or training purposes. I give consent for my individual data to be presented anonymously at professional meetings and/or published in a scientific journal.

I understand that one of my rights involves confidentiality. Within certain limits, information revealed by me will be kept strictly confidential, and will not be revealed to any other person or agency without my written permission. If I give my written permission to release information to my health insurance company, employee assistance program, or other health benefits program, I understand that clinicians or psychological associates may disclose the nature of services, the diagnosis, the dates of services, the fees charged, and other relevant information specifically requested by other mental health professionals and/or clinics.

I understand that a new federal law, HIPAA, provides new privacy protections for medical records and new patient rights with regard to the use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that the clinic provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that the clinic has provided you with this information.

I understand that there are certain limits to confidentiality, in which it is required by law and/or professional ethics that a clinician or psychological associate reveal information to other persons or agencies, without my permission. These limits to confidentiality are as follows:

A. If I threaten grave bodily harm or death to a reasonably identified person, the clinician or psychological associate is required (1) to inform appropriate legal authorities and the intended victims; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

B. If I express a serious intent to grievously harm myself, it may be necessary for the clinician or psychological associate (1) to reveal information to family members and/or persons authorized to respond to such emergencies, in order to protect me from harm; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

C. If a court of law issues a legitimate court order, the clinician or psychological associate may be required to provide information that is specifically described in the court order.

D. If I am being evaluated or treated by order of a court of law, the results of the evaluation or treatment ordered may be revealed to the court.

E. If the clinician or psychological associate has good reason to suspect that a child, elderly person, or disabled person is a victim of physical abuse, sexual abuse, or neglect, he/she is required to report the abuse or neglect to the Department of Human Services and/or law enforcement authorities.

F. If I use psychological treatment and/or records on my behalf in a legal proceeding, the records must be made available to both parties by written consent.

G. UCO is required to provide information requested by a legal guardian of a minor child, including a non-custodial parent who has maintained parental status.

H. If a government agency is requesting information for health oversight activities or to prevent terrorism (Patriot Act), UCO may be required to provide it.

I. If I file a worker's compensation case, UCO may be required, upon appropriate written request, to provide all clinical information relevant to or bearing upon the injury for which the claim was filed.

J. If I file a complaint or lawsuit against UCO or the professional staff, UCO may disclose relevant information regarding myself in order to defend itself.

If any of these situations were to arise, UCO would make every effort to fully discuss it with me before taking action, and would limit disclosure to what is necessary.

I understand these limitations to confidentiality as outlined above.

I also understand that the fee for psychological services is $_____. I must give twenty-four hours notice if I wish to cancel an appointment. For therapy services, the full session fee will be charged if less than 24 hours notice is provided. Information and assistance regarding scheduling of appointments and payment for fees for psychological services are provided by the UCO Director.

I am expected to pay for services at the time they are provided, unless other arrangements have been made in advance. For assessment services, half of the fee is due at the first appointment; with the balance due before the report will be written.

I have been given a copy of this consent form for my personal records.

I understand and agree that my responsibilities as a client include the following:

1. Keep regular appointments and actively participate in treatment.

2. Attempt any therapeutic assignments I have agreed to perform.

3. Disclose to my clinician or psychological associate whenever I feel in crisis and/or suicidal, to work with them to come up with a crisis plan, and to give UCO discretion regarding needed disclosures in a crisis situation both while waiting to obtain services, and while in treatment.

4. Not to come to the clinic under the influence of alcohol or other drugs. If I were to appear intoxicated, I agree to refrain from driving. Failure to do so would require UCO to make a DUI report.

5. Never bring a weapon of any sort to UCO.

6. Ask the clinician or psychological associate questions right away if I am uncertain about any aspect of my services or UCO policies.

7. Pay the agreed upon fees as scheduled.

Client *or* Parent/Legal Guardian (if under 18) _____
Signature

Psychological Associate: or Clinician _____
Signature

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DEMOGRAPHIC FORM

(To be completed by each person receiving therapy, assessment, or consultation services through UCO)

Date of Intake: ____ / ____ / _____

Name of person completing form: _____ _____ ___
Last Name First Name MI

Name of client: _____ _____ ___
(if different from above) Last Name First Name MI

Birth Date: _____ / _____ / ____ Age: _____ Gender (circle one): Male Female
Month Day Year

Mailing Address: _____ _____ ___ ____
Street City State Zip

Telephone: _____ _____ _____
Home Cell Work

May we leave a message stating that we are calling from UCO? (circle one): YES NO

Years of Education: _____ Highest Degree Completed: _____

Marital Status: _____ Years Married: _____ Number of previous marriages: _____

Ethnicity: Caucasian _____ African American _____ Native American _____

Asian _____ Pacific Islander _____ Multiracial _____

Other (please complete) _____

Height (in.): _____ Weight (in lbs.): _____

Client Occupation: _____ _____ _____ _____
Title Company Name City State

Spouse Occupation: _____ _____ _____ _____
Title Company Name City State

Client Annual Income: $ _____ Spouse Annual Income: $ _____

Total Combined Income for Past Year (include financial aid, SSDI, etc.): $_____

Person responsible for payment of services (if not you):

_____ _____
Name Relation to you

_____ _____ ___ _____
Address City State Zip

_____ _____
Home Phone number Cell Phone number

Emergency Contact: _____ _____
Name Relationship to you

_____ _____ ____ _____
Address City State Zip

_____ _____
Home Phone number Cell / Work Phone number

Please list the names, age, gender, and relationship of all individuals living at your current residence.

Name	Age	Gender	Relationship

Please list all the individuals who you think will be involved in therapy.

Name	Age	Gender	Relationship

Please list all living members of your family of origin (parents, brothers, sisters, step-siblings, etc.)

Name	Age	Gender	Relation

Physician / : _____
Clinic Name

_____ _____ ____ _____
Address City State Zip

_____
Office Phone Number

List all prescription and non-prescription medications/drugs taken within the last 6 months.

Name of Med.	Quantity/Frequency	Reasons Taken	Start Date to Finish Date

Are you currently receiving services from another therapist/counselor? (circle one) YES NO

If yes, name of counselor and clinic name: _____ _____
Name Clinic

Have you ever been treated by another therapist/counselor? (circle one) YES NO

If yes, who and when? _____ _____
Therapist/Counselor Name Dates seen

Why did you seek services then?
_____

Who referred you to UCO? If self-referred, how did you find out about our services?
_____

Briefly describe the major reasons for seeking our services at this time.
_____
_____
_____

How would you rate the present state of your physical health? (circle one number)
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

How would you rate the present state of your emotional health? (circle one number)
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

How serious would you say this problem is right now? (circle one number)
Not at all 1 2 3 4 5 6 7 8 9 10 Very

How likely do you think the problem is to change? (circle one number)
Not at all 1 2 3 4 5 6 7 8 9 10 Very

How stressful has your life been in the past six months? (circle one number)

Not at all 1 2 3 4 5 6 7 8 9 10 Very

Is there any other information you would like us to be aware of at this time? If so, please write it below.

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Client name: _____ DOB: __ / __ / ____
Client ID: _____ Date: __ / __ / ____

Summary of presenting problem:

_____
_____
_____
_____
_____
_____

Diagnosis:

Axis I ____.__ _____
____.__ _____
____.__ _____
____.__ _____
Axis II ____.__ _____
____.__ _____
_____
Axis III _____
_____
Axis IV _____
_____
Axis V GAF = _____

Services recommended:

☐ Therapy _____

☐ Diagnostic assessment _____

☐ Referral _____

Psychological Associate: _____ _____
or Clinician Name Signature

Supervisor: _____ _____
(if needed) Name Signature

"Before we go further today, I want to ask you about some common problems that people who seek our services might have. Afterwards, I'll ask you about what specifically brings you into the clinic today. Do you have any questions?"

Previous Diagnoses

___ 1. Have you ever been previously diagnosed with an emotional or behavioral problem?

What? _____

When? _____

By who? _____

___ 2. Have you ever sought psychological services or counseling in the past?

When? _____

By who? _____

Adjustment Problems

___ 1. Have you experienced any significant stressors within the last six months?

Please describe _____

_____

___ 2. Do you think your behavior has significantly changed over the last six months?

(if yes) How so? _____

_____

Mood Disorders

A. Depressive Episode

___ 1. In the last month has there been a period of time when you felt depressed or irritable most of the day nearly every day?

___ 2. What about being a lot less interested in most things you used to enjoy?

Have you had any of the following symptoms during the last month?

___ Weight change

___ Worthlessness / guilt

___ Energy loss

___ Suicidal ideation

___ Psychomotor agitation / retardation

___ Hypersomnia / Insomnia

___ Concentration difficulties

___ Thinking about death

B. Manic Episode

___ 1. In the last month, has there been a period of time when you were feeling so good or hyper that other people thought you were not your normal self?

___ 2. What about a time when you were so irritable that you shouted started arguments?

Have you had any of the following symptoms during the last month?

___ Grandiosity ___ Need for little to no sleep

___ Racing thoughts ___ Starting lots of different projects

___ Distractibility ___ Reckless behavior

Anxiety Disorders

A. General Anxiety Disorder

___ 1. In the last six months have you been particularly anxious or nervous?

___ 2. Do you worry a lot about things that may happen?

Have you had any of the following symptoms during the last month?

___ Restlessness ___ Concentration difficulties

___ Fatigue ___ Sleep disturbances

___ Muscle tension ___ Irritability

B. Specific Phobia

___ 1. Is there any specific thing that you are especially afraid of, such as heights, blood, enclosed spaces, or certain animals or insects?

___ 2. Does this fear interfere with your life in any way?

What are you very afraid of?

_____

C. Obsessive-compulsive Disorder

___ 1. Do you ever have thoughts that you cannot get out of your mind, such as being contaminated by germs or fears?

___ 2. Do you ever do something over and over again, such as washing your hands or checking something several times to make sure you did it right?

Please describe these thoughts or behaviors.

_____

_____

_____

_____

D. Panic Disorder

___ 1. Have you ever had a panic attack when you suddenly felt frightened, anxious, or you were going to die?

(if yes) How many times? _____

___ 2. Were any of these attacks "out of the blue"?

How long did the attack last? _____

During the attack did you experience any of the following?

___ Pounding heart
___ Trembling / chills
___ Feeling of choking
___ Dizziness
___ Sweating
___ Shortness of breath / difficulty breathing
___ Chest pain
___ Nausea / abdominal pain

E. Posttraumatic Stress Disorder

___ 1. Have you ever experienced or witnessed an event that involved actual or threatened death or injury to yourself or others?

(if yes) What event? _____

(if yes) When? _____

___ 2. Did your response involve intense fear, helplessness, or horror?

___ 3. Have you had any of these symptoms since the event?

___ Recurrent recollections/ distressing dreams
___ Acting/ feeling like event is recurring
___ Intense distress or reactivity to cues
___ Avoidance of trauma related thoughts, feelings, people, places
___ Inability to recall aspects of trauma
___ Diminished interest in activities
___ Withdrawal / seeming detached
___ Restricted range of affect
___ Increased arousal (e.g., sleep difficulties, irritability, difficulty concentrating, hypervigilance, exaggerated startle response)

Developmental History

___ 1. Were there any perinatal issues during your birth such as low birth weight or other complications?

(if yes) What? _____

___ 2. Did you meet the physical/ social milestones that would indicate a normal development such as talking and walking?

___ 3. Did you suffer from any childhood illness or physical injuries that you would deem abnormal or out of the ordinary?

(if yes) What? _____

Social History

___ 1. Have you ever been married before?

(if so) How many times? _____

___ 2. Are you currently married at this time?

(if so) How long? _____

3. Would you describe your relationships with your family members as:

____ Great

____ Good

____ Fair

____ Poor

___ 4. Are there any family members that you have a particularly poor/ great relationship with?

(if so, please indicate poor/ great) Who? _____

5. How would you describe your social life?

____ Great

____ Good

____ Fair

____Poor

Why? _____

Medical History

___ 1. Do you suffer from any chronic physical illness?

(if so) What?_____

___ 2. Have you ever experienced any serious physical accidents?

(if so) What?_____

(if so) When? _____

___ 3. In the past, have you suffered from any major illnesses?

(if so) What?_____

Attention-deficit / Hyperactivity Disorder

___ 1. Do you demonstrate any of these symptoms more than people around you?

__ Careless errors in work

__ Difficulty sustaining attention to tasks

__ Failing to listen when spoken to directly

__ Failing to follow through on instructions

__ Avoiding tasks that require concentration

__ Often losing things

__ Forgetfulness in daily activities

__ Being distracted by outside stimuli

__ Difficulty organizing tasks

___ 2. __ Feeling like you need to stand up or move

__ Restlessness / fidgeting / squirming

__ Talking excessively

___ Blurting out answers before questions are finished

__ Often interrupting others

__ Often feeling "on the go"

___ 3. Where do you demonstrate the above behaviors?

___ Home ___ School / Work

___ With friends ___ In the community

Substance Use

___ 1. Do you consume alcohol?

___ How many times per week? ___ How many drinks per time?

___ 2. Have you taken any of the following drugs within the last 12 months?

___ Sedatives / Hypnotics / Anxiolytics (e.g., Quaalude, Valium, Xanax) _____

_____

___ Cannabis (i.e., marijuana) _____

___ Stimulants (e.g., amphetamine, crystal meth) _____

___ Opioids (e.g., heroin, morphine, opium, darvon) _____

___ Cocaine (e.g., snorting, IV, freebase, crack) _____

___ Hallucinogens (e.g., LSD, PCP, mescaline) _____

___ Other (e.g., steroids, Ecstasy, huffing) _____

___ 3. Have you ever tried to cut down or stop drinking or taking drugs?

___ 4. Have you ever been so drunk or high that you could not remember something important that happened?

___ 5. Have you ever found that when you started drinking you ended up drinking much more than intended?

___ 6. Do you spend a lot of time drinking, being high, or hung over?

___ 7. Have you ever drunk or used drugs in a situation in which it might have been dangerous (e.g., drunken driving)?

___ 8. Have you ever drunk so often that you started to drink instead of working or spending time at hobbies or with friends/family?

Academic History

___ 1. How far did you get in school? What were your grades?

_____

___ 2. Were you in any special classes?

(if yes) Which one(s) and why? _____

___ 3. Did you ever repeat a grade?

(if yes) Which one and why? _____

___ 4. In which classes did you excel? Struggle?

_____

_____

Work History

___ 1. Are you currently employed?

(if yes) Where? _____

___ 2. Is this job typical of the work you generally do?

(if no) What do you usually do? _____

___ 3. What was the reason you left your last job?

_____

Risk Management (if any of the below are endorsed, complete Suicidality Interview)

___ 1. Do you feel as though you are at risk of harming yourself?

(if yes) Why and how? _____

_____

___ 2. Have you ever attempted to harm yourself in the past?

(if yes) When and how? _____

_____

___ 3. Do you feel as though you are at risk of harming other people?

(if yes) Why and how?_____

_____

___ 4. Have you ever attempted to harm other people in the past?

(if yes) Why and how? _____

_____

Strengths

___ 1. What would you describe as your special talents or strengths?

_____

_____

___ 2. (if applicable) What are your family's greatest strengths or assets when confronting a problem?

_____

_____

___ 3. Who do you turn to or what actions do you take when things become difficult?

_____

_____

"I'm now going to ask you about some areas of daily functioning. Please tell me if you have had any problems in these areas over the last six months."

Assessment of Functioning in Life Domains (Describe strengths and needs in each area.)

Sleep	□ Adequate	□ Decreased	□ Increased	□ Other
Describe _____				
Food / appetite	□ Adequate	□ Decreased	□ Increased	□ Other
Describe _____				
Employment / school	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Finances / income	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Legal issues	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Housing	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Other ADLs	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Cultural / spiritual	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Personal safety	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Transportation	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Social life / family	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Self-care	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				
Medical needs	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Medications	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Dental care	□ No issues	□ Needs	□ Impaired by MH	□ N/A for client
Describe _____				

"Now, I would like you to describe for me what has caused you to seek services at this time. In your own words, what is the problem? Why now?"

Mental Status Examination (Complete immediately after intake interview.)

Appearance	Thought Processes	Orientation
☐ Age / culture appropriate ☐ Meticulous ☐ Unkempt ☐ Inappropriate ☐ Eccentric ☐ Age / size congruent ☐ Slumped ☐ Relaxed ☐ Rigid / tense ☐ Other _____ Comments _____ _____	☐ Age / culture appropriate ☐ Circumstantial ☐ Concrete ☐ Tangential ☐ Aggressive ☐ Obsessive ☐ Phobias ☐ Blocking ☐ Paranoid ideation ☐ Delusions ☐ Other _____ Comments _____ _____	☐ Age / culture appropriate ☐ Disoriented to ☐ Time ☐ Place ☐ Date ☐ Situation Comments _____ _____
Mood / Affect	**Cognitive Functioning**	**Motor Activity**
☐ Age / culture appropriate ☐ Flat / blunted ☐ Labile ☐ Incongruent ☐ Depressed ☐ Expansive ☐ Anxious / fearful ☐ Angry ☐ Other _____ Comments _____ _____	Remote memory ☐ Present ☐ Limited Recent memory ☐ Present ☐ Limited ability to abstract ☐ Present ☐ Limited Comments _____ _____	☐ Age / culture appropriate ☐ Agitated ☐ Hyperactive ☐ Lack of movement ☐ Tremors ☐ Tics ☐ Mannerisms ☐ Facial grimacing Comments _____ _____

Perceptual Processes	Behavior	Speech
☐ Age / culture appropriate	☐ Age / culture appropriate	☐ Age / culture appropriate
☐ Imagination	☐ Poor eye contact	☐ Slow
☐ Depersonalization	☐ Attends to task	☐ Rapid
☐ Other _____	☐ Distractible	☐ Soft
Hallucinations (specify)	☐ Cooperative	☐ Loud
☐ Auditory	☐ Friendly	☐ Mute
☐ Visual	☐ Withdrawn / passive	☐ Profuse
☐ Tactile	☐ Suspicious	☐ Pressured
☐ Olfactory	☐ Guarded	☐ Age intelligible
☐ Somatic	☐ Ingratiating	☐ Unintelligible
	☐ Hostile	☐ Slurred
Insight / Judgment	☐ Bizarre	☐ Mumbled
☐ Age / culture appropriate		☐ Clear
☐ Understands consequences	Verbally	☐ Whiny
☐ Denial / resistance	☐ Interacts	☐ Blocked
☐ Blames others	☐ Initiates	☐ Preservations
☐ Aware of problem	☐ Interrupts	☐ Stuttering
☐ Poor impulse control	☐ Redirects	☐ Impaired by medical condition
☐ Discerns right from wrong		
Comments _____	Comments _____	Comments _____
_____	_____	_____

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SUICIDALITY INTERVIEW

Client name: _____ DOB: __ / __ / ____

Therapist: _____ Date: __ / __ / ____

Review confidentiality and limits of confidentiality. Be sure you have obtained informed consent.

Important Note: If, during the course of this interview, the client endorses recent (within the past three to six months) or current suicidal intentions or attempt(s), and has either a plan or the means necessary to carry out an attempt, you should initiate a suicide contract **and** contact your supervisor for consultation **before allowing the client to leave the clinic.**

History of suicidal behavior

___ 1. Have you ever attempted to injure or kill yourself in the past?
(if yes) When and how? _____

_____

___ 2. Were you hospitalized? When, where and for how long? _____

_____

___3. How have you been doing since your last attempt? (e.g., medications, therapy, support)

_____

_____

___4. What led to your previous suicidal ideation or attempt? (e.g., depression, pain, to hurt someone else, while on drugs, during a manic episode)

_____

_____

___5. (Assess for current and past levels of depression, administer a BDI-II if currently endorsed)

On a scale of 1 to 10, with "1" meaning "not at all" and "10" meaning "the worst depression you can imagine", please rate

___ Your depression today.
___ The highest your depression has been in the last 3 months.
___ The highest your depression was at its worst.
___ When at its worst, did you have any thoughts of hurting or killing yourself?
___ How high was it when you attempted to kill or injure yourself in the past?

Current suicide behavior

"You told me earlier you had considered harming yourself recently."

___ 1. (Ideation frequency) How often do you have these thoughts? When was the last time?

___ 2. (Method) Have you thought about how you would do it? What method would you use?

___ 3. (Availability) Do you have access to _____? Where is it?

___ 4. (Place) Have you thought about where you would go to do this?

___ 5. (Protective factors) What has kept you from hurting yourself? What are the reasons you have not done so? Have you ever acted out any part of the plan? How did you decide not to follow through?

Assessing the suicidal crisis

___ 1. (Triggers) What events in your life have led you to want to hurt yourself? Why has this become a problem now?

___ 2. (Functioning) Have you been able to go to school/ work/ social activities? Do you think your ability to take care of yourself or others has changed? (make note of personal hygiene)

___ 3. (Sleep) Have you had any sleep problems, such as difficulty in falling asleep, repeated awakenings, or early morning awakenings?

___ 4. (Eating) Have your eating habits changed recently? Have you lost or gained weight recently?

___ 5. (Somatic symptoms) Have you been experiencing any physical illness or problems lately?

___ 6. (Coping) How have you tried to cope with these problems so far? What has been effective in helping you feel better? What has not helped?

___ 7. (Intention) "On a ten point scale, with "1" meaning "no intention at all" and "10" meaning "I plan to kill myself as soon as I can", how likely do you feel it is that you will harm yourself before our next session?

_____

___ 8. (Support system) Who is currently available to help you out? Friends? Family? Get permission to call or contact them, now or in the future.

Name:	Relationship:	Phone Number:
_____	_____	____ - ____ - _____
_____	_____	____ - ____ - _____
_____	_____	____ - ____ - _____

If there is recent or current suicidal ideation or intent, let the client know you are concerned about them. Inform them that you want to consult with your supervisor to make sure you have assessed the situation appropriately. Ask them to wait and get assurance that they will do so.

Notes and Disposition of Case:

Psychological Associate: or Clinician _____ Name _____ Signature

Supervisor: (if needed) _____ Name _____ Signature

Considerations in Determining the Urgency of the Situation

Specificity

- How specific is the suicide plan? In general, the more specific, concrete, and well-thought out the plan, the greater the risk.

Lethality

- How lethal is the suicide plan? Does the plan include a high-lethality method which is readily available and a secluded location? The greater the overall lethality, the greater the risk. The rough outline of the RELATIVE lethality of various methods is as follows:

  High Lethality - Shooting, Hanging
  Moderate to High Lethality - Drugs, Toxins, Gasses
  Low Lethality - Slashing wrists

High-Risk Factors

- The following list contains factors which, if present, increase the risk of suicide. The greater the number of factors present, the greater the risk.
  1. Previous suicide attempts
  2. Alcohol or substance use/abuse
  3. Isolation or withdrawal from others
  4. Cognitive disruption -- confusion, disorientation
  5. Hostility directed toward self or external objects
  6. Open expression of a wish for death
  7. Depression co-occurring with any of the following:
     - Recent lessening of profound depression
     - Excessive guilt
     - Feelings of worthlessness and loss of hope
     - Anxiety and psychomotor agitation
     - Recent significant weight loss
     - Sleep disturbances
     - Eating disturbance

SAD PERSONS Scale

- **S**ex — 1 if patient is male, 0 if female
- **A**ge — 1 if patient is (25-34; 35-44; 65+)
- **D**epression — 1 if currently or in recent past
- **P**revious attempt — 1 if present
- **E**thanol abuse — 1 if present
- **R**ational thinking loss — 1 if patient is psychotic for any reason
- **S**ocial support lacking — 1 if this is lacking, especially with recent loss of a significant other
- **O**rganized Plan — 1 if plan made and method lethal
- **N**o spouse — 1 if divorced, widowed, separated, or single (for males)
- **S**ickness — 1 *especially* if chronic, debilitating, severe

Total score: ___ / 10

0-2 equals little risk, 3-4 equals follow patient closely, 5-6 equals strongly considering hospitalization, and 7-10 equals a very high risk, hospitalize or commit.