Tandra T, Baker, Tapestry of Wellness, LLC
LPC-MH, LAC, QMHP & Linehan Board Certified DBT Clinician

PATIENT REGISTRATION SHEET

Today's Date:	Please Print	

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address:	City:	State:	ZIP Code:	
Home phone #: ( )	Cell/Other contact #: ( )	Social Security #:	Birth Date: / /	Sex: ❑ M ❑ F
Email:				
Employer:	Occupation:	Work phone #: ( )		
Street Address:	City:	State:	ZIP Code:	
Referring Doctor (if required by insurance):				
Notify Primary Care Physician? ❑ YES ❑ NO	Name of Primary Care Physician	Contact #: ( )		

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone #: ( )	Cell phone #: ( )

INSURANCE INFORMATION

Insured's Last Name **(if different):**	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone #: **(if different)** ( )	Cell/Other contact #: ( )	Social Security #:	Birth Date: / /	Sex: ❑ M ❑ F
Insurance Company:	Insurance Billing Address:		Insurance phone #: ( )	
Policy #:	Group #:	Relationship to Insured:	❑ Self ❑ Spouse ❑ Dependent	

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company:	Insurance Billing Address:		Insurance phone #: ( )	
Policy #:	Group #:	Relationship to Insured:	❑ Self ❑ Spouse ❑ Dependent	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. *I understand that I am financially responsible for any balance.* I also authorize Tandra T. Baker, Tapestry of Wellness, LLC & those acting on her behalf, and my insurance company to release any information required to process my claims.

Right to Refuse Treatment: I understand that I have the right to refuse any treatment.
Confidentiality: I understand that all information concerning me is held in confidence and can only be released with my written permission, with the following exceptions: my therapist is legally required to report to designated authorities when it is believed someone is a danger to themselves or others, including child/elder abuse/neglect, or as required by federal or state law. Your therapist may be involved in case consultation within DBT Teams and Midwest Health Management Services as needed.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

Patient/Guardian signature *Date*

*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations.***
*** Otherwise, your account will be charged the full fee for the session time. Thank you for your cooperation. ***

Tandra T. Baker, Tapestry of Wellness, LLC
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5708 S. Remington Place, Suite 400
Sioux Falls, SD 57108
Tel: 605-530-2968

Intake Information

Client Name: _____ **Date:** _____

Check which of the following you have had in the past 6 months:

- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Depressed Mood
- ☐ Suicidal thoughts
- ☐ Suicide attempt
- ☐ Fear
- ☐ Decreased Sleep
- ☐ Increased Sleep
- ☐ Relationship concerns
- ☐ Anger
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Increased alcohol consumption
- ☐ Racing thoughts
- ☐ Delusions
- ☐ Hallucinations
- ☐ Hopelessness
- ☐ Increased energy
- ☐ Trauma
- ☐ Loss
- ☐ Inability to focus
- ☐ Medical concerns
- ☐ Self-harming
- ☐ Tearfulness
- ☐ Legal problems
- ☐ Other _____

Briefly describe why you are seeking help at this time?

_____

_____

_____

Have you had any previous counseling? Y ____ N _____
If yes, who? _____
Name **Phone Number**

May we contact them? Y _____ N _____ (additional Release of Information needed to contact)

Describe any current or recurrent health problems you or your family may have?

_____

_____

List all medications in use (name, dosage, frequency, who prescribes them):

_____

_____

Any other information you would like the therapist to know:

_____

_____

_____

What is your general goal for counseling?

_____

_____

_____

Who referred you? _____

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Financial Policy

Thank you for choosing me your health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. If you are uncertain of the cost for a specific service, you are encouraged to inquire about this. Please know that it is your responsibility to contact your insurance company and to know the benefits that you have under your policy.

Fees:

Payment /Co-pay is due at The Time of Service.

- **With Health Insurance**
  - Diagnostic Assessment (up to three sessions) - $250
  - Individual Sessions - $110 (16-37 min); $145 (38-52 min); $200 (53-60 min)
  - Family/Couples Sessions – $200 (53-60 min)
  - DBT Group Sessions - $80 (75-90 min)
  - Family Therapy (With or Without Client Present) - $200
- **Without Health Insurance – MEDICARE and/or MEDICAID is not accepted**

  Cash Fee:
  - Diagnostic Assessment (up to three sessions) - $200
  - Individual & Family/Couples Sessions - $170
  - DBT Group Sessions - $75
  - No Show Appointment & Late Cancellation Fee - $170
  - No Show Fee for DBT Group - $75
  - HPAP Meeting On Site/Missed Session - $45
  - Court Prep Fee - $350/hour *(pre-payment required)*
  - Court Testimony Fee - $400/hour *(pre-payment required)*

Payments:

- Cash, Checks, Visa, Mastercard or Discover Card are accepted
- Payment is due at the time of service
- For personal checks that are written and returned there will a $40 charge added to your bill. If a check is returned twice, a check will no longer be accepted

I, the undersigned client, hereby knowingly and with full understanding state that I am covered under insurance and agree to pay the agreed amount at the time of each visit for services received by Tandra T. Baker, Tapestry of Wellness, LLC, LPC-MH, LAC, QMHP. I understand that this amount is a good faith estimate of the client obligation but is not necessarily the amount owed by me. I further understand that this amount will be applied to any amounts owed for service rendered by Tandra T. Baker, Tapestry of Wellness, LLC, LPC-MH, QMHP, LAC, and that it is not total or final payment on my bill. After insurance processes my claim, and my portion is clearly defined, I will be billed for the difference of what my insurance plan processes as my portion, less the above referenced amounts paid at the time of service. If insurance does not cover services I agree that I am fully responsible for payment.

I have read, completely understand and agree to the above policy and the fees set for the counseling sessions.

Patient Signature: _____ Date: _____

Printed Name: _____

Therapist Signature: _____ Date: _____

Tandra T. Baker, LPC-MH, LAC, QMHP

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Online HPAP Support Meeting Authorization Form

Eligibility for Online Support Meetings:
Participants interested in participating in the online HPAP (Health Professionals Assistance Program) Support Meetings must first consult with Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC to discuss eligibility as well as the terms and conditions that apply. If it is determined that online support meetings are appropriate, participants must submit written verification/agreement to the terms and conditions before meetings are attended.

After eligibility is determined Tandra will send you a link that allows you access to the online platform. Prior to joining the meeting it is required that you schedule, and attend, an online interview and orientation session with Tandra. You will need to have all agreements and consents signed and returned to Tandra prior to being allowed into the meeting.

Who benefits from the Meetings:
HPAP Support Meetings are most suitable for participants who have previously engaged in formal counseling services / treatment and who are seeking support while engaged in the Midwest Health Management Services / South Dakota Health Professionals Assistance Program or those seeking support on their own. In addition these services are most effective for issues that are unrelated to major crisis, active addiction behaviors, severe mental health issues, suicidal, homicidal or violent behavior.

Online support meetings are intended for participants who have limited access, availability or financial means to receive direct, face-to-face support services. Although online support meetings may be helpful, direct, face-to-face services are highly recommended and encouraged, especially for participants either looking for long-term treatment or participants in major crisis.

If it is determined at any point in the support meeting that your needs are greater than what can be effectively addressed online, Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC reserves the right to refuse and/or end support meetings with you.

Online HPAP Support Meetings does NOT provide crises counseling and is not appropriate for participants who are suicidal, homicidal or engaging in violent behavior or who present as suicidal, homicidal or violent. Have a recent history (within last 12 months) of a major psychiatric episode, hospitalizations due to an overdose/suicide attempt/psychiatric episode/eating disorder or who is actively participating in addiction behaviors. Failure to disclose this information or knowingly misleading her excludes Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC from any legal obligations or liability related to said participant.

Nature of Online Support Meetings and What you can expect:
The duration of support meetings is different for each participant and can be difficult to estimate. Generally participants continue in the online support meetings until they have been discharged or have successfully completed the program/contract with Midwest Health Management Services / South Dakota Health Professional Assistance Program. Some participants choose to continue past that time as well and are asked to make an agreement for a certain length of time determined by both the participant and Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC.
You as the participant understands that online/phone/text/email support have limitations (as well as benefits) compared to in-person meetings, among those being the lack of "personal" face-to-face interactions, the lack of visual and audio cues, and limitations of internet connection at times. You understand that telephone/online support meetings is not psychotherapy with me; is not a substitute for medication under the care of a psychiatrist or doctor. You understand that online/ telephone support meetings may not be appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts. If a life threatening crisis should occur, you agree to contact a crisis hotline in your area, call 911, or go to

a hospital emergency room. You also understand that I follow the professional laws and regulations put in place by the Counselor Licensing Board of the State of South Dakota (USA) as well as the American Counseling Association. The support meetings will be considered to take place in the state of South Dakota (USA).

When participants attend the support meetings, it is because they want something to be different in their lives. It may also be a recommendation put forth by your participation agreement with Midwest Health Management Services / South Dakota Health Professional Assistance Program. The following agreements are expected:

- That you will fully participate in the meetings, both offering and receiving peer feedback.
- Myself along with your peers will support you effectively utilizing your skills and help you devise various ways to get what you want, as far as that is possible, in an effective and healthy way.
- You agree to attend all scheduled meetings, to arrive on time and stay the full allotted time
- You will maintain confidentiality of all those involved
- You will join the meeting in a secure location so that others may not hear or see
- You understand there are no guarantees of what you will experience, and that you enter this Agreement and use Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC support meetings at your own risk
- You agree that you understand the possible advantages and disadvantages of online support meetings and shall not hold accountable Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC for any information or insight distributed here.
- If you are not feeling satisfied with your support for any reason, you are asked to discuss this directly with me. I will work with you to problem solve what might be preventing the most effective support.
- If you are unable to attend a meeting that you notify Tandra prior to the meeting time.
- You keep all payment arrangements.

Privacy Policy:
According to mental health licensing statutes, the law protects the privacy of all communications between a participant and practitioner. Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC is in compliance with the requirements of HIPPA. Confidentiality is taken seriously and discussing or releasing your information to any individual, agency, or corporation except if such release is requested by a signed authorization form (see below); or if a participant indicates intent to do harm to her/himself or others.

Confidentiality Policy and Limits of Confidentiality:
All support meetings are strictly confidential and may not be revealed to anyone without your written permission. There are exceptions to confidentiality where disclosure is required by law (see below). Additionally, there may be times that consultation with an adjunct colleague is necessary to discuss aspects of the meetings to support our work together. The Notice of Privacy Practices provides detailed information about how private information about your health care is protected and under what circumstances it may be shared.

Confidentiality of cell phones, text messages, and e-mail are generally considered unsecured ways of communication you agree to participate in the meetings being fully aware of this and at the same time understand that Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC will attempt to make it as secure as she can and askes the same of you.

I make every effort to keep all information confidential. Likewise, I ask that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends. I encourage you to only communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured. Be sure to fully exit all online meetings and password protect your emails, phone and text messages.

If we are unable to connect or are disconnected during a meeting due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible please contact me to follow up.

Legal Exemptions to Confidentiality:
Legal exceptions to confidentiality are in place to protect your safety and the safety of others. This includes when there is reasonable suspicion of child abuse (physical, sexual, emotional, neglect), adult dependent care abuse, elder abuse/neglect, and when a participant threatens to harm or kill others, or intent to damage another person's property. Legally, I am a mandated reporter of abuse or intent to harm another. If you're homicidal and make a serious threat to hurt another person or persons I will contact 911 and make every attempt when the intended victim or victims. Additionally, if I am court ordered to release records, I must abide by the court order and I may be compelled by court order to testify under and must answer all questions honestly.

Telephone and Emergency Procedures:
If you need to speak with me between sessions, please call 605.530.2968. Your call will be returned as soon as possible. Messages are checked daily. Messages are checked less frequently on weekends and holidays. If an emergency situation arises that requires immediate attention, you may call the emergency National Suicide Hotline at 800-784-2433 or dial 911. If a
life-threatening crisis should occur, you agree to contact a crisis hotline, call 911 or go to a hospital emergency room.

Payment for Services:
The orientation meeting and each support meeting fee is $30.00. Payment is due at the time of service.

Cancellation Policy:
Cell phones cannot guarantee confidentiality, however, if for any reason you are not able to attend the meeting please call or send a text message to me at 605.530.2968. If the meeting is cancelled due to Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC not being able to attend I will do my best to send a text message informing you of this prior to the meeting time. You will not be charged for that meeting. There will be times that a make-up meetings will be offered at a different date and time.

No-Show and Missed Meetings:
If you do not show up for a scheduled meeting (and you have not notified Tandra prior) you will be charged the full fee ($30) for the meeting. You are responsible for keeping track and attending the meetings, however if you would like text message reminder of the meeting please let me know.

It is understandable that occasionally a meeting will be cancelled or missed due to illness or emergency. However, your regular meeting day/time has been reserved for you. My current schedule does not allow for a great deal of flexibility with respect to continual cancellations, rescheduled meetings or no shows. If you find that your schedule is no longer able to accommodate the meeting time reserved for you, please discuss this with me and we will do our best to find an alternative solution. However, please note that should on-going cancellations, missed meetings, coming to the meetings late, leaving the meetings early, late payment / non-payment become an issue, and if after discussing other options with you and these issue have not changed, I will need to open up your reserved time to my wait list and add you to the wait list. If you prefer not to be placed on the waitlist, then I will refer you back to Midwest Health Management Services / South Dakota Health Professionals Program and/or terminate with you until you are able to attend.

<u>You are given three (3) excused missed meetings per calendar year without financial obligation. After the third missed meeting you will be billed the full session fee.</u>

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Internet Access:
Online Support Meetings are held through the HIPAA compliant platform VSee. The meeting is held in Central Standard Time (CST). You will need to have access to a secure computer that allows both video and audio communication. You may find that you will want headphones as it can reduce feedback that may be experienced on occasion.

By signing this form I understand that online support meetings are technical in nature and that there may be problems with Internet connectivity, which is the fault of neither Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC and myself. Internet availability may be limited or disrupted by things such as server maintenance, upgrades, or other problems (such as software or hardware malfunction) or natural or man-made disasters (such as Internet viruses, terrorist acts and so forth). These types of problems are beyond the control of Tandra T. Baker and myself.

Although Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC has taken a significant number of steps to ensure the confidentiality and privacy of Online communication(s) between you and I, these actions, in whole or in part, cannot guarantee the security of Internet transmissions. I permanently agree to release and indemnify Tandra T.

Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC from all suits, claims, and other actions originating from services provided.

Release of Information:
By signing this agreement you are providing mutually unrestricted consent for Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC to seek consultation with other professionals if/when necessary. You agree Tandra T. Baker, LPC-MH, LAC, QHMP, Tapestry of Wellness, LLC also may consult with those at Midwest Health Management Services / South Dakota Health Professionals Assistance Program.

Your Signature Below Indicates that:
You have read this agreement and agree to its terms.
You acknowledge that you have read the HIPAA information.
You understand the 3-miss rule.
Agree to the payment agreement and agree to pay $30 at the time of service and for missed sessions if applicable.

Participant Signature *Date*

Tandra T. Baker, LPC-MH, LAC, QMHP *Date*

Tapestry of Wellness, LLC
Tandra T. Baker
LPC-MH, LAC, QMHP & Linehan Board Certified DBT Clinician
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Card Payment Agreement

Client Name: _____ **Date:** _____

Credit Card Type	
Credit Card Number	
Expiration Date	
3 or 4 digit Security Code	
Name on Card	
Zip Code	

I agree that my card will be charged after:

- **$30 after each meeting**
- **$30 for each No Show/Late Cancellation (if not within a 24-hour notice window). There are no expections to this policy**
- **$30 after you miss three meetings within a calendar year. There are no exceptions to this policy**

I agree to allow ***Tandra T Baker, Tapestry of Wellness, LLC, LPC-MH, LAC, QMHP*** to charge the card listed above for the purpose of payment. I agree that if my card expires I will supply my updated card information. I also identify that my card will be charged for all charges unless ***Tandra T Baker, Tapestry of Wellness, LLC, LPC-MH, LAC, QMHP*** is notified in writing to stop making charges to this credit card and an alternative form of payment is established.

I agree to all the above terms and conditions.

Signed: _____ Date: _____

Tapestry of Wellness, LLC
Tandra T. Baker
LPC-MH, LAC, QMHP & Linehan Board Certified DBT Clinician
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Release Authorization Form

I, _____, whose Date of Birth is _____, authorize *Tandra T. Baker, Tapestry of Wellness, LLC, LPC-MH, QMHP, LAC* to disclose to and/or obtain the following information from:

_____

_____

[Name of Person or Title of Person or Organization]

Description of Information to be Disclosed:

_____ Assessment	_____ Psychological Evaluation	_____ Diagnosis
_____ Psychosocial Evaluation	_____ Continuing Care Plan	_____ Other
_____ Treatment Plan/Summary	_____ Alcohol & Drug Use Evaluation	
_____ Presence/Participation in Treatment	_____ Progress in Treatment	
_____ Demographic Information	_____ Mutually Unrestricted	

Purpose:
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:_____

Revocation:
I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Tandra T. Baker, Tapestry of Wellness, LLC, 5708 S. Remington Place, Suite 400, Sioux Falls, SD 57108. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:
Unless sooner revoked, this consent expires in one year from the signed date, or as otherwise indicated:
_____

Conditions:
I further understand that *Tandra T. Baker, Tapestry of Wellness, LLC,* will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
_____

Form of Disclosure:
Unless you have specifically requested in writing that the disclosure be made in certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure:
Federal law prohibits this person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

_____

Signature of Patient/Client/Guardian **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual) power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

_____

Tandra T Baker, MA, LPC-MH, LAC, QMHP **Date**

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Tandra T. Baker
LPC-MH, LAC, QMHP & Linehan Board Certified DBT Clinician
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NAME: _____ **DATE:** _____

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you *think you might have felt*. Please answer honestly. **All questions refer to the last week. If you felt different ways at different times in the week, give a rating for how things were for you on average. Please be sure to answer each question.**

In the course of last week...		not at all	a little	rather	much	very strong
1	It was hard for me to concentrate	0	1	2	3	4
2	I felt helpless	0	1	2	3	4
3	I was absent-minded and unable to remember what I was actually doing	0	1	2	3	4
4	I felt disgust	0	1	2	3	4
5	I thought of hurting myself	0	1	2	3	4
6	I didn't trust other people	0	1	2	3	4
7	I didn't believe in my right to live	0	1	2	3	4
8	I was lonely	0	1	2	3	4
9	I experienced stressful inner tension	0	1	2	3	4
10	I had images that I was very much afraid of	0	1	2	3	4
11	I hated myself	0	1	2	3	4
12	I wanted to punish myself	0	1	2	3	4
13	I suffered from shame	0	1	2	3	4
14	My mood rapidly cycled in terms of anxiety, anger, and depression	0	1	2	3	4
15	I suffered from voices and noises from inside or outside my head	0	1	2	3	4
16	Criticism had a devastating effect on me	0	1	2	3	4
17	I felt vulnerable	0	1	2	3	4
18	The idea of death had a certain fascination for me	0	1	2	3	4
19	Everything seemed senseless to me	0	1	2	3	4
20	I was afraid of losing control	0	1	2	3	4
21	I felt disgusted by myself	0	1	2	3	4
22	I felt as if I was far away from myself	0	1	2	3	4
23	I felt worthless	0	1	2	3	4

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Now we would like to know in addition the quality of your **overall** personal state in the course of the last week. 0% means **absolutely down**, 100% means **excellent**. Please check the percentage which comes closest.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
(very bad) ←										→ (excellent)

BSL - Supplement: Items for Assessing Behavior

	During the last week.....	Not at all	once	2-3 times	4-6 times	Daily or more often
1	I hurt myself by cutting, burning, strangling, headbanging etc.	0	1	2	3	4
2	I told other people that I was going to kill myself	0	1	2	3	4
3	I tried to commit suicide	0	1	2	3	4
4	I had episodes of binge eating	0	1	2	3	4
5	I induced vomiting	0	1	2	3	4
6	I displayed high-risk behavior by knowingly driving too fast, running around on the roofs of high buildings, balancing on bridges, etc.	0	1	2	3	4
7	I got drunk	0	1	2	3	4
8	I took drugs	0	1	2	3	4
9	I took medication that had not been prescribed or if had been prescribed, I took more than the prescribed dose	0	1	2	3	4
10	I had outbreaks of uncontrolled anger or physically attacked others	0	1	2	3	4
11	I had uncontrollable sexual encounters of which I was later ashamed or which made me angry.	0	1	2	3	4

Please double-check for missing answers

WE THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

PLEASE RETURN THE QUESTIONNAIRE TO YOUR THERAPIST

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Name: _____ **Date:** _____

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question

		Yes	No
1.	Have you used drugs other than those required for medical reasons?		
2.	Have you abused prescription drugs?		
3.	Do you abuse more than one drug at a time?		
4.	Can you get through the week without using drugs (other than those required for medical reasons)?		
5.	Are you always able to stop using drugs when you want to?		
6.	Do you abuse drugs on a continuous basis?		
7.	Do you try to limit your drug use to certain situations?		
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?		
9.	Do you ever feel bad about your drug abuse?		
10.	Does your spouse (or parents) ever complain about your involvement with drugs?		
11.	Do your friends or relatives know or suspect you abuse drugs?		
12.	Has drug abuse ever created problems between you and your spouse?		
13.	Has any family member ever sought help for problems related to your drug use?		
14.	Have you ever lost friends because of your use of drugs?		

		Yes	No
15.	Have you ever neglected your family or missed work because of your use of drugs?		
16.	Have you ever been in trouble at work because of drug abuse?		
17.	Have you ever lost a job because of drug abuse?		
18.	Have you gotten into fights when under the influence of drugs?		
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20.	Have you ever been arrested for driving while under the influence of drugs?		
21.	Have you engaged in illegal activities in order to obtain drug?		
22.	Have you ever been arrested for possession of illegal drugs?		
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?		
25.	Have you ever gone to anyone for help for a drug problem?		
26.	Have you ever been in a hospital for medical problems related to your drug use?		
27.	Have you ever been involved in a treatment program specifically related to drug use?		
28.	Have you been treated as an outpatient for problems related to drug abuse?		

Office Use Only: Code: _____

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Name: _____ **Date:** _____

The Michigan Alcohol Screening Test (MAST)

Directions: read each question carefully and answer yes or no to the following questions:

1. Do you feel you are a normal drinker? ("normal" is defined as drinking as much or less than most other people)
___ Yes ___ No

2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?
___ Yes ___ No

3. Does any near relative or close friend ever worry or complain about your drinking?
___ Yes ___ No

4. Can you stop drinking without difficulty after one or two drinks?
___ Yes ___ No

5. Do you ever feel guilty about your drinking?
___ Yes ___ No

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
___ Yes ___ No

7. Have you ever gotten into physical fights when drinking?
___ Yes ___ No

8. Has drinking ever created problems between you and a near relative or close friend?
___ Yes ___ No

9. Has any family member or close friend gone to anyone for help about your drinking?
___ Yes ___ No

10. Have you ever lost friends because of your drinking?
___ Yes ___ No

11. Have you ever gotten into trouble at work because of drinking?
___ Yes ___ No

12. Have you ever lost a job because of drinking?
___ Yes ___ No

13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking?
___ Yes ___ No

14. Do you drink before noon fairly often?
___ Yes ___ No

15. Have you ever been told you have liver trouble, such as cirrhosis?
___ Yes ___ No

16. After heavy drinking, have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?
___ Yes ___ No

17. Have you ever gone to anyone for help about your drinking?
___ Yes ___ No

18. Have you ever been hospitalized because of drinking?
___ Yes ___ No

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
___ Yes ___ No

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem?
___ Yes ___ No

21. Have you been arrested more than once for driving under the influence of alcohol?
___ Yes ___ No

22. Have you ever been arrested, or detained by an official for a few hours, because of other behavior while drinking?
___ Yes ___ No

PSS-I-5

Name: _____ **Date:** _____

TRAUMA SCREEN

Many people are exposed to a disturbing or traumatic event at some point in their lives. These experiences can happen in any of the following ways:

1. Directly experiencing the event
2. Witnessing the event
3. Learning that the event happened to a close family member or close friend
4. Experiencing repeated or intense exposure to distressing details of the event (e.g. emergency workers collecting human remains)

Examples of traumatic events include: natural disasters, accidents, sexual assaults, physical assaults, combat, childhood sexual abuse torture, or life-threatening illness.

Have you experienced such an event?
____Yes
____ No

Please briefly describe the experience which is the **most distressing and the most haunting for you currently**.

If you are unsure, briefly describe the experience anyway:

_____

_____

_____

_____

Did this event included:

a. Actual or threatened death? Yes No
b. Actual or threatened serious injury? Yes No
c. Actual or threatened sexual violation Yes No

When did this event occur? _____

PSS-I-5

Questions should be about the most currently distressing trauma. Each item below should be asked in reference to the past month (if < 1 month since trauma, ask "Since the event..."). Probe all positive responses (e.g., "How often has this been happening?") following the instructions provided in the PSS-I-5 manual.

0		2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

RE-EXPERIENCING (need one): [probe, then quantify]

1. Have you had unwanted distressing memories about the trauma?
2. Have you been having bad dreams or nightmares related to the trauma?
3. Have you had the experience of feeling as if the trauma were actually happening again?
4. Have you been very EMOTIONALLY upset when reminded of the trauma?
5. Have you had PHYSICAL reactions when reminded of the trauma (e.g., sweating, heart racing)?

AVOIDANCE (Need one): [probe, then qualify]

6. Have you been making efforts to avoid thoughts or feelings related to the trauma?
7. Have you been making efforts to avoid activities, situations, or places that remind you of the trauma or that feel more dangerous since the trauma?

CHANGES IN COGNITION AND MOOD (Need two): [probe, then qualify]

8. Are there any important parts of the trauma that you cannot remember?
9. Have you been viewing yourself, others, or the world in a more negative way (e.g."I can't trust people," "I'm a weak person")?
10. Have you blamed yourself for the trauma or for what happened afterwards? Have you blamed others that did not directly cause the event for the trauma or what happened afterwards?
11. Have you had intense negative feelings such as fear, horror, anger, guilt or shame?
12. Have you lost interest in activities you used to do?
13. Have you felt detached or cut off from others?
14. Have you had difficulty experiencing positive feelings?

0		2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

INCREASED AROUSAL AND REACTIVITY (need two): [probe then quantify]

15. Have you been acting more irritable or aggressive?

16. Have you been taking more risks or doing things that might cause you or others harm (e.g., driving recklessly, taking drugs, having unprotected sex)?

17. Have you been overly alert or on-guard (e.g., checking to see who is around you, etc.)?

18. Have you been jumpier or more easily startled?

19. Have you had difficulty concentrating?

20. Have you had difficulty falling or staying asleep?

TOTAL SCORE (add items 1-20) =_____

DISTRESS AND INTERFERENCE

21. How much have these difficulties been bothering you?

22. How much have these difficulties been interfering with your everyday life (e.g. relationships, work, or other important activities)?

SYMPTOM ONSET AND DURATION

23. How long after the trauma did these difficulties begin? [circle one]
    a. Less than 6 months
    b. More than 6 months

24. How long have you had these trauma-related difficulties? [circle one]
    a. Less than 1 month
    b. More than 1 month