

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

**PATIENT REGISTRATION SHEET**

<b>Today's Date:</b>	<b>Please Print</b>	
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**PATIENT INFORMATION**

Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> F
Email:							
Employer:			Occupation:		Work phone #: ( )		
Street Address:		City:		State:		ZIP Code:	
Referring Doctor (if required by insurance):							
Notify Primary Care Physician? <input type="checkbox"/> YES <input type="checkbox"/> NO		Name of Primary Care Physician			Contact #: ( )		

**IN CASE OF EMERGENCY**

Emergency Contact Name:		Home phone #: ( )	Cell phone #: ( )
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**INSURANCE INFORMATION**

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

**SECONDARY INSURANCE INFORMATION (IF APPLICABLE)**

Insurance Company:		Insurance Billing Address:			Insurance phone #: ( )		
Policy #:	Group #:	Relationship to Insured:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> 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. \***

## Intake Information

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Increased appetite            | <input type="checkbox"/> Loss               |
| <input type="checkbox"/> Panic Attacks         | <input type="checkbox"/> Decreased appetite            | <input type="checkbox"/> Inability to focus |
| <input type="checkbox"/> Depressed Mood        | <input type="checkbox"/> Increased alcohol consumption | <input type="checkbox"/> Medical concerns   |
| <input type="checkbox"/> Suicidal thoughts     | <input type="checkbox"/> Racing thoughts               | <input type="checkbox"/> Self-harming       |
| <input type="checkbox"/> Suicide attempt       | <input type="checkbox"/> Delusions                     | <input type="checkbox"/> Tearfulness        |
| <input type="checkbox"/> Fear                  | <input type="checkbox"/> Hallucinations                | <input type="checkbox"/> Legal problems     |
| <input type="checkbox"/> Decreased Sleep       | <input type="checkbox"/> Hopelessness                  | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Increased Sleep       | <input type="checkbox"/> Increased energy              |   |
| <input type="checkbox"/> Relationship concerns | <input type="checkbox"/> Trauma                        |   |
| <input type="checkbox"/> Anger                 |  |   |

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? \_\_\_\_\_

Tandra T. Baker, Tapestry of Wellness, LLC  
LPC-MH, LAC, QMHP, Linehan Board Certified DBT Clinician  
5708 S. Remington Place, Suite 400  
Sioux Falls, SD 57108  
Tel: 605-530-2968

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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: \_\_\_\_\_

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

Date: \_\_\_\_\_

Tapestry of Wellness, LLC  
Tandra T. Baker  
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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:**

- \$45 after each HPAP support meeting;
- \$\_\_\_\_\_ for Co-pay/Co-insurance/Deductible if a service is submitted to your health insurance
- \$45 for a No Show/Late Cancellation (must be notified within 24-hours prior to agreed upon time). There is no exception 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: \_\_\_\_\_

## **AGREEMENT FOR HPAP SUPPORT GROUP**

Welcome to the HPAP Support Group facilitated by Tandra T. Baker, LPC-MH, LAC, QMHP, Tapestry of Wellness, LLC. This document contains important information about professional services and business policies. It also contains summary information about the Health Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and new patient right with regard to use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information.

Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you may have. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

### **SERVICES:**

You are entering a HPAP Support Group. You have been referred to this group and it has been determined that the HPAP Support Groups are likely to be useful to you. However, there are no guarantees.

### **SUPPORT GROUP AGREEMENT:**

Group support is a method that can be very helpful for people and often provides growth and change opportunities. In order for this group to be as useful as possible for everyone the following are expectations for all group members.

### **ATTENDANCE:**

1. Your HPAP Support Group will be held every other week – which group you are in will depend on availability.
2. Support sessions will last 60-90 minutes each. The full program will be dependent upon your contract with the Midwest Health Management Services and South Dakota Health Professionals Assistance Program or your private contract with Tandra T. Baker, Tapestry of Wellness, LLC.
3. Participants are expected to commit to attending ALL scheduled support sessions unless there is a crisis. Hit and Missed attendance is harmful to the group process and disrupts the progress individuals can make within the group.

### **SOCIALIZING WITH GROUP MEMBERS:**

Group members are welcome to have outside contacts with each other. If you want to forge these relationships you may share your contact information with the members that you choose. We will not give out your information.

### **CONFIDENTIALITY:**

It is very important that things that are talked about in the group are not repeated outside. You may, of course want to discuss your experience with people close to you but even then it is important not to attach names or specific information to the talk. In our experience, it is extremely rare for there to be any break in confidentiality. Please be sure that you do not talk about others, just as you don't want others to talk about you outside the group.

### **FEELINGS AND BEHAVIORS:**

It is normal to feel anxious about being in a group. Members will need to work actively on the problems and concerns that brought them into the group. The more you involve yourself in the group, the more you will get out of it. Always try to put feelings into words. Every member is equal and has the right to participate despite individual differences. The group is a place where you can try out new ways of talking to people, a place to take some risks.

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However, abusive language, name calling, threats or actual violence will not be permitted and you may be asked to leave the group.

**RELEASE OF INFORMATION:**

By signing this contract you are agreeing to a mutually unrestricted Release of Information between Tandra Baker, LPC-MH, LAC, QMHP, Tapestry of Wellness, LLC and Midwest Health Management Services / South Dakota Health Professionals Assistance Program. Additionally, you agree that this is a mutually unrestricted Release of Information between Tandra Baker, LPC-MH, LAC, QMHP, Tapestry of Wellness, LLC and any backup support group facilitator and HPAP consultation needs. This information is for the purpose of your comprehensive HPAP care. Furthermore, by signing this agreement you are agreeing to a mutually unrestricted Release of Information between Tandra Baker, LPC-MH, LAC, QMHP, Tapestry of Wellness, LLC and your individual therapist, if you have one.

**PROFESSIONAL FEES, BILLING, AND PAYMENT;**

1. The fee for every Group Session is \$45.00
2. You will be expected to pay for each session at the time it is held through cash, check or card, unless we agree otherwise. If you choose to have a credit/debit/flex card on file it is your responsibility to keep the card current. *Please make checks payable to Tapestry of Wellness, LLC*
3. You are required to pay for all sessions that you attend. However, in the event that you are unable to attend you will be allowed THREE excused group sessions, for which you will not be obligated to pay, per calendar year. **If you are absent more than three sessions per calendar year, you will be billed and expected to pay for missed sessions.**
4. In the event of the therapist canceling a group session you will not be financially responsible for that session and it will not be counted towards your three excused group sessions.
5. In an event when the therapist is unable to be the physical office at times that rather than cancelling the meeting your therapist will offer the meeting on a HIPAA secure online platform, Vsee. In this event you will need to provide your email address so an emailed invitation can be sent to you and you can create a login and password. You will need to and have a computer/ipad/phone with a camera, microphone and speakers you will also want to be connected to the internet. The fee for this meeting will remain the same as your normal fee.
6. Returned checks will be assessed a \$40 office administrative fee as well as any bank charges.
7. If your account is more than 90 days delinquent and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In most cases, the only information we release about the client's treatment would be the client's name and address, the nature of the service provided, and amount due.

\*\*\*\*\*AMOUNT I AGREE TO PAY AT EACH GROUP SESSION: \$45.00

**YOUR SIGNATURE BELOW INDICATES THAT:**

You have read this agreement and you agree to its terms  
You acknowledge that you have read the HIPPA information

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Print Name- Patient

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Patient Signature

Date

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

Date

**Tapestry of Wellness, LLC**  
**Tandra T. Baker**  
**LPC-MH, LAC, QMHP & Linehan Board Certified DBT Clinician**  
**5708 S. Remington Place, Suite 400, Sioux Falls, SD 57108**  
**Tel: (605) 530-2968**

**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:**

<input type="checkbox"/> Assessment	<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Psychosocial Evaluation	<input type="checkbox"/> Continuing Care Plan	<input type="checkbox"/> Other
<input type="checkbox"/> Treatment Plan/Summary	<input type="checkbox"/> Alcohol & Drug Use Evaluation	
<input type="checkbox"/> Presence/Participation in Treatment	<input type="checkbox"/> Progress in Treatment	
<input type="checkbox"/> Demographic Information	<input type="checkbox"/> 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

Tapestry of Wellness, LLC  
Tandra T. Baker  
LPC-MH, LAC, QMHP & Linehan Board Certified DBT Clinician  
5708 S. Remington Place, Suite 400, Sioux Falls, SD 57108  
Tel: (605) 530-2968

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



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**

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?		

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

MAST

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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:

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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.

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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

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### 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?

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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

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**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