

CLIENT OUTPATIENT REGISTRATION QUESTIONNAIRE

NAME: _____

SOCIAL SECURITY # _____ - _____ - _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (_____) _____ BIRTH PLACE: CITY: _____ STATE: _____

<u>GENDER:</u>	<u>ETHNICITY:</u>	<u>MARITAL STATUS:</u>	<u>EMPLOYMENT:</u>	<u>RACE:</u>
MALE	CUBAN	NEVER MARRIED	DISABLED	ASIAN
FEMALE	HAITIAN	MARRIED	FULL TIME	BLACK
	MEXICAN	WIDOWED	HOME MAKER	HISPANIC
	PUERTO RICAN	DIVORCED	PART TIME	MULTI RACIAL
	OTHER HISPANIC	SEPARATED	RETIRED	NATURAL HAWAIIAN
	NONE OF ABOVE		STUDENT	WHITE
			UNEMPLOYED	

HOW MANY CHILDREN DO YOU HAVE? _____ DO THEY LIVE WITH YOU? YES / NO

HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD? _____ EDUCATION LEVEL _____

DO YOU RECEIVE: SOCIAL SECURITY INSURANCE YES / NO
SOCIAL SECURITY DISABILITY INSURANCE YES / NO

DO YOU HAVE ANY ADVANCE DIRECTIVES: LIVING WILL YES / NO
HEALTH CARE SURROGATE YES / NO

DO YOU HAVE ANY HEARING LOSS? YES / NO
IF YES, HOW DO YOU PREFER TO COMMUNICATE? _____

PRIMARY LANGUAGE: _____ HAVE YOU EVER SERVED IN THE US MILITARY: YES / NO

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: (_____) _____

RELEASE OF INFORMATION

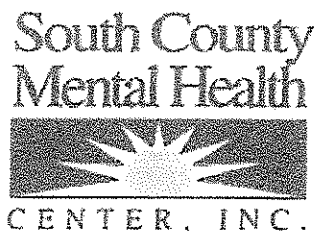
WOULD YOU LIKE TO SIGN A RELEASE OF INFORMATION FOR YOUR EMERGENCY CONTACT OR A DIFFERENT PERSON? YES / NO

IF YES, NAME OF PERSON: _____ PHONE: (_____) _____

RELATIONSHIP: _____

DO YOU HAVE ANY HEALTH INSURANCE: YES / NO

IF YES, WHAT KIND: _____



CONTROLLED MEDICATIONS

Below is a list of controlled medications that South County does **NOT** prescribe. This is NOT a complete list.

Common Benzodiazepines

<u>Name Brand</u>	<u>Generic</u>
Xanax	Alprazolam
Klonopin	Clonazepam
Ativan	Lorazepam
Valium	Diazepam
Librium	Chlordiazepoxide
Ambien	Zolpidem
Lunesta	Eszopiclone
Restoril	Tempazepam
Serax	Oxazepam
Suboxone	

Common Stimulants

<u>Name Brand</u>	<u>Generic</u>
Adderall, Adderall XR	
Concerta, Ritalin	Methylphenidate
Dexedrine	Dextroamphetamine
Focalin, Focalin XR	Dexmethylphenidate
Vyvanse	Lisdexamphetamine

South County Mental Health Center
Initial Client Questionnaire

Chart #: _____

Page 1 of 2

Client Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Reason for Referral _____

Are you seeking a psychiatric evaluation for possible medications? Yes ☐ No ☐

Are you seeking weekly counseling services? Yes ☐ No ☐

Controlled Substance Notification: South County Mental Health Center does not prescribe controlled substances, to include Benzodiazepines and Opiates.

<u>Past Medical History</u>	<u>Yes</u>	<u>No</u>	<u>If yes, When?</u>
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Thyroid Disease	☐	☐	_____
Liver/Kidney Disease	☐	☐	_____
Peptic Ulcer Disease	☐	☐	_____
Asthma	☐	☐	_____
Stroke	☐	☐	_____
Other (please list)	☐	☐	_____

Psychiatric Disorders (please list) ☐ ☐ If yes, When?

Surgeries (please list) ☐ ☐ If yes, When?

Current Medications – please include psychiatric and medical (write on back if needed)

<u>Medication</u>	<u>Dosage</u>	<u>Directions</u>	<u>Prescribed by?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies (please list) _____

South County Mental Health Center
Initial Client Questionnaire

Chart #:

Page 2 of 2

Social History

Marital Status: Married Single Divorced Widowed/er Significant Other

Level of Education Completed _____ Occupation _____

	<u>Yes</u>	<u>No</u>	<u>If yes, how much?</u>
Tobacco Use	☐	☐	_____
Alcohol Use	☐	☐	_____
Recreational Drugs	☐	☐	_____

Family History - has anyone in your family ever had?

	<u>Yes</u>	<u>No</u>	<u>If yes, who?</u>
Cancer	☐	☐	_____
Stroke/TIA	☐	☐	_____
Alzheimer's disease	☐	☐	_____
Psychiatric Disorders	☐	☐	_____
Seizures	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____

Symptom Checklist – Are you experiencing?

	<u>Yes</u>	<u>No</u>	<u>If yes, how long?</u>
Depression	☐	☐	_____
Anxiety	☐	☐	_____
Thoughts of harming yourself	☐	☐	_____
Thoughts of harming someone else	☐	☐	_____
Repetitive thoughts	☐	☐	_____
Nervousness	☐	☐	_____
Difficulty focusing	☐	☐	_____
Increased sleep	☐	☐	_____
Decreased sleep	☐	☐	_____
Poor appetite	☐	☐	_____
Increased appetite	☐	☐	_____
Lack of motivation	☐	☐	_____
Sensory disturbances i.e. voices/visions	☐	☐	_____
Wishing you were dead	☐	☐	_____
Memory problems	☐	☐	_____
Shortness of breath	☐	☐	_____

Reviewed by: Staff Signature _____

Date _____

**South County Mental Health
Center, Inc.**

16158 South Military Trail
Delray Beach, FL 33484
(561) 495-0522 / 737-8400
Fax (561) 496-5064

Client Name _____

Chart #: _____

CONSENT FOR TREATMENT

I, _____, an applicant for the services of SCMHC voluntarily consent to treatment

Or

I, _____, acting as representative or guardian, voluntarily grant permission to SCMHC to render treatment, as deemed necessary, for the above named applicant.

CONSENT FOR TREATMENT

I hereby authorize SCMHC professional staff to administer treatment. I certify that I have been informed of the nature and the purpose of this treatment, alternative treatment modalities, approximate length of care, and I have been informed that this consent can be revoked orally or in writing prior to or during the treatment period. **I understand that I am in a facility where medical, nursing, and behavioral health students train under the supervision of a professional staff.**

CONSENT FOR MEDICATION

I understand that if medications are prescribed for me, the risks, benefits and possible side effects of such medications shall be explained to me. When medication is prescribed, I understand that I may request discontinuation of the medication at any time and discuss other treatment options. Medications may impair mental and physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery. The use of alcohol and/or other central nervous system depressant drugs are to be avoided due to the possible potential effects and hypotension. I understand that if I experience side effects that I should contact my case manager or doctor/ARNP immediately.

CONSENT FOR MEDICAL HEALTH EMERGENCY

In the event of an illness or medical emergency, I grant permission to the authorities of SCMHC to authorize medical services. These services may include Emergency Room or Inpatient/Outpatient care considered essential for my condition or illness.

In the event of an illness or medical emergency, I further authorize the physician, hospital or other professional providing the healthcare to release to SCMHC the medical records information specific to that episode of care.

COMMUNICABLE DISEASES

I understand that if a reportable communicable disease is diagnosed during the course of treatment, this diagnosis shall be reported to the State agencies along with patient identification in accordance with the Florida Statutes on communicable diseases and confidentiality.

I have read and fully understand the above Consent for Treatment. No guarantee or assurance has been made to me as to the results that may be obtained. I have read and fully understand the above, my questions have been answered and, to the best of my knowledge, the information supplied by me is correct and accurate.

CLIENT: _____
Printed Name Signature Date

PARENT/GUARDIAN: _____
Printed Name Signature Date

WITNESS: _____
Printed Name Signature Date

South County Mental Health Center, Inc. 16158 South Military Trail Delray Beach, FL 33484 (561) 495-0522 / 737-8400 Fax (561) 496-5064	Client Name _____ Chart #: _____
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OUTPATIENT CLIENT RIGHTS AND RESPONSIBILITIES STATEMENT

YOU HAVE THE RIGHT TO: ▪ Be treated with courtesy, respect and dignity. ▪ You have the right to privacy. ▪ Prompt and fair answers to questions. ▪ Know who is providing services and who is in charge of your care. ▪ Know what help is available if you do not speak English. ▪ Know what rules and regulations apply to your behavior. ▪ Be told what problem you may have, what care is planned, what other kind of care is available, risks, benefits, and outcomes. ▪ Take part in decisions on your care. Get easy to follow information on the care options and what kinds of care there is for you. ▪ You have the right to say no. Refuse care, unless the law says care must be given. ▪ Tell us if you are not happy with your treatment and make suggestions for improvements. ▪ Information on the cost of treatment before care is given and if requested, counseling on how to pay for your care. ▪ Admission or the provision of services and benefits without discrimination on the basis of race, color or national origin, handicap, or age. ▪ Help with any emergency psychiatric problem that will get worse if help is not given.	YOU ARE RESPONSIBLE FOR: ▪ Telling the SCMHC staff – the best you can – all you know about your problem. What sicknesses you had in the past, if you have been in the hospital before, what medicine you take, and other things about your health. ▪ Telling SCMHC staff about any changes in how you feel. ▪ Letting SCMHC staff know that you understand what care you are going to get and you understand what you are supposed to do to help yourself. ▪ Being actively involved in your Treatment/Service Planning and treatment. ▪ Making sure you follow your Treatment/Service Plan. ▪ Not missing appointments, and calling if you can't make the appointment. ▪ What happens if you refuse help or do not follow the Treatment/Service Plan. ▪ Following all rules on client care and conduct while you are being treated at SCMHC. ▪ Providing SCMHC Staff information about changes in your address, marital or financial status.
I understand that I have the right to file a Title VI discrimination complaint or an abuse complaint with DCF or HHS by calling the Florida Abuse Registry at 1-800-96-ABUSE (962-2873), Disability Rights Florida at 1-800-342-0823 or The Joint Commission at 1-800-994-6610	

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

CLIENT: _____

Printed Name	Signature	Date
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PARENT/GUARDIAN

Printed Name	Signature	Date
--------------	-----------	------

The staff signature below shows that I have explained this statement to the client and have offered them a copy of this form.

STAFF SIGNATURE: _____

Printed Name	Signature	Date
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South County Mental Health Center, Inc. 16158 South Military Trail Delray Beach, FL 33484 (561) 495-0522 / 737-8400 Fax (561) 496-5064	Primary Care Physician (PCP) or Other Physician Contact Client Name: _____ Chart#: _____ (Or Place Client Identification Sticker Here) Date: _____
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At South County Mental Health Center we strive to provide the most comprehensive treatment for you. Based on this, we are asking that you allow us to notify your Primary Care Physician (PCP) that you are now involved in mental health counseling and/or psychiatric services. In this way there is a continuum of care between practitioners who are committed to your care and well-being.

Should you change or add providers we ask that you notify staff working with you so that we can update this information.

I will authorize the exchange and release of my information regarding pertinent health and medical needs between South County Mental Health Center, Inc. and the physician identified below. I am aware that disclosure of this information is for the purpose of assisting with diagnosis and treatment. PCP/Physician Name: _____ Address: _____ City, State, ZIP: _____ Phone: _____ FAX: _____	
Client Name (Print)	Date
Client Signature	

I currently do not have a PCP and understand that it has been recommended that I obtain one. Should I need assistance with this I will be referred to the Physicians referral program in my area. Once obtained I will notify the clinician and/or case manager assigned to my case so that the above process can be completed.	
Client Name (Print)	
Client Signature	Date

I choose not to have my PCP or any other medical provider notified of my treatment at SCMHC. I understand that should I be prescribed medication or a significant event that warrants medical consultation arises, this issue will again be discussed with me. If necessary, a medical emergency permits use and disclosure of protected health information between health care providers for treatment (the provision, coordination, or management of health care and related services) for an individual including consultation between providers regarding a client and referral of a client.	
Client Name (Print)	
Client Signature	Date

Client's Printed Name

Client's HIM number

**SOUTH COUNTY MENTAL HEALTH CENTER, INC.
16158 SOUTH MILITARY TRAIL
DELRAY BEACH, FLORIDA 33484**

PRIVACY ACKNOWLEDGEMENT FORM

I, the undersigned, acknowledge that I have received from South County Mental Health Center a privacy notice in accordance with HIPAA and FIPA (Florida Information Protection Act) guidelines. I understand that South County Mental Health Center will make every effort to protect my personal health information and Healthcare Record in a confidential manner.

Client Signature

Date

Parent/Guardian Signature
(if client is a minor)

Date

Staff Signature/Credentials/ID#

Date

South County Mental Health Center, Inc. 16158 South Military Trail Delray Beach, Florida 33484 (561) 495-0522 / 737-8400 Fax (561) 496-5064	AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED HEALTHCARE INFORMATION (PHI) Client Name: _____ Chart # : _____ D.O.B. _____ S.S. # : _____
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I hereby request and authorize To/From _____

Name of person(s) or agency holding the Information _____

Address _____

To release written or verbal mental health and other information specified below:

☐ Admission Summary	☐ TCM Assessment			
☐ Discharge Summary	☐ Medication History	From:	(Date)	To: (Date)
☐ History & Physical	☐ Lab Reports	From:	(Date)	To: (Date)
☐ Psychiatric Evaluation	☐ Progress Notes	From:	(Date)	To: (Date)
☐ Biopsychosocial Evaluation	☐ School Records			
☐ Treatment Plan	☐ Aftercare Plan			☐ Client Status
☐ Narrative Summary	☐ Psychological testing			☐ Verbal Progress Summary
☐ Drug & Alcohol Treatment Records	☐ Intake Assessment			☐ Other: _____

To/From _____

Name of person(s) or agency requesting information _____

Address _____

For the purpose of _____

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR part 2 and HIPAA regulation 45 CFR. There are other special restrictions that apply to the release of information regarding HIV, abuse reports, etc. I also understand that if my medical condition contains treatment notes, diagnosis, or test results of HIV/AIDS and/or related conditions, these records shall also be released. I understand that once the above information is disclosed, then it may not be protected by Federal or State Privacy Laws or Regulations.

I understand that I have the right to refuse to sign this authorization or to rescind my authorization at any time prior to the release of the information. Cancellation will be effective upon the date the notice is received by the provider, but shall exclude information already furnished to the recipient before the date. A general medical authorization and subpoena duces tecum without a specific authorization to release psychiatric information must have this waiver from the client or his/her empowered representative. In the absence of my written notice, this authorization shall be revoked automatically 1 (one) year after the date of the consent as it appears below.

FORM(S) IN WHICH INFORMATION IS TO BE RELEASED : ORAL _____ WRITTEN _____ FAX _____

Expiration Date: _____

_____ Signature of Competent Client	_____ Printed Name of Competent Client	_____ Date (mm/dd/yy)	_____ Time (am/pm)
_____ When applicable, Signature of: () Guardian, () Guardian Advocate, () Health Care surrogate/proxy or () Personal Representative (if deceased)	_____ Printed Name of Substitute Decision Maker	_____ Date (mm/dd/yy)	_____ Time (am/pm)
_____ Signature of Witness	_____ Printed Name of Witness	_____ Date (mm/dd/yy)	_____ Time (am/pm)

I wish to revoke my authorization to release HIM information: Initials _____ Date _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected pursuant to 42 CFR part 2, HIPAA regulation 45 CFR, and Florida Statutes 394.4615, and Florida Administrative Code 65E5.250. Any further disclosure is strictly prohibited unless the client provides specific written authorization for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public record law. Date sent out: _____

NATIONAL VOTER REGISTRATION ACT
Preference Form

Client's preference (check the box only in 1, or 2)

If you do not check any box, it will be considered that you chose not to register or update your voter registration at this time.

1. If you are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No, I decline

2. If you are registered to vote where you live now, would you like to update your voter registration record? ☐ Yes ☐ No, I decline

CLIENT PRINT NAME

CLIENT SIGNATURE

DATE

=====Notice of Rights=====

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250.

Forms for filing a complaint are available at <http://election.dos.state.fl.us/nvra/index.shtml> or call 1-850-245-6200 (Authority: National Voter Registration Act (42 U.S.C. 1973gg); sections 97.023, 97.058 and 97.0585, F.S.)

=====

SCMHC Use Only (check all that apply)

(Note: Only a client who is eligible can decline or accept an opportunity to register to update a record on his or her behalf)

- Be a U.S. citizen (a lawful permanent resident cannot register or vote)
- Be at least 18 years old (you may pre-register if you are at least 16 although you cannot vote until you are 18).
- Be a Florida resident
- Have had your right to vote restored if you have ever been convicted of a felony
- Have had your right to vote restored if a court has ever declared you to be mentally incapacitated as to your right to vote

1. Is client eligible to vote? ☐ Yes ☐ No
2. Client applied for: ☐ New services/assistance ☐ Renewal of services/assistance ☐ Address change
3. How client applied: ☐ In Person ☐ By phone ☐ At Home ☐ Online/web service
4. Client: ☐ Submitted registration application ☐ Was sent form/application on ____/____/____(date)
☐ Did not complete application/took form/application

CLIENT COPY



FINANCIALLY ASSISTED AGENCIES (FAA) NETWORK CONSENT TO DISCLOSE CONFIDENTIAL INFORMATION IN CLIENT RECORD

AGENCY NAME: South County Mental Health Center, Inc.

This document is intended to provide you with information regarding our disclosure of confidential information contained in your client record.

The Financially Assisted Agencies (FAA) Network is a collaborative group of organizations that provide health and human services funded by Palm Beach County Board of County Commissioners.

The Financially Assisted Agencies (FAA) Network is committed to ensuring that the information maintained in your client records remains confidential, secure, and can be accessed only by individuals authorized to do so.

The Financially Assisted Agencies (FAA) Network uses a data collection and management system. **Your information will be maintained securely and is only shared with your consent, by signing this form.**

The Financially Assisted Agencies (FAA) Network service providers will disclose to authorized staff the required data base demographic and Personal Health Information (PHI) about you. Disclosure is for the purpose of coordinating payment for care and to demonstrate that the quality of care provided is in accordance with accepted standards.

Information entered into the database will be maintained for an indefinite timeframe.

You have the right to request a copy of your file.

You have the right to refuse to answer any or all questions you consider sensitive.

You have the right to cancel this release of information for any future data input; however certain programs may have statutory mandated information requirements.

Client Name: _____

CLIENT NAME: _____

South County Mental Health Center, Inc.

_____(AGENCY NAME) is mandated to collect certain personal information that is entered and saved in a database system. Records are maintained in an encrypted database, on a secure server. Aggregate reports may be used for advocacy, and any client information used will be done so without revealing names or other information that would identify any specific client.

I _____ (Print Name) hereby provide my consent and authorization for South County Mental Health Center, Inc. (AGENCY NAME) to enter my client-specific service information in the encrypted database. This authorization allows the disclosure and sharing of the information entered into the database with the funder of the Financially Assisted Agency (FAA) Network.

Client Signature

Date

Witness Signature

Date

CLIENT NAME: _____

Acknowledgement of receipt of this form:

This is to acknowledge that I have reviewed this form, and have discussed it with the worker whose signature appears below. I consent to entering into a client-provider relationship in order to receive needed services. I have:

_____ Received a copy of this form
(Initial)

_____ Declined a copy of this form
(Initial)

Patient-Client / Representative / Guardian's Signature

Date

Patient- Client Representative / Guardian's Relationship

Agency Representative Signature

Date

Printed Name of Agency Representative

THE ORIGINAL SIGNED COPY OF THIS FORM IS FILED IN THE PATIENT/CLIENT'S RECORD

CLIENT NAME: _____

WITHDRAWAL OF CONSENT

I, _____ hereby WITHDRAW THIS CONSENT, effective

Date of withdrawal

Client/Representative

Signature Date

Client/Representative Signature

Signature/Date

Witness

Client ID

Client Date of Birth

Personal Safety Plan

Name: _____

Date: _____

You can document on this form suggested calming strategies IN ADVANCE of a crisis. You can list things that are helpful when you are under stress or are upset. You can also identify things that make you angry. Staff and residents receiving services can enter into a "partnership of safety" using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions.

1. Calming Strategies:

It is helpful for us to be aware of things that help you feel better when you're having a hard time. Please indicate (5) activities that have worked for you, or that you believe would be the most helpful. If there are other things that work well for you that we didn't list, please add them in the box marked "Other". We may not be able to offer all of these alternatives, but we would like to work together with you to determine how we can best help you while you're here.

☐ Listen to music	☐ Exercise
☐ Read a book	☐ Pace in the halls
☐ Wrapping in a blanket	☐ Have a hug with my consent
☐ Write in a journal	☐ Drink a beverage
☐ Watch TV	☐ Dark room (dimmed lights)
☐ Talk to staff	☐ Medication
☐ Talk with peers on the unit	☐ Read religious or spiritual material
☐ Call a friend or family member	☐ Write a letter
☐ Voluntary time in the quiet room/comfort room	☐ Hug a stuffed animal
☐ Take a shower	☐ Do artwork (painting, drawing)
☐ Go for a walk with staff	☐ Other? (Please list below)

2. What are some of the things that make you angry, very upset or cause you to go into crisis? What are your "triggers"?

☐ Being touched	☐ Called names or made fun of
☐ Security in uniform	☐ Being forced to do something
☐ Yelling	☐ Physical force
☐ Loud Noise	☐ Being isolated
☐ Contact with person who is upsetting	☐ Some else lying about my behavior
☐ Being restrained	☐ Being threatened

3. Signals of Distress: Please describe your warning signals, for example, what you know about yourself, and what other people may notice when you begin to lose control. Check those things that most describe you when you're getting upset. This information will be helpful so that together we can create new ways of coping with anger and stress:

☐ Sweating	☐ Clenching teeth
☐ Crying	☐ Not taking care of self
☐ Breathing hard	☐ Running
☐ Yelling	☐ Clenching fists
☐ Hurting others	☐ Swearing
☐ Throwing Objects	☐ Not eating
☐ Pacing	☐ Being rude
☐ Injuring self: (Please be specific)	☐ Other? (Please list below)

11. Trauma History:

Do you have any issues regarding abuse such as sexual or physical abuse that you would like to talk about with staff, or with a counselor? Yes _____ No _____

Would you like more information on these issues in classes or support groups? Yes _____ No _____

12. Anything Else?

Is there anything else that would make your stay easier and more comfortable? For example, do you have any special issues like cultural, diet, sexual preference, appearance, etc. that you think could contribute to misunderstandings or cause problems for you? Please describe:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

The Personal Safety Form Information should be presented to the treatment team and incorporated into the treatment plan for this individual. Each individual shall receive a copy. This form has been adapted from an original form created by the Massachusetts Department of Mental Health.

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		Circle	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.			Score:

Interpretation of Score		
Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	N/A
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? <u>Note:</u> By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	N/A	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	N/A	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? <u>Note:</u> Do not answer "yes" for any event you already reported in Questions 1-9	No Yes	N/A	N/A

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____

DATE: _____

Over the last 2 weeks, how often have you been
bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns

+

+

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

Generalized Anxiety Disorder (GAD-7 Anxiety) Scale

Over the last two weeks how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

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

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

☐
☐
☐
☐

Source: Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved.
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COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann
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RISK ASSESSMENT VERSION

(* elements added with permission for Lifeline centers)

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Suicidal and Self-Injury Behavior (Past week)		Clinical Status (Recent)	
☐ Actual suicide attempt	☐ Lifetime	☐ Hopelessness	
☐ Interrupted attempt	☐ Lifetime	☐ Helplessness*	
☐ Aborted attempt	☐ Lifetime	☐ Feeling Trapped*	
☐ Other preparatory acts to kill self	☐ Lifetime	☐ Major depressive episode	
☐ Self-injury behavior w/o suicide intent	☐ Lifetime	☐ Mixed affective episode	
Suicide Ideation (Most Severe in Past Week)		☐ Command hallucinations to hurt self	
☐ Wish to be dead		☐ Highly impulsive behavior	
☐ Suicidal thoughts		☐ Substance abuse or dependence	
☐ Suicidal thoughts with method (but without specific plan or intent to act)		☐ Agitation or severe anxiety	
☐ Suicidal intent (without specific plan)		☐ Perceived burden on family or others	
☐ Suicidal intent with specific plan		☐ Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)	
Activating Events (Recent)		☐ Homicidal ideation	
☐ Recent loss or other significant negative event		☐ Aggressive behavior towards others	
Describe:		☐ Method for suicide available (gun, pills, etc.)	
		☐ Refuses or feels unable to agree to safety plan	
☐ Pending incarceration or homelessness		☐ Sexual abuse (lifetime)	
☐ Current or pending isolation or feeling alone		☐ Family history of suicide (lifetime)	
Treatment History		Protective Factors (Recent)	
☐ Previous psychiatric diagnoses and treatments		☐ Identifies reasons for living	
☐ Hopeless or dissatisfied with treatment		☐ Responsibility to family or others; living with family	
☐ Noncompliant with treatment		☐ Supportive social network or family	
☐ Not receiving treatment		☐ Fear of death or dying due to pain and suffering	
Other Risk Factors		☐ Belief that suicide is immoral, high spirituality	
☐		☐ Engaged in work or school	
		☐ Engaged with Phone Worker *	
		Other Protective Factors	
		☐	

Describe any suicidal, self-injury or aggressive behavior (include dates):

SUICIDAL BEHAVIOR (Check all that apply, so long as these are separate events; must ask about all types)		Lifetime	Past 3 months
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, <i>as a result of act</i> . Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is <i>any</i> intent/desire to die associated with the act, then it can be considered an actual suicide attempt. <i>There does not have to be any injury or harm</i> , just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. Have you made a suicide attempt? Have you done anything to harm yourself? Have you done anything dangerous where you could have died? What did you do? Did you _____ as a way to end your life? Did you want to die (even a little) when you _____? Were you trying to end your life when you _____? Or Did you think it was possible you could have died from _____? Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)? (Self-Injurious Behavior without suicidal intent) If yes, describe:		Yes No ☐ ☐ Total # of Attempts _____	Yes No ☐ ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior? Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything? If yes, describe:		Yes No ☐ ☐ Total # of interrupted _____	Yes No ☐ ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything? If yes, describe:		Yes No ☐ ☐ Total # of aborted or self-interrupted _____	Yes No ☐ ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)? If yes, describe:		Yes No ☐ ☐ Total # of preparatory acts _____	Yes No ☐ ☐ Total # of preparatory acts _____
		Most Recent Attempt Date:	Most Lethal Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death		Enter Code _____	Enter Code _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care		Enter Code _____	Enter Code _____

SUICIDAL IDEATION		Lifetime: Time He/She Felt Most Suicidal	Past 1 month
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.			
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. <i>Have you actually had any thoughts of killing yourself?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it." <i>Have you been thinking about how you might do this?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to "I have the thoughts but I definitely will not do anything about them." <i>Have you had these thoughts and had some intention of acting on them?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
INTENSITY OF IDEATION The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.			
<u>Lifetime - Most Severe Ideation:</u> Type # (1-5) _____ Description of Ideation _____		Most Severe	Most Severe
<u>Recent - Most Severe Ideation:</u> Type # (1-5) _____ Description of Ideation _____			
Frequency <i>How many times have you had these thoughts?</i> (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day		—	—
Duration <i>When you have the thoughts how long do they last?</i> (1) Fleeting - few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8 hours/persistent or continuous (3) 1-4 hours/a lot of time		—	—
Controllability <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (6) Does not attempt to control thoughts		—	—
Deterrents <i>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (4) Deterrents most likely did not stop you (2) Deterrents probably stopped you (5) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (6) Does not apply		—	—
Reasons for Ideation <i>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</i> (1) Completely to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (2) Mostly to get attention, revenge or a reaction from others (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (6) Does not apply		—	—