

Welcome to Psychiatric Solutions. We are fully committed to you and promise to deliver the highest quality of care in a welcoming, friendly, and confidential environment.

The contents of this packet are intended to help us meet your needs. Please read and review the enclosed information, sign and date all forms where indicated, and bring the completed packet to your appointment.

**Please note: You will not be able to attend your appointment unless this packet is completed.**

In this packet, you will find the following information:

- **Consent for Services:** You have the right to give or refuse consent to treatment.
- **Patient Financial Responsibilities**
- **Notice of Privacy Practices: Acknowledgement of Receipt**
- **Authorization for Disclosure of Health Information:** You give us permission to release medical records to individuals, therapists, and/or doctors pertaining to your care. (Optional)
- **New Patient Packet:** Please provide us with as much accurate information as possible in this packet to allow us to provide you with the best possible care.

We look forward to working with you and want to provide you with the best possible care. If you have any questions, comments, or concerns, please ask a member of your team.

## COUNSELOR DISCLOSURE STATEMENT

The State of Washington requires us to disclose the following information to you about Psychiatric Solutions:

### **SPOKANE ADDRESS:**

Psychiatric Solutions  
1620 North Mamer Rd. Building B-100  
Spokane Valley, WA 99216

Division of Behavioral Health and Recovery (DBHR) License Number: 200528

### **AGENCY PHILOSOPHY:**

At Psychiatric Solutions, we believe that a multi-disciplinary approach is the most effective method to providing quality care. We are proud of our high patient satisfaction. Our staff is knowledgeable, compassionate, and skilled in the most effective psychotherapeutic techniques.

Our Spokane behavioral health facility has a psychiatrist, psychologists, marriage and family therapists, social workers and a psychiatric health nurse practitioner available to help our patients. Together, we work under the direction of board-certified psychiatrists with a long history of service to patients in Eastern Washington. Our psychiatrists assess patients, prescribe and manage medications, and provide individualized treatment as needed.

### **COUNSELOR EDUCATION & CREDENTIALS:**

1. **Clinician Name:** Alicia Tomlinson, LSWAIC  
**Credential Type:** Social Worker Associate Independent Clinical License  
**Credential Number:** SC60998709
2. **Clinician Name:** Jennah Kay Marie Blossom, LMHCA  
**Credential Type:** Mental Health Counselor Associate  
**Credential Number:** MC61053752
3. **Clinician Name:** Lindsey Barre, LSWAIC  
**Credential Type:** Social Worker Associate Independent Clinical License  
**Credential Number:** SC61151736
4. **Clinician Name:** Victoria Marie Facciola, LMHCA  
**Credential Type:** Mental Health Counselor Associate  
**Credential Number:** MC61024422

### **METHODS OR TECHNIQUES AND TYPE OF COUNSELING USED BY PSYCHIATRIC SOLUTIONS CLINICIANS:**

Psychiatric Solutions provides comprehensive, personalized treatment programs for behavioral health disorders. We combine our evidence-based treatment with personalized integrative interventions. We utilize person-centered, strengths-based and solution-focused therapies during the course of the treatment program.

### **FEE INFORMATION/BILLING PRACTICES:**

Please refer to the Financial Responsibility Agreement and Attendance Policy Acknowledgement.

**COUNSELOR DISCLOSURE STATEMENT (CONTINUED)**

**CONFIDENTIALITY:**

Please refer to the Informed Consent for Therapeutic Services.

**COMPLAINTS/GRIEVANCES:**

Please refer to the Grievance Procedure.

Contact information to make a complaint about a healthcare provider to the Department of Health (DOH) is available upon request.

**SIGNATURE**

My signature indicates that I have provided the client listed below with a copy of Psychiatric Solutions Counselor Disclosure Statement for my location (where applicable). I have reviewed the education, training, experience, methods and/or techniques and type of counseling used by Psychiatric Solutions clinicians with the client listed below.

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor Name (printed w/credential): \_\_\_\_\_

My signature indicates that I have been provided with a copy of Psychiatric Solutions Counselor Disclosure Statement and that I have read and understand the information. I understand that during the course of my treatment at Psychiatric Solutions, my treatment team may consist of any or all of the therapists listed on this disclosure in addition to any or all of the disciplines listed above.

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a minor, guardian/parent\*:

Please print name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\*Required if client is a minor and under the state-mandated age of consent.

**INDIVIDUAL RIGHTS**

**You Have the Right to:**

1. Receive services without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria.
2. Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service.
3. Be reasonably accommodated in the event of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences.
4. Be treated with respect, dignity, and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.
5. Be free of any sexual harassment.
6. Be free of exploitation, including physical and financial.
7. Have all clinical and personal information treated in accord with state and federal confidentiality regulations.
8. Review your clinical records in the presence of the Administrator or designee and be given an opportunity to request amendments or corrections.
9. Participate in the creation of your individualized care plan and be offered a copy.
10. Receive a copy of patient grievance procedures upon request and to lodge a complaint or grievance with the agency, if you believe that your rights have been violated.
11. File a complaint with the Department of Health when you feel the agency has violated a requirement that regulates behavioral health agencies.
12. Report concerns about the safety and quality of your care to The Joint Commission. A report can be filed with The Joint Commission here: [www.jointcommission.org/report\\_a\\_complaint.aspx](http://www.jointcommission.org/report_a_complaint.aspx). The Joint Commission’s Customer Service line can also be reached at (630) 792-5800.

**SIGNATURE**

Insured’s Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Insured’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a minor, guardian/parent\*:

Please print name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\*Required if client is a minor and under the state-mandated age of consent.

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## STATEMENT OF UNPROFESSIONAL CONDUCT

Counselors are subject to discipline by the Department of Health. Cause for disciplinary action for unprofessional conduct is found in RCW 18.130.180 and includes the following:

1. The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW.
2. Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
3. All advertising which is false, fraudulent, or misleading;
4. Incompetence, negligence, or malpractice which result in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
5. Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;
6. The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, violation of any drug law, or prescribing controlled substances for oneself;
7. Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
8. Failure to cooperate with the disciplining authority by:
  - a. Not furnishing any papers, documents, records, or other items;
  - b. Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority.
  - c. Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or
  - d. Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder.
9. Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;
10. Aiding or abetting an unlicensed person to practice when a license is required;
11. Violation of rules established by any health agency;
12. Practice beyond the scope of practice as defined by law or rule;
13. Misrepresentation or fraud in any aspect of the conduct of the business or profession;
14. Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;
15. Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

**STATEMENT OF UNPROFESSIONAL CONDUCT (CONTINUED)**

- 16. Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;
- 17. Conviction of any gross misdemeanor or felony relating to the practice of the person’s profession. For the purpose of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96 RCW.
- 18. The procuring, or aiding or abetting in procuring, a criminal abortion;
- 19. The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means or procedure which the licensee refuses to divulge upon demand on the disciplining authority;
- 20. The willful betrayal of a practitioner-patient privilege as recognized by law;
- 21. Violation of chapter 19.68 RCW;
- 22. Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;
- 23. Current misuse of:
  - a. Alcohol;
  - b. Controlled substance; or
  - c. Legend drugs;
- 24. Abuse of a client or patient or sexual contact with a client or patient;
- 25. Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vender of medical or health-related products or services intended for patients, in contemplation of a sale of for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

Anyone having questions or wishing to file a complaint should write or call:

Washington State Department of Health  
 Health Systems Quality Assurance  
 Complaint Intake  
 P.O. box 47857  
 Olympia, WA 98504-7857  
 Local: 360-236-4700  
 Email: [HSQAComplaintIntake@doh.wa.gov](mailto:HSQAComplaintIntake@doh.wa.gov)

**SIGNATURE**

Patient’s Name: _____	Birth Date: _____
Patient’s Signature: _____	Date: _____
If a minor, guardian/parent:	
Please print name: _____	Relationship: _____
Signature: _____	Date: _____
Staff Signature: _____	Date: _____

**CONSENT FOR SERVICES**

**The Right to Consent**

Washington law provides that all patients, including those who receive behavioral health services, have the right to give or refuse consent of treatment. All mental health patients have the right to:

- An explanation of their diagnosis;
- Information about their recommended treatment, including the possible risks and expected benefits;
- Any alternatives to the recommended treatment, along with the risks and benefits of such alternatives; and
- Give or refuse to give consent for treatment.

By signing below, I am voluntarily agreeing to receive mental health services from Psychiatric Solutions. These services may include psychiatric evaluation, psychotherapy and medication management. I understand that I may decide to stop such treatment or services at any time. I understand that my medical information is protected by federal and state confidentiality laws and that my treatment information will be kept confidential to the extent possible by law.

\_\_\_\_\_ **I have read and have understood the information above regarding Consent for Services.**  
 (Initial)

**NOTICE OF PRIVACY PRACTICE**

**Notice of Privacy Practices: Acknowledgement of Receipt**

By signing this form, you acknowledge receipt of the 'Notice of Privacy Practices' of Psychiatric Solutions, P.C. Our 'Notice of Privacy Practices' provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our 'Notice of Privacy Practices' is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 509-863-9608.

If you have any questions about our 'Notice of Privacy Practices', please contact Psychiatric Solutions, P.C.

I acknowledge receipt of the 'Notice of Privacy Practices' of Psychiatric Solutions, P.C.

\_\_\_\_\_ **I acknowledge receipt of the "Notice of Privacy Practices" of Psychiatric Solutions, P.C.**  
 (Initial)

**SIGNATURE**

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a minor, guardian/parent\*:

Please print name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\*Required if client is a minor and under the state-mandated age of consent.

**SUBSTANCE USE CONTRACT**

Patient (Name): \_\_\_\_\_

Agrees to avoid the use of any non-prescribed substances for recreational or self-medication purposes while participating in this program at Psychiatric Solutions. I understand that failing to do so will jeopardize my eligibility to participate further in the program through Psychiatric Solutions. This agreement is based on my understanding of the fact that using illicit drugs will interfere with my ability to achieve therapeutic gains. I also agree to the following:

1. I agree to be assessed for Agonist therapy and agree to consider this treatment if the treatment team believes it would be beneficial for my progress.
2. I agree to consider residential substance abuse treatment, if I experience multiple failures in compliance.
3. It is the policy of Psychiatric Solutions that when you enter the program we have the right to require you to submit to a urinalysis. The testing will be at random and may or may not be required during your program attendance.
4. I understand that the purpose of this agreement is to ensure my successes in treating my mental health issues without the interference of substances. I also understand that this agreement will be utilized as a treatment tool to help me comply with my treatment goals. I also understand that failing to comply with the above terms repeatedly will jeopardize my ability to participate in the program.

\_\_\_\_\_ **I have read and have understood the information above regarding the Substance Use Contract.**  
(Initial)

**CONSENT FOR DRUG TEST**

Patient (Name): \_\_\_\_\_

Hereby gives his/her permission for testing his/her urine at a lab designated for such for the duration of his/her treatment attendance.

The results of the urine analysis will be kept confidential to the extent possible by law. If the lab report returns positive, this does not necessarily mean that you will be unable to continue treatment with Psychiatric Solutions. The purpose of this test is to help measure and formulate your needs and treatment strategy. Thank you for your cooperation.

Psychiatric Solutions would also like to notify you that there will be a collection charge from our office and the urine analysis will be sent to an outside source for processing. Billing for this service will be in accordance with standard Psychiatric Solutions, P.C., policies.

\_\_\_\_\_ **I have read and have understood the information above regarding Consent for Drug Test.**  
(Initial)

**SIGNATURE**

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a minor, guardian/parent\*:

Please print name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\*Required if client is a minor and under the state-mandated age of consent.



**CONFIDENTIALITY STATEMENT**

**GENERAL**

All information concerning patients, their presence in this program, and their medical condition is confidential. This privacy is protected by both federal and state laws. In signing below, I acknowledge that I have been informed of the requirement for confidentiality with respect to patients, and that I agree to abide by the same.

**CONFIDENTIALITY OF SUBSTANCE ABUSE PATIENT RECORDS**

The confidentiality of alcohol and drug abuse patient records maintained by Psychiatric Solutions is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser, unless:

- The patient consents in writing;
- The disclosure is allowed by a court order; or
- To report suspected abuse of a child or vulnerable adult;
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations (Federal Regulations 45 CFR Parts 160 & 164 and 42CFR, Part 2) by this program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations

Federal law and regulations do not protect any information about a crime committed by a patient either at this program or against any person who works for this program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

**PARTICIPATION IN GROUPS**

I understand that all issues discussed in groups in which I participate are highly confidential. Such information shall not be discussed outside the group sessions with anyone other than my therapist or physician.

My signature below indicates my agreement to comply with the confidentiality policy.

\_\_\_\_\_ **I have read and have understood the information above regarding the Confidentiality Statement.**  
 (Initial)

**SIGNATURE**

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a minor, guardian/parent\*:

Please print name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\*Required if client is a minor and under the state-mandated age of consent.

**INSURANCE BENEFITS**

I hereby authorize payment of the insurance benefits otherwise payable to me to be paid directly to my physician. I hereby authorize release of information necessary to file a claim with my insurance company. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

\_\_\_\_\_ I have read and have understood the information above regarding Insurance Benefits.  
 (Initial)

**SIGNATURE**

Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Insured's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a minor, guardian/parent\*:

Please print name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\*Required if client is a minor and under the state-mandated age of consent.

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PATIENT FINANCIAL RESPONSIBILITIES**

The fundamental ingredient in the psychotherapeutic relationship is clear communication between the doctor and the patient. This philosophy extends to our policies on fees and services. Please feel free to discuss these with us at any time.

**INSURANCE:** If you have insurance that covers this service, we will be happy to bill your insurance company. **Your co-payment is due and payable at the time of each session.** If you are unable to make payment at the time of service, your appointment will be rescheduled.

**\*\*We will need a copy of your current insurance card at the time of your appointment. If you do not have your insurance card with you at the time of your appointment, you must present one within 30 days of your appointment or all charges will be billed to you.**

Please note that the Mental Health portion of insurance coverage often differs from other medical coverage. Pre-authorization is often required. Some mental health services may not be covered by your health insurance plan or may only be partially covered. We strongly suggest you contact your insurance company before treatment begins to be certain that you thoroughly understand both your obligation and that of the insurance company regarding mental health coverage. If we provide services to you that are not covered by your health insurance plan, you will be responsible for payment in full for those services. If we provide services to you that are only partially covered by your health insurance plan, you may be responsible for the remainder of payment for those services. Your signature below constitutes agreement to pay for such services.

As a courtesy, our office will contact your insurance company on your behalf to check your benefits and work to obtain authorization for services rendered. If we are not contracted with your insurance company, and if no out-of-network benefits are available, we will work with your insurance company to try and obtain 'Single Case Agreement.' Please understand an authorization of a Single Case Agreement is not a guarantee of payment and we will be unaware of how your benefits will be applied until your claim is processed by your insurance company. We highly recommend and encourage you to call your insurance company to verify your benefits and understand them prior to any service rendered. Any questions regarding how your insurance company processed your claim needs to be directed to your insurance company. All co-pays are required at the time of service. If you are in one of our programs it is required that your care, be followed by a physician. Your co-pay is required at each of those office visits.

**I understand that I am financially responsible for any balance not covered by my insurance carrier, including but not limited to deductibles, co-pays, co-ins, or any out-of-pocket percentages. A copy of this signature is as valid as the original.**

**LATE CANCELLATIONS AND MISSED APPOINTMENTS:** Your appointment time has been reserved for you. If you must cancel an appointment, contact us within 24 hours at (509) 863-9779 so that we may schedule another patient on the waiting list. If our office is not notified of a cancellation 24 hours in advance of your scheduled appointment, **you will be charged \$125 fee for a no-show for appointments. As a courtesy to our office and other patients, we ask that you please cancel your appointments within the 24-hour period to avoid the no-show charge, and to allow us to schedule another patient during that time. The PHP and IOP programs are excluded from this policy but we strongly encourage all patients to provide as much notice as possible prior to missing a session. Please be informed that three consecutive no-shows could lead to termination of care.**

**CONSULTATIVE REPORTS AND FORMS:** As a courtesy, we will send a report to the professional who referred you at no additional charge. You may need to request completion of other reports or forms. Fees for this service are determined on an individual basis; **typically, the charge is \$15** depending on the length and complexity of the report. Insurance does not cover this service and payment is due upon completion of the report.

You may have a copy of this for your records upon request.

\_\_\_\_\_ **I have read and have understood the information above regarding Patient Financial Responsibilities.**  
 (Initial)

**SIGNATURE**

Patient's Name: _____	Birth Date: _____
Patient's Signature: _____	Date: _____
If a minor, guardian/parent:	
Please print name: _____	Relationship: _____
Signature: _____	Date: _____

**NEW PATIENT PACKET**

**How did you hear about us?**    Website    Billboard    Referred by: \_\_\_\_\_    Other: \_\_\_\_\_

**For what problem(s) do you seek help?**

**DEMOGRAPHICS**

Name:		Date of Birth (DOB):		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Primary Care Physician:				SSN:	
Home Address:			City	State	Zip
Mailing Address:			City	State	Zip
Phone Numbers:	Home:	OK to leave Msg: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell:	OK to leave Msg: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Work:	OK to leave Msg: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	OK to leave Msg: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address:					
Emergency Contact:		Phone #:	Relationship:		

**IF PATIENT IS A MINOR:**

Do you have legal custody? <input type="checkbox"/> Yes <input type="checkbox"/> No	If divorced, has either parent had parental rights terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Legal Guardian's Name:	Relationship to Patient:
Legal Guardian's SSN:	Guardian's DOB:
Is Patient a Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	School:

**INSURANCE INFORMATION**

<b>Primary Insurance:</b>	Policy Holder Name:
Patient ID #:	Policy Holder DOB:
Group #:	Relationship:
<b>Secondary Insurance:</b>	Policy Holder Name:
Patient ID #:	Policy Holder DOB:
Group #:	Relationship:

<b>PSYCHIATRIC HISTORY (Please check any that apply)</b>					
	<b>DURING THE PAST 4 WEEKS, HOW MUCH HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?</b>	<b>NOT BOTHERED (0)</b>	<b>BOTHERED A LITTLE (1)</b>	<b>BOTHERED A LOT (2)</b>	
Stomach pain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Back pain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain in your arms, legs, or joints (knees, hips, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Menstrual cramps or other problems with your periods (WOMEN ONLY)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting spells		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeling your heart pound or race		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain or problems during sexual intercourse		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation, loose bowels, or diarrhea		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea, gas, or indigestion		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeling tired or having low energy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble sleeping		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<b>OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?</b>	<b>NOT AT ALL (0)</b>	<b>SEVERAL DAYS (1)</b>	<b>MORE THAN HALF THE DAYS (2)</b>	<b>NEARLY EVERY DAY (3)</b>
Feeling down, depressed, irritable, or hopeless		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Little interest or pleasure in doing things		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling asleep, staying asleep, or sleeping too much		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite, weight loss, or overeating		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself—or that you are a failure, or that you have let yourself or your family down		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things like schoolwork, reading, or watching TV		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people could have noticed		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead or of hurting yourself in some way		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>YES</b>	<b>NO</b>
In the <b>past year</b> have you felt depressed or sad most days, even if you felt okay sometimes?				<input type="checkbox"/>	<input type="checkbox"/>
<b>IF YOU CHECKED OFF ANY OF THESE 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?</b>					
<b>NOT DIFFICULT AT ALL</b>	<b>SOMEWHAT DIFFICULT</b>	<b>VERY DIFFICULT</b>	<b>EXTREMELY DIFFICULT</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

	YES	NO
Has there been a time in the <b>past month</b> when you have had serious thoughts about ending your life?	<input type="checkbox"/>	<input type="checkbox"/>
Have you <b>EVER</b> , in your <b>WHOLE LIFE</b> , tried to kill yourself or made a suicide attempt?	<input type="checkbox"/>	<input type="checkbox"/>

**CHOOSE THE ONE STATEMENT IN EACH GROUP THAT BEST DESCRIBES THE WAY YOU HAVE BEEN FEELING FOR THE PAST WEEK.**

*Check the box next to the number/statement selected. Please note: the word "occasionally" when used here means once or twice; "often" means several times or more; and "frequently" means most of the time.*

**QUESTION 1**

- 0** I do not feel happier or more cheerful than usual.
- 1** I occasionally feel happier or more cheerful than usual.
- 2** I often feel happier or more cheerful than usual.
- 3** I feel happier or more cheerful than usual most of the time.
- 4** I feel happier or more cheerful than usual all of the time.

**QUESTION 2**

- 0** I do not feel more self-confident than usual.
- 1** I occasionally feel more self-confident than usual.
- 2** I often feel more self-confident than usual.
- 3** I feel more self-confident than usual most of the time.
- 4** I feel extremely more self-confident all of the time.

**QUESTION 3**

- 0** I do not need less sleep than usual.
- 1** I occasionally need less sleep than usual.
- 2** I often need less sleep than usual.
- 3** I frequently need less sleep than usual.
- 4** I can go all day and night without any sleep and still not feel tired.

**QUESTION 4**

- 0** I do not talk more than usual.
- 1** I occasionally talk more than usual.
- 2** I often talk more than usual.
- 3** I frequently talk more than usual.
- 4** I talk constantly and cannot be interrupted.

**QUESTION 5**

- 0** I have not been more active (either socially, sexually, at work, home or school) than usual.
- 1** I have occasionally been more active than usual.
- 2** I have often been more active than usual.
- 3** I have frequently been more active than usual.
- 4** I am constantly active or on the go all the time.

*Permission for use granted by EG Altman, MD*

	<b>CHECK THE COLUMN THAT SHOWS HOW OFTEN EACH OF THESE THINGS HAPPEN TO YOU (NO RIGHT OR WRONG ANSWERS)</b>	<b>NEVER (0)</b>	<b>SOMETIMES (1)</b>	<b>OFTEN (2)</b>	<b>ALWAYS (3)</b>
1. I worry about things		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I am scared of the dark		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When I have a problem, I get a funny feeling in my stomach		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I feel afraid		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I would feel afraid of being on my own at home		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I feel scared when I have to take a test		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I feel afraid if I have to use public toilets or bathrooms		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I worry about being away from my parents		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I feel afraid that I will make a fool of myself in front of people		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I worry that I will do badly at my school work		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I am popular amongst kids my own age		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I worry that something awful will happen to someone in my family		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I suddenly feel as if I can't breathe when there is no reason for this		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I have to keep checking that I have done things right (like the switch is off, or the door is locked)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I feel scared if I have to sleep on my own		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I have trouble going to school in the mornings because I feel nervous or afraid		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I am good at sports		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I am scared of dogs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I can't seem to get bad or silly thoughts out of my head		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. When I have a problem, my heart beats really fast		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I suddenly start to tremble or shake when there is no reason for this		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I worry that something bad will happen to me		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I am scared of going to the doctor's or dentist's		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. When I have a problem, I feel shaky		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I am scared of being in high places or lifts (elevators)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I am a good person		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I have to think of special thoughts to stop bad things from happening (like numbers or words)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. I feel scared if I have to travel in the car, or on a bus or a train		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I worry what other people think of me		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. I feel happy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. All of a sudden I feel really scared for no reason at all		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. I am scared of insects or spiders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. I suddenly become dizzy or faint when there is no reason for this		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. I feel afraid if I have to talk in front of my class		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. My heart suddenly starts to beat too quickly for no reason		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	NEVER (0)	SOMETIMES (1)	OFTEN (2)	ALWAYS (3)
37. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. I like myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. I am afraid of being in small closed places, like tunnels or small rooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. I have to do some things over and over again (like washing my hands, cleaning, or putting things in a certain order)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. I get bothered by bad or silly thoughts or pictures in my mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. I have to do some things in just the right way to stop bad things happening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. I am proud of my school work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. I would feel scared if I had to stay away from home overnight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES		NO	
Is there something else that you are really afraid of?	<input type="checkbox"/>			<input type="checkbox"/>
Please write down what it is:				
How often are you afraid of this thing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	IN THE PAST MONTH, HOW MUCH HAVE YOU BEEN BOTHERED BY...	NOT AT ALL (1)	A LITTLE BIT (2)	MODERATELY (3)	QUITE A BIT (4)	EXTREMELY (5)
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Repeated, disturbing <i>dreams</i> of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Suddenly <i>acting or feeling</i> as if a stressful experience were happening again (as if you were reliving it)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Feeling <i>very upset</i> when something reminded you of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Avoid <i>thinking about or talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Avoid <i>activities or situations</i> because they remind you of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Trouble <i>remembering important parts</i> of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Loss of <i>interest in things that you used to enjoy</i> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Feeling <i>distant or cut off</i> from other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Trouble <i>falling or staying asleep</i> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Having <i>difficulty concentrating</i> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Being " <i>super alert</i> " or watchful on guard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Feeling <i>jumpy</i> or easily startled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>THE CAGE (ACRONYM) IS A 4-ITEM QUESTIONNAIRE THAT CAN INDICATE POTENTIAL PROBLEMS WITH ALCOHOL ABUSE. PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:</b>	<b>YES (1)</b>	<b>NO (0)</b>
	Have you ever felt you need to <u>C</u> ut down on your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
	Have people <u>A</u> nnoyed you by criticizing your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever felt <u>G</u> uilty about drinking?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever felt you needed a drink first thing in the morning ( <u>E</u> ye-opener) to steady your nerves or get rid of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>

	<b>COLUMBIA-SUICIDE SEVERITY RATING SCALE SUICIDE IDEATION DEFINITIONS AND PROMPTS</b>	<b>PAST MONTH</b>	
<b>Ask questions 1 and 2</b>		<b>YES</b>	<b>NO</b>
1)	<b>Wish to be Dead:</b> <u><i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></u> (Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.)	<input type="checkbox"/>	<input type="checkbox"/>
2)	<b>Suicidal Thoughts:</b> <u><i>Have you actually had any thoughts of killing yourself?</i></u> (General non-specific thoughts of wanting to end one’s life/commit suicide, “ <i>I’ve thought about killing myself</i> ” without general thoughts of ways to kill oneself/associated methods, intent, or plans.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>If YES to 2, ask questions 3, 4, 5, and 6. If NO, go directly to question 6.</b>		<b>YES</b>	<b>NO</b>
3)	<b>Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</b> <u><i>Have you been thinking about how you might kill yourself?</i></u> (Person 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. “ <i>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> ”)	<input type="checkbox"/>	<input type="checkbox"/>
4)	<b>Suicidal Intent (without Specific Plan):</b> <u><i>Have you had these thoughts and had some intention of acting on them?</i></u> (Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to “ <i>I have the thoughts but I definitely will not do anything about them.</i> ”)	<input type="checkbox"/>	<input type="checkbox"/>
5)	<b>Suicidal Intent with Specific Plan:</b> <u><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></u> (Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.)	<input type="checkbox"/>	<input type="checkbox"/>
6)	<b>Suicide Behavior Question:</b> <u><i>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</i></u> (Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>If YES, ask: <u>How long ago did you do any of these?</u></b> <input type="checkbox"/> Over a year ago? <input type="checkbox"/> Between three months and a year ago? <input type="checkbox"/> Within the last three months?			

QUESTIONS ABOUT PRIOR SUICIDE ATTEMPTS AND/OR SELF HARM		YES	NO
Have you attempted suicide in the past? (Over a year ago)		<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was the last suicide attempt? Please describe how you attempted suicide:			
Altogether, how many suicide attempts have you had?			
Currently are you having thoughts about hurting someone else?		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever harmed yourself without intending suicide? (I.e., cutting on yourself, burning yourself, etc.)		<input type="checkbox"/>	<input type="checkbox"/>

QUESTIONS ABOUT EATING HABITS						
	ALWAYS (3)	USUALLY (2)	OFTEN (1)	SOMETIMES (0)	RARELY (0)	NEVER (0)
I am terrified about being overweight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I avoid eating when I am hungry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find myself preoccupied with food.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have gone on eating binges where I feel that I may not be able to stop.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I cut my food into small pieces.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am aware of the calorie content of foods that I eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I particularly avoid food with a high carbohydrate content (i.e., bread, rice, potatoes, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that others would prefer if I ate more.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I vomit after I have eaten.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel extremely guilty after eating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am occupied with a desire to be thinner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think about burning up calories when I exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people think I am too thin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am preoccupied with the thought of having fat on my body.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take longer than others to eat my meals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I avoid foods with sugar in them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I eat diet foods.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that food controls my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I display self-control around food.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that others pressure me to eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I give too much time and thought to food.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am uncomfortable after eating sweets.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I engage in dieting behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I like my stomach to be empty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have the impulse to vomit after meals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy trying new rich foods.	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

	NEVER	ONCE A MONTH OR LESS	2-3 TIMES A MONTH	ONCE A WEEK	2-6 TIMES A WEEK	ONCE A DAY OR MORE
A. Gone on eating binges where you feel that you may not be able to stop? (Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Ever made yourself sick (vomited) to control your weight or shape?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Exercised more than 60 minutes a day to lose or to control your weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADHD DIAGNOSTIC RATING SCALE				
<i>Consider the context of what is appropriate for the age of your child. How would you rate your child's behaviors in the following areas over the past six months:</i>	NEVER (0)	OCCASIONALLY (1)	OFTEN (2)	VERY OFTEN (3)
Does not pay attention to details or makes careless mistakes with, for example, homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty keeping attention to what needs to be done	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not seem to listen when spoken to directly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty organizing tasks and activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is easily distracted by noises or other stimuli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is forgetful in daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fidgets with hands or feet or squirms in seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaves seat when remaining seated is expected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runs about or climbs too much when remaining seated is expected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty playing or beginning quiet play activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is "on the go" or often acts as if "driven by a motor"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talks too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurts out answers before questions have been completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty waiting his or her turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interrupts or intrudes in on others' conversations and/or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Argues with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Actively defies or refuses to go along with adults' requests or rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deliberately annoys people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blames others for his or her mistakes or misbehaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	NEVER (0)	OCCASIONALLY (1)	OFTEN (2)	VERY OFTEN (3)	
Is touchy or easily annoyed by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is angry or resentful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is spiteful and wants to get even	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bullies, threatens, or intimidates others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Starts physical fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is truant from school (skips school) without permission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is physically cruel to people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has stolen things that have value	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deliberately destroys others' property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has used a weapon that can cause serious harm (bat, knife, brick, gun)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is physically cruel to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has deliberately set fires to cause damage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has broken into someone else's home, business, or car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has stayed out at night without permission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has run away from home overnight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has forced something into sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is fearful, anxious, or worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is afraid to try new things for fear of making mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feels worthless or inferior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blames self for problems, feels guilty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is sad, unhappy, or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is self-conscious or easily embarrassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<b>EXCELLENT</b>	<b>ABOVE AVERAGE</b>	<b>AVERAGE</b>	<b>SOMEWHAT OF A PROBLEM</b>	<b>PROBLEMATIC</b>
Overall school performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mathematics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participation in organized activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>THIS CHILD STANDS OUT AS DIFFERENT FROM OTHER CHILDREN OF HIS/HER AGE IN THE FOLLOWING WAY:</b>	<b>NO (0)</b>	<b>SOMEWHAT (1)</b>	<b>YES (2)</b>
	Is old-fashioned or precocious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Is regarded as an “eccentric professor” by the other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lives somewhat in a world of his/her own with restricted idiosyncratic intellectual interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Accumulates facts on certain subjects (good rote memory) but does not really understand the meaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has a literal understanding of ambiguous and metaphorical language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has a deviant style of communication with a formal, fussy, old-fashioned or “robotlike” language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Invents idiosyncratic words and expressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has a different voice or speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Expresses sounds involuntarily; clears throat, grunts, smacks, cries or screams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Is surprisingly good at some things and surprisingly poor at others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Uses language freely but fails to make adjustment to fit social contexts or the needs of different listeners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lacks empathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Makes naïve and embarrassing remarks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has a deviant style of gaze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wishes to be sociable but fails to make relationships with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Can be with other children but only on his/her terms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lacks best friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lacks common sense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Is poor at games: no idea of cooperating in a team, scores “own goals”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has clumsy, ill-coordinated, ungainly, awkward movements or gestures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has involuntary face or body movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has difficulties in completing simply daily activities because of compulsory repetition of certain actions or thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has special routines: insists on no change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shows idiosyncratic attachment to objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Is bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has markedly unusual facial expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has markedly unusual posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

QUESTIONS ABOUT YOUR THOUGHT PROCESSES		YES	NO
While fully awake, have you heard voices talking that other people could not hear?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you seen things, such as faces, animals, or ghosts, that other people could not see?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever tasted, smelled, or felt things touching you or crawling on you when nothing was there?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you often felt or believed that people were watching you, following you, talking about you, reading your mind, putting thoughts into your mind, trying to hurt you, trying to control you in some way, or plotting against you?	<input type="checkbox"/>	<input type="checkbox"/>	
QUESTIONS ABOUT YOUR SLEEP		YES	NO
How many hours do you sleep?			
Do you have problems falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have problems staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have problems waking up earlier than you should?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your spouse or significant other complain that you snore too loudly?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have nightmares at night?	<input type="checkbox"/>	<input type="checkbox"/>	
WERE YOU EVER A VICTIM OF:		YES	NO
Childhood physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Childhood sexual abuse (molestation)	<input type="checkbox"/>	<input type="checkbox"/>	
Childhood neglect	<input type="checkbox"/>	<input type="checkbox"/>	

PRIOR PSYCHIATRIC HOSPITALIZATIONS				<input type="checkbox"/> NONE
Name of Hospital	City/State	Dates of Service/Duration	Reason For Hospitalization	
PREVIOUS AND CURRENT PSYCHIATRIC/COUNSELING CARE				<input type="checkbox"/> NONE
Name of Psychiatrist/Counselor	Address/Phone Number	Dates of Service/Duration	Frequency of Visits	
Do you have a Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of last physical exam:		
Physician's name:		Physician's phone number:		
PRIOR HISTORY OF ELECTROCONVULSIVE THERAPY OR TMS				<input type="checkbox"/> NONE
ECT and/or TMS	Dates of Treatment	Reason you had it done	Outcome	

**PAST MEDICATIONS (PLEASE PROVIDE INFORMATION TO ANY THAT APPLY)**

**ANTIPSYCHOTICS**

Medication Generic Name/Brand Name	Date of Trial	Highest dose taken at any time	Duration of time on medication	Why was it discontinued	Benefits/Side effects from taking the medication
Aripiprzole/Abilify					
Clozaril/Clozapine					
Geodon/Ziprasidone					
Haldol/Haloperidol					
Invega/Invega Sustenna					
Latuda/Lurasidone					
Navane/Thiothixene					
Prolixin/Fluphenazine					
Risperdal/Risperidone					
Saphris/Asenapine					
Seroquel/Quetiapine					
Stelazine/Trifluoperazine					
Symbyax/Olanzapine/Fluoxetine					
Trilafon/Perphenazine					
Vraylar/Cariprazine					
Zyprexa/Olanzapine					

**ANTIDEPRESSANTS**

Anafranil/Clomipramine					
Asendin/Amoxapine					
Celexa/Citalopram					
Cymbalta/Duloxetine					
Deplin/Methylfolate					
Desyrel/Trazodone					
Effexor/Venlafaxine					
Elavil/Endep/Amitriptyline					
Lexapro/Escitalopram					
Luvox/Fluvoxamine					
Nardil/Phenelzine					
Norpramin/Desipramine					
Pamelor/Aventyl/Nortriptyline					
Paxil/Pexeva/Paroxetine					
Pristiq/Desvenlafaxine					
Prozac/Sarafem/Fluoxetine					
Remeron/Mirtazapine					
Serzone/Nefazodone					
Sinequan/Adapin/Doxepin					
Tofranil/Imipramine					
Trintellix/Vortioxetine					
Viibryd/Vilazodone					
Wellbutrin/Zyban/Bupropion					
Zoloft/Sertraline					



PAST MEDICATIONS (CONTINUED)					
MOOD STABILIZERS					
Medication Generic Name/Brand Name	Date of Trial	Highest dose taken at any time	Duration of time on medication	Why was it discontinued	Benefits/Side effects from taking the medication
Depakote/Depakene/Valproic Acid					
Lamictal/Lamotrigine					
Lithium/Eskalith/Lithobid					
Neurontin/Gabapentin					
Tegretol/Equetro/Carbamazepine					
Topamax/Topiramate					
Trileptal/Oxcarbazepine					
ANXIETY/SLEEP					
Ambien/Zolpidem					
Ativan/Lorazepam					
BuSpar/Buspirone					
Centrax/Prazepam					
Dalmane/Flurazepam					
Klonopin/Clonazepam					
Librium/Chlordiazepoxide					
Lunesta/Eszopiclone					
Restoril/Temazepam					
Rozerem/Ramelteon					
Serax/Oxazepam					
Sonata/Zaleplon					
Tranxene/Clorazepate					
Valium/Diazepam					
Xanax/Alprazolam					
STIMULANTS					
Adderall/Adderall XR					
Concerta/Methylphenidate					
Focalin/Dexmethylphenidate					
Metadate/Methylin/ Methylphenidate					
Ritalin/Methylphenidate					
Strattera/Atomoxetine					
OTHERS					
Aricept/Donepezil					
Artane/Trihexyphenidyl					
Cogentin/Benztropine					
Exelon/Rivastigmine					
Lyrica/Pregabalin					
Namenda/Memantine					
Provigil/Modafinil					
Reminyl/Galantamine					
Suboxone/Buprenorphine					

CURRENT MEDICATIONS		
Medication	Dose/Frequency	Start Date

PHARMACY	
Pharmacy Name	Pharmacy Address/Phone Number

MEDICAL HISTORY <i>(Please check any that apply)</i>							
<input type="checkbox"/>	AIDS/HIV Positive	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	Porphyria	<input type="checkbox"/>	Parathyroid Disease
<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	Esophageal reflux	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	Poisoning
<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Polycystic Ovarian Syndrome
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Radiation Treatments
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Fainting Spells/Dizziness	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Recent Weight Loss
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	Renal Dialysis
<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Stomach/Intestinal Disease
<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Cancer:	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Swelling of Limbs
<input type="checkbox"/>	Cataract	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	Traumatic Injury
<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Congenital Heart Disorder	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>	Tumors or Growths
<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	Pacemaker insertion	<input type="checkbox"/>	Urinary Tract Infections
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	Vision Loss
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	Wheezing

<b>MEDICAL HISTORY (CONTINUED)</b>	
Any special dietary needs or restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Any ongoing dental issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Any recent change in appetite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Any weight loss or weight gain of more than 10 lbs in the last 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: <input type="checkbox"/> weight loss <input type="checkbox"/> weight gain
<p style="text-align: center;">On a scale from 0–10, please choose your pain level <b>today</b>:</p> (No Pain)   0   1   2   3   4   5   6   7   8   9   10   (Excruciating) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Please explain:
<p style="text-align: center;">On a scale from 0–10, please choose your pain level for the <b>last 30 days</b>:</p> (No Pain)   0   1   2   3   4   5   6   7   8   9   10   (Excruciating) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Please explain:
Are there other medical issues you would like us to consider during your treatment? Please explain:	
Do you have any implantable devices? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Women ONLY:</b>	<b>Number of:</b> Pregnancies ____    Caesarean sections ____    Abortions ____    Stillbirths ____    Miscarriages ____ <input type="checkbox"/> D&C <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Ovary Removal <input type="checkbox"/> Breast Surgery
<b>Other illnesses not listed above OR comments:</b>	

<b>ALLERGIES</b>	
<b>MEDICATIONS</b>	<b>REACTION</b>
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal
<b>FOOD/OTHER</b>	<b>REACTION</b>
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Lethal

SUBSTANCE USE HISTORY								
Substance	Past OR Present	Route	Frequency	Quantity	Age of First Use	Date of Last Use	Heaviest Use (amount/frequency)	# of days used in last 30 days
Alcohol	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Caffeine (pills or beverages)	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Cocaine	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Crystal / Methamphetamine	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Heroin / Other Opiates	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Inhalants	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
LSD or Hallucinogens	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Marijuana	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Methadone	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Pain Killers	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
PCP	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Stimulants (pills)	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Tranquilizers / Sleeping Pills	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Ecstasy	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Nicotine	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Barbiturates	<input type="checkbox"/> Past / <input type="checkbox"/> Present							
Benzodiazepine	<input type="checkbox"/> Past / <input type="checkbox"/> Present							

**What is your drug of choice?**

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**Have you ever experience any of the following in relation to your substance abuse? (Check all that apply; explain if yes)**

- Have people around tell you that you have a problem with (substance) \_\_\_\_\_
- Taking larger amounts than intended \_\_\_\_\_
- Symptoms of dependence (needing larger amounts in order to get the same effects) \_\_\_\_\_
- Impaired ability to complete social-/home-/work-related tasks \_\_\_\_\_
- Symptoms of withdrawal (physical/emotional/mental) \_\_\_\_\_
- Substance related legal issues \_\_\_\_\_

---

**Have you received treatment for substance abuse?**     Yes     No

*If yes, please explain:*

---

**Do you think you need treatment, or are you open to treatment for substance abuse?**     Yes     No

SOCIAL HISTORY			
CHILDHOOD			
Parents	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	Siblings	# of Siblings: _____ Your placement in birth order: _____
Place of birth:		Significant relationships:	
Significant life events from age 0–12:			

ADOLESCENCE
Describe any impact puberty had on your emotional development:
Describe relevant factors about your psychosexual history that impacted your emotional development:
Describe your school performance:
Describe your past relationships (peers, dating, other):
Describe any early experiences with drugs and alcohol:

ADULTHOOD	
Education	Highest level of schooling completed: <input type="checkbox"/> Grade _____ <input type="checkbox"/> High School/GED <input type="checkbox"/> Professional/Vocational School <input type="checkbox"/> Some college <input type="checkbox"/> Bachelor’s Degree <input type="checkbox"/> Graduate <input type="checkbox"/> Other _____
Employment	Work History: <hr/> Current:    Employer: _____    Address: _____ Occupation: _____    Dates: _____
Military	<input type="checkbox"/> Yes <input type="checkbox"/> No    Branch: _____ <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserves <input type="checkbox"/> Veteran Did you receive a service-connected disability rating? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what rating? _____
Legal	Have you ever been arrested or convicted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DUI <input type="checkbox"/> Drug Related <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Other _____ Please explain:

**SOCIAL HISTORY (CONTINUED)**

**RELATIONSHIPS**

Marital Status  Single     Married – How many times? \_\_\_\_\_     Divorced – How many times? \_\_\_\_\_     Widowed

If married, describe relationship with spouse: \_\_\_\_\_

If divorced, length of previous marriage and reason for divorce: \_\_\_\_\_

If not married, describe significant relationships: \_\_\_\_\_

Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age	Sex	Quality of relationship

Current living situation (who lives in your home):

Do you have family nearby?  Yes     No    Please describe:

Please list any spiritual/religious variables that may impact your treatment:

**FAMILY HISTORY**

*\*\*Please list the name(s) and relationship to you of any blood relative who have suffered from or been treated for mental/ emotional/ psychological problems, including depression, nervousness, suicide/suicide attempts, alcoholism, drug abuse, schizophrenia, phobias, etc., or from neurological or unusual diseases.*

Family Member Name & Relation	Diagnosis	Type of Problem
Father:		
Mother:		
Sibling: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
Sibling: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
Grandfather: <input type="checkbox"/> PATERNAL <input type="checkbox"/> MATERNAL		
Grandmother: <input type="checkbox"/> PATERNAL <input type="checkbox"/> MATERNAL		
Uncle: <input type="checkbox"/> PATERNAL <input type="checkbox"/> MATERNAL		
Aunt: <input type="checkbox"/> PATERNAL <input type="checkbox"/> MATERNAL		
Cousin: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> PATERNAL <input type="checkbox"/> MATERNAL		

## Notice of Privacy Practices

Psychiatric Solutions PC 1620 N Mamer, Spokane Valley, WA 99216

**Effective Date: December 19, 2017**

**Edited: December 19, 2017**

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

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#### **A. How this Medical Practice May Use or Disclose Your Health Information**

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with a pharmacist who needs it to dispense a

prescription to you, or a laboratory that performs a test. We will not share information with other physicians or other health care providers without your written authorization to do so. Medical information about you may also be shared with members of your family if we believe you are in danger of harming yourself or another person.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our transcriptionist who performs services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We **may** use and disclose medical information to contact and remind you about appointments. If you are not home, we **may** leave this information on your answering machine or in a message left with the person answering the phone. However, we make every attempt to protect your confidentiality by **not** leaving the name of your provider on your answering machine or with anyone who may answer the phone. It is our office policy to leave a message similar to the following when confirming your appointment: "This message is for [name of patient]. This is [name of staff person] calling from your doctor's office to confirm your appointment on [date and time]. Please call our office at 899-3370 should you have any questions."

5. Sign in sheet. We do not use sign in sheets. However, we may use and disclose medical information about you by calling out your **first name only** when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location or your general condition in the event of an emergency only. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. Under normal circumstances, we may also disclose information to someone who is involved with your care or helps pay for your care without your written authorization. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We will not use or disclose your medical information without your written authorization at any point in the future related to such activities.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. **Duty to warn** or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel. **Volk-** If a statement of harm is made where a victim or victims cannot be identified the provider will make a report to crime check or law enforcement personnel.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly

authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer. **Note: we are not currently accepting any worker's compensation cases at this time.**

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

## **B. When This Medical Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **C. Your Health Information Rights**

1. Right to Request Special Privacy Protections. You have the right to



request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular address or contact you by phone only at a certain number. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy.** Mental Health records are not typically available for your inspection and copying. They are subject to different protections than other medical records, such as the records kept by your primary care physician. We are not required to provide you access to inspect and copy your mental health records; this access is at the discretion of the physician. If you wish to access your mental health records, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. Should your physician approve such a request, we may charge a reasonable fee, as allowed by California law. We may deny your request for the reasons stated above. If we deny your request to access your mental health records, you will have the right to have them transferred to another mental health professional.

4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 4 (appointment reminders), 5 (check-in procedures), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices.

7. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

#### **D. Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted on the back of your physician's door, and will offer you a copy at each appointment.

#### **E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services  
Office of Civil Rights  
Hubert H. Humphrey Bldg.  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

You will not be penalized for filing a complaint.