NOTICE OF PRIVACY PRACTICES

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

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all records of your care generated by a provider of Psychological Health-Roanoke.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe examples of the way we use and disclose health information:

For Treatment:

We may use health information about you to provide treatment or services and continuity of care with other healthcare providers.

For Payment:

We may use and disclose health information about your treatment and services to bill and collect payment from you, or a third party payer. We may also tell your health plan about treatment you are going to receive to determine whether your plan will pay.

For Health Care Operations:

- To remind you that you have an appointment for medical care
- To tell you about health-related benefits or services

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Future Communications:

We may communicate to you via newsletters, mail outs or other means regarding treatment options and health related information.

Law Enforcement/Legal Proceedings:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Psychological Health- Roanoke you have the **RIGHT TO**:

Inspect and Copy:

You have the right to inspect and obtain a copy of the health information used to make decisions about your care. We may deny your request to inspect and copy in certain circumstances. If you are denied access you may request that the denial be reviewed. Another licensed health care professional chosen by Psychological Health-Roanoke will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Please turn over

Amend:
If you feel that your health information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Psychological Health-Roanoke. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures:
You have the right to request an accounting of disclosures. This pertains to disclosures we make of your health information for purposes other than treatment where an authorization was not required.

Request Restrictions:
You have the right to request a restriction or limitation on the health information we use or disclose about you. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. **We are not required to agree to your request**. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment.

Request Confidential Communications:
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. Psychological Health-Roanoke will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services and related correspondence. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of This Notice:
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE
We reserve the right to change this notice at any time.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with Psychological Health-Roanoke. You may also file a complaint with the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that provided to you.

Psychological Health-Roanoke-PATIENT REGISTRATION

Date: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email:_____

Patient: _____
First Middle Last

Address _____
Street and PO Box

_____
City State Zip Code

Age _____ Birth Date _____ Social Security # _____

Patient Employer Name: _____
Employer Address _____
_____

Spouse _____ DOB: _____ Social Security #_____
Employer Name/Address _____
Occupation: _____ Employer Phone _____

Do you have Medical Insurance? **Yes, Please provide a copy to the receptionist at time of check-in.**
If No, then payment is due in full date of service.

REQUIRED INFORMATION:
In case of emergency, who should be notified? _____ Phone: _____
Relation to patient:_____

I authorize treatment deemed necessary by the health care providers of Psychological Health- Roanoke.

A law enacted in Virginia in 1989, authorizes health care providers to test their patients for HIV antibodies and other blood borne pathogens when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV) and other blood borne pathogens. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies and other blood borne pathogens and the testing would be explained. You could be given the opportunity to ask any questions you might have at that time.

I authorize Psychological Health-Roanoke to release to my health plan any and all information which it deems necessary regarding my care and treatment to insure prompt payment of all charges for services provided. I herby assign the payment of all insurance benefits to Psychological Health- Roanoke for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Psychological Health-Roanoke for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicare or Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. Payment shall be due within thirty days of receipt of a statement.

In consideration of the services rendered and to be rendered pursuant to my request for medical services from Psychological Health- Roanoke, I hereby waive any right to a jury trial should Psychological Health-Roanoke have to file suit to collect my account.

METHODS OF PAYMENT:

Our office accepts the following payment methods:

Cash, Personal Check and Credit Cards.

For returned checks we assess a $50.00 NSF charge, and report to the local Commonwealth attorney's office checks that are not paid within 2 weeks of being returned to our office.

If fees are not paid, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The parties agree that all claims, disputes and other matters of action shall be brought within and decided in the Commonwealth of Virginia.

You agree, in order for us to service our account or to collect any amounts you may owe, that we may contact you by telephone at any telephone number associated with you account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THIS INFORMATION.

_____ _____

Patient Signature Date

Psychological Health- Roanoke
Informed Consent for Treatment

Confidentiality

Clinicians and staff in Psychological Health-Roanoke value the patient-therapist and patient-physician relationships and strive to keep all information confidential. We only release information to others with your written permission.

Here are some important exceptions to this confidentiality of which we want you to be aware. These include:

- Suspected child abuse or neglect
- Suspected abuse or neglect of an elderly or incapacitated adult
- Patient is thought to be an immediate threat to self or others
- Court-ordered releases with regard to legal actions
- Misconduct by a health care provider
- Workers Compensation
- If you are licensed or certified by a health regulatory board or hold a multistate license, and your condition places you or the public at risk

Other Matters Related to Confidentiality

- It may occasionally be helpful or necessary to consult about a patient with another professional. In these consultations, the physician/therapist makes every effort to avoid revealing the identity of the patient. The consultant is, of course, also legally bound to maintain confidentiality.
- If insurance reimbursement is requested, we are required to provide the insurer relevant information such as diagnosis and/or treatment plan.
- If the patient is under eighteen years of age, please be aware that while the specific content of therapy is confidential, parents have a right to receive general information on the progress of the treatment and have legal access to the record.

I understand that my therapist will discuss my diagnosis as well as the method of treatment. The nature of the treatment has been described to me as well as possible side effects and alternative forms of treatment. I understand I may withdraw from treatment at any time, but if I decide to do this, I will discuss my plan with this physician/therapist before acting on it.

The physician/therapist has further discussed with me scheduling policies, fees to be charged, and matters relating to insurance, and if applicable, preauthorization and utilization review issues.

If you need to change an appointment, please give us a minimum 24 hours notice. We reserve the right to assess service charge to patients who break or fail to attend their appointment commitments with us and who fail to give us at least 24 hours notice of their intention to do so. Follow-up appointments will only be made when any outstanding co-payment balance is paid.

I have read the above; fully understand the diagnosis, the nature of treatment, the alternatives to this treatment, the fees, and the limits of confidentiality and give consent for treatment.

I acknowledge that I have been given the Psychological Health-Roanoke Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

Patient: _____ Date: _____

Provider: _____ Date: _____

PATIENT'S RIGHTS AND RESPONSIBILITIES

Statement of Patient Rights

*Patients have the right to be treated with dignity and respect.
*Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability or source of payment.
*Patients have the right to have their treatment and other information kept private.
*Only in life-threatening situations or if required by law, can records be released without a signed consent from patients.
*Patients have the right to information from staff/providers in language they can understand.
*Patients have the right to an easy to understand explanation of their condition and treatment.
*Patients have the right to know all about their treatment choices regardless of cost coverage.
*Patients have the right to get information about services offered by their providers and patient role in the treatment process.
*Patients have the right to request professional information about their provider.
*Patients have the right to know the clinical guidelines used in providing and/or managing their care.
*Patients have the right to provide suggestions on office policies and procedures.
*Patients have the right to complain and to know about their complaint, grievance and appeals process.
*Patients have the right to know State and Federal laws governing their rights and responsibilities.
*Patients have the right to participate in the formation of their plan of care.

Statement of Patient Responsibilities

*Patients are responsible for providing their medical provider with information needed to deliver quality care.
*Patients are responsible for informing their provider when/if their treatment plan is no longer effective.
*Patients are responsible to follow their treatment plans and to inform their provider of any changes to the treatment plan made by other providers including any changes in their medications.
*Patients are responsible for reviewing their care and treatment plans continuously and reporting effectiveness or ineffectiveness of the care plan to their provider.
*Patients are responsible for treating those giving them care with dignity and respect.
*Patients should not be involved in any conscious behavior that could endanger the safety of their provider, office staff or other patients.
*Patients are responsible for keeping their appointments, arriving on time and notifying the office of any cancellation at least 24 hours prior to the appointment.
*Patients are responsible for addressing questions about their care to their provider and ensure understanding of their care and their role in the treatment process.
*Patients are responsible for notifying their provider of any concerns regarding payment or insurance coverage.

I understand my rights and responsibilities as stated above.

_____

Patient Signature ***Date***

Psychological Health Roanoke
Financial Policies

Name _____

Failed Appointment and Late Cancellation Policy

WE ASK THAT YOU GIVE 24 HOURS NOTICE IF YOU INTEND TO CANCEL AN APPOINTMENT.

Appointments cancelled with less than 24 hours notice and appointments not kept will result in a mandatory $25 scheduling charge unless there is illness or an emergency. Your therapist may also bill you for your missed or cancelled appointment. Your insurance will not pay for missed or cancelled appointments. Please discuss this policy with your therapist.

Co-Payment Policy

Insurance companies **require** us to collect applicable co-payments at **every** visit. If a co-payment is missed, it is to be paid at your next visit. **Failure to pay two consecutive co-payments will result in your not being able to schedule future appointments until paid.**

Collection Policy

Please note that all accounts 90 days in arrears are subject to be submitted to a collection agency. The amount will include the balance owed plus all collection agency fees.

I understand the Policies described above.

_____ _____

Signature Date

Psychological Health Roanoke PC

Patient Name_____

Date _____ DOB _____

Release for Coordination With Primary Care Physician:

For the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my primary care physician. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release, which can be done at any time. **Name of Primary Care Physician**

_____

☐ **I do not have a Primary Care Physician.**

(Check One) I do ☐ I do NOT ☐ give permission to the practitioner named above to exchange information about my current treatment with my primary care physician.

SIGNATURE IS REQUIRED

Patient (Guardian) Signature_____ Date _____

Signature of Witness _____ Date _____

Below this line is to be completed by Psychological Health Roanoke Clinician

To:_____

_____

_____

Dear Dr. _____:

In an effort to coordinate care, I want to inform you that your patient (named above) was seen by me on _____ for treatment of _____.

Current recommendations for the type and setting of treatment include:

( ) Individual Psychotherapy **( ) Evaluation**

( ) Family Psychotherapy **( ) Intensive Outpatient Program**

( ) Group Psychotherapy **( ) Partial Hospitalization Program**

( ) Inpatient Unit

Comments:_____

_____

If you need any further information, please contact me at 540-772-5140 or fax at 540-772-5157.

Sincerely,

Clinician: _____

Psychological Health Roanoke PC

Patient Name_____

Date _____ DOB _____

Release for Coordination With Psychiatrist:

For the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my psychiatrist. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release, which can be done at any time.

Name of Psychiatrist

_____

☐ **I do not have a psychiatrist.**

(Check One) I do ☐ I do NOT ☐ give permission to the practitioner named above to exchange information about my current treatment with my Psychiatrist.

SIGNATURE IS REQUIRED

Patient (Guardian) Signature_____ Date _____

Signature of Witness _____ Date _____

Below this line is to be completed by Psychological Health Roanoke Clinician

To:_____

_____

_____

Dear Dr. _____:

In an effort to coordinate care, I want to inform you that your patient (named above) was seen by me on _____ for treatment of _____.

Current recommendations for the type and setting of treatment include:

( ) Individual Psychotherapy **( ) Evaluation**

( ) Family Psychotherapy **( ) Intensive Outpatient Program**

( ) Group Psychotherapy **( ) Partial Hospitalization Program**

( ) Inpatient Unit

Comments:_____

_____If you need any further information, please contact me at 540-772-5140 or fax at 540-772-5157.

Sincerely,

Clinician: _____

Patient Health Questionnaire-9

(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answer)	**Not At All**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have you let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work. Take care of things at home, or get along with other people? (Please circle your answer)

Not difficult At All	**Somewhat Difficult**	**Very Difficult**	**Extremely Difficult**

NAME_____ **DATE:**_____

THE MOOD DISORDER QUESTIONNAIRE

If you are currently suffering from depression or have had problems with depression in the past- please answer the following questions.

1.	**Was there ever a time when you did not feel like yourself and...**	**YES**	**NO**
	…you felt so good, upbeat and energetic that others felt you were not acting like yourself ?		
	…were acting so hyperactive that you got into trouble?		
	…you were so irritable that you shouted at people or started fights or arguments?		
	…you felt much more self-confident than usual?		
	…you got much less sleep than normal and found you didn't really miss it?		
	…you were much more talkative or spoke faster than usual?		
	…thoughts raced through your head or you couldn't slow your mind down?		
	…you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
	…you had much more energy than usual?		
	…you were much more active or did many more things than usual?		
	…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
	…you were much more interested in sex than usual?		
	…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
	…spending money got you or your family into trouble?		
2.	**If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please circle one response only.***	**YES**	**NO**
3.	**How much of a problem did any of these cause you-like being unable to work; having family, money, or legal troubles; getting into arguments or fights? *Please circle one response only.***	**No Problem** **Moderate Problem**	**Minor Problem** **Serious Problem**

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the **last** 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

_____

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

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

PSYCHOLOGICAL HEALTH - ROANOKE
INTAKE INFORMATION

PLEASE HELP US BE OF ASSISTANCE TO YOU BY THOROUGHLY COMPLETING THIS QUESTIONNAIRE.

DATE:_____ **AGE:**_____

NAME:_____

WHO REFERRED YOU TO OUR DEPARTMENT?_____

BRIEFLY STATE WHAT BROUGHT YOU HERE, AND HOW IT DEVELOPED:

_____
_____
_____
_____

ON THE SCALE BELOW, ESTIMATE THE SEVERITY OF YOUR SYMPTOMS (CHECK ONE):

_____	_____	_____	_____	_____
MILDLY UPSETTING	**MODERATELY SEVERE**	**SEVERE**	**EXTREMELY SEVERE**	**INCAPACITATING**

WHOM HAVE YOU CONSULTED ABOUT THE ABOVE AND WHAT HAVE YOU TRIED? (PLEASE INCLUDE NAME(S) OF PREVIOUS COUNSELORS)

_____
_____
_____

EDUCATIONAL BACKGROUND

HIGHEST EDUCATIONAL DEGREE OR VOCATIONAL PROGRAM:_____

SCHOOL ATTENDED:_____ **YEAR COMPLETED:**_____**GPA:**_____

MEDICAL/LIFESTYLE INFORMATION

HEIGHT? _____ **WEIGHT?** _____**WHEN WAS YOUR LAST EXAM?**_____

DOCTORS NAME:_____

PLEASE LIST ANY SURGICAL OPERATIONS OR MAJOR HEALTH PROBLEMS:

_____

_____

_____

MEDICAL INFORMATION

PLEASE LIST ANY SIGNIFICANT ACCIDENTS:_____

HAVE YOU EVER RECEIVED A HEAD INJURY?_____ **IF SO, WHEN?**_____

HAVE YOU EVER HAD A SEIZURE?_____**IF SO, WHEN?**_____

PLEASE LIST ALL MEDICATIONS YOU TAKE (INCLUDE DOSAGE AND SIDE EFFECTS):

_____

_____

_____

_____

LIST ANY ALLERGIES OR DRUG SENSITIVITIES:

_____

_____

IF YOU WORK WITH OR HAVE CONTACT WITH CHEMICALS PLEASE LIST THEM:_____

_____

CHECK THE HOSPITALS WHERE YOU HAVE RECEIVED INPATIENT PSYCHIATRIC TREATMENT AND/OR SUBSTANCE ABUSE:

( ) ROANOKE MEMORIAL HOSPITAL
( ) CATAWBA HOSPITAL
( ) MT. REGIS
( ) UNIVERSITY OF VIRGINIA
( ) OTHER :_____

( ) ST ALBANS PSYCHIATRIC HOSPITAL
( ) LEWIS GALE MEDICAL CENTER
( ) VIRGINIA BAPTIST HOSPITAL
( ) LIFE CENTER OF GALAX

WHAT ARE YOUR EXERCISE HABITS?_____

_____

WHAT DO YOU DO FOR RELAXATION OR FUN?_____

_____

DESCRIBE YOUR USE OF ALCOHOL, CIGARETTES & STREET DRUGS. HOW MUCH? HOW OFTEN?:_____

_____

_____

_____

_____

FAMILY INFORMATION

MARITAL STATUS: (CHECK ALL THAT APPLY):

( ) SINGLE ( ) ENGAGED ( ) GAY ( ) MARRIED

( ) SEPARATED ( ) DIVORCED ( ) LESBIAN ( ) WIDOW /ER

( ) BI-SEXUAL ( ) TRANSGENDER

YOUR CHILDREN (INCLUDE AGES):_____
_____
_____

PLEASE LIST ALL CURRENT MEMBERS OF YOUR HOUSEHOLD:_____
_____
_____

FAMILY OF ORIGIN:

BIRTHPLACE : _____ **RAISED:**_____
State/City/Country **State/City/Country**

FATHER ( ) LIVING ( ) DECEASED CAUSE OF DEATH:_____
FATHER'S NAME:_____
YOUR AGE AT TIME OF HIS DEATH:_____**IF LIVING, WHERE?**_____
FATHER'S AGE:_____**FATHER'S OCCUPATION:**_____

MOTHER ( ) LIVING ( ) DECEASED CAUSE OF DEATH:_____
MOTHER'S NAME:_____
YOUR AGE AT TIME OF HER DEATH:_____**IF LIVING, WHERE?**_____
MOTHER'S AGE:_____**MOTHER'S OCCUPATION:**_____

ANY STEP-PARENT(S) AND/OR GUARDIAN(S)' NAME(S):_____
_____

PARENTS DIVORCED?_____**YOUR AGE WHEN THEY SEPARATED?**_____

BROTHER(S) AND SISTER(S): (INCLUDE AGES):_____
_____

HAVE ANY FAMILY MEMBERS BEEN TREATED FOR EMOTIONAL PROBLEMS?_____
WHO?_____**DIAGNOSIS :**_____
WHO?_____**DIAGNOSIS:**_____

STRESS CHECKLIST (ADULTS)

PLEASE CHECK ALL THAT APPLY *OVER THE PAST YEAR*:

( ) DEATH OF SPOUSE
( ) MARITAL SEPARATION
( ) PERSONAL INJURY OR ILLNESS
( ) DEATH OF CLOSE FAMILY MEMBER
( ) CHANGE IN HEALTH OF FAMILY MEMBER
( ) MARITAL RECONCILIATION
( ) PREGNANCY AND/OR ABORTION
( ) BUSINESS ADJUSTMENT
( ) CHANGE IN FINANCIAL STATE
( ) CHANGE IN RESIDENCE
( ) CHANGE TO DIFFERENT LINE OF WORK
( ) CHANGE IN RESPONSIBILITIES AT WORK
( ) CHANGE IN WORK HOURS/CONDITIONS
( ) FORECLOSURE MORTGAGE/LOAN
( ) CHANGE IN NUMBER OF SPOUSE ARGUMENTS
( ) SON/DAUGHTER LEAVING HOME
( ) INVOLVEMENT IN EXTRAMARITAL AFFAIR
( ) OUTSTANDING PERSONAL ACHIEVEMENT
( ) CHANGE IN SLEEPING HABITS
( ) CHANGE IN NUMBER OF FAMILY GET TOGETHERS
( ) DIVORCE
( ) JAIL TERM
( ) MARRIAGE
( ) FIRED AT WORK
( ) RETIREMENT
( ) SEX DIFFICULTIES
( ) GAIN OF NEW FAMILY MEMBER
( ) DEATH OF CLOSE FRIEND
( ) CHANGE IN SCHOOL
( ) TROUBLE WITH BOSS
( ) BEGIN OR END OF SCHOOL
( ) CHANGE IN RECREATION
( ) SPOUSE BEGIN OR STOP WORK
( ) CHANGE IN LIVING CONDITIONS
( ) CHANGE IN CHURCH ACTIVITY
( ) TROUBLE WITH IN-LAWS
( ) REVISION OF PERSONAL HABITS
( ) CHANGE IN SOCIAL ACTIVITIES
( ) CHANGE IN EATING HABITS
( ) MINOR VIOLATIONS OF THE LAW

CHECKLIST FOR ADOLESCENTS

(PLEASE CHECK ALL THAT APPLY)

( ) PARENT DIED
( ) PARENT TRAVEL AS PART OF JOB
( ) CLOSE FAMILY MEMBER DIED
( ) PARENT REMARRIED
( ) PARENTS RECONCILED
( ) CHANGE IN HEALTH OF FAMILY MEMBER
( ) SCHOOL DIFFICULTIES
( ) BIRTH OF SIBLING
( ) CHANGE IN FAMILY'S FINANCIAL CONDITION
( ) CHANGE IN NUMBER OF FIGHTS WITH SIBLINGS
( ) THEFT OF PERSONAL POSSESSION
( ) OLDER BROTHER/SISTER LEFT HOME
( ) OUTSTANDING PERSONAL ACHIEVEMENT
( ) MOVE TO ANOTHER PART OF TOWN
( ) CHANGE IN PERSONAL HABITS
( ) MOVE TO A NEW HOUSE
( ) CHANGES IN SLEEP
( ) CHANGE OF FRIENDS
( ) CHANGE IN NUMBER OF FAMILY GET TOGETHERS
( ) PUNISHED FOR NOT TELLING THE TRUTH
( ) PARENTS DIVORCED
( ) PARENTS SEPARATED
( ) PERSONAL ILLNESS /INJURY
( ) PARENT FIRED FROM JOB
( ) MOTHER GOES TO WORK
( ) MOTHER BECAME PREGNANT
( ) SCHOOL ADJUSTMENT
( ) STARTED A NEW ACTIVITY
( ) INJURY/ILLNESS OF CLOSE FRIEND
( ) THREATENED BY VIOLENCE AT SCHOOL
( ) CHANGE IN RESPONSIBILITIES
( ) TROUBLE WITH GRANDPARENTS
( ) MOVE TO ANOTHER CITY
( ) RECEIVED OR LOST PET
( ) TROUBLE WITH TEACHER
( ) CHANGE IN NEW SCHOOL
( ) VACATION WITH FAMILY
( ) CHANGE IN EATING
( ) CHANGES IN AMOUNT OF TV VIEWING