

## 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 \_\_\_\_\_

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Spouse \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer Name/Address \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Phone \_\_\_\_\_

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**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 hereby 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
- For third party payers and their agents for purposes of reimbursement
- For crime investigation if it occurs on our premises

**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.***

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***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



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
- ( ) Family Psychotherapy
- ( ) Group Psychotherapy
- ( ) Inpatient Unit
- ( ) Evaluation
- ( ) Intensive Outpatient Program
- ( ) Partial Hospitalization Program

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<sub>PC</sub>**

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:**

- |   |  |
|---|--|
| <input type="checkbox"/> Individual Psychotherapy | <input type="checkbox"/> Evaluation                      |
| <input type="checkbox"/> Family Psychotherapy     | <input type="checkbox"/> Intensive Outpatient Program    |
| <input type="checkbox"/> Group Psychotherapy      | <input type="checkbox"/> 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
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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.	<b>Was there ever a time when you did not feel like yourself and...</b>	<u>YES</u>	<u>NO</u>
	...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.	<b>If you checked YES to more than one of the above, have several of these ever happened during the same period of time? <i>Please circle one response only.</i></b>	<u>YES</u>	<u>NO</u>
3.	<b>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? <i>Please circle one response only.</i></b>	<u>No Problem</u>	<u>Minor Problem</u>
		<u>Moderate Problem</u>	<u>Serious Problem</u>

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

Over the <b>last</b> 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

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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      MODERATELY      SEVERE      EXTREMELY      INCAPACITATING  
UPSETTING      SEVERE      SEVERE      SEVERE

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:**

- |  |   |
|--|---|
| <input type="checkbox"/> ROANOKE MEMORIAL HOSPITAL | <input type="checkbox"/> ST ALBANS PSYCHIATRIC HOSPITAL |
| <input type="checkbox"/> CATAWBA HOSPITAL          | <input type="checkbox"/> LEWIS GALE MEDICAL CENTER      |
| <input type="checkbox"/> MT. REGIS                 | <input type="checkbox"/> VIRGINIA BAPTIST HOSPITAL      |
| <input type="checkbox"/> UNIVERSITY OF VIRGINIA    | <input type="checkbox"/> LIFE CENTER OF GALAX           |
| <input type="checkbox"/> OTHER :                   | _____   |

**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?:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **STRESS CHECKLIST (ADULTS)**

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

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

## **CHECKLIST FOR ADOLESCENTS**

**(PLEASE CHECK ALL THAT APPLY)**

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