Psychological Health-Roanoke
Colonnade One Corporate Center
2840 Electric Road, Suite 200A
Roanoke, Virginia 24018
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AUTHORIZATION TO RELEASE PROFESSIONAL INFORMATION

Patient Name: _____

Date of Birth: _____ Phone #: _____

Information to be exchanged between: **Psychological Health- Roanoke**

And:

Name/Agency _____
Street Address _____
City, State, Zip Code _____
Phone & Fax Numbers _____

Purpose of Release:

Continuity of Care Communication Legal Representation
Other: _____

Information to be released:

Psychological Test Results	Educational Evaluations	
Written Treatment Information	Recommendations	PLEASE DO NOT FAX OVER
Verbal Treatment Information	Any & All Information	10 PAGES, USE MAIL INSTEAD
Other:_____		

I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments. If information pertaining to drug and alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal Confidentiality Rules (45 CRF Part 2). Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I certify this authorization is made voluntarily, I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. A copy may be accepted in lieu of the original.

I understand I may revoke this authorization at any time, except to the extent that action has already been taken.

Please check one of the following options below:

____**This consent will expire at the end of one year from the date below.**
____**This consent will automatically renew each year unless notification is received to revoke.**

Date: _____ Signature of Patient: _____

Date: _____ Signature of Parent/Guardian: _____

Date: _____ Signature of Witness: _____

Name _____ Date_____

MISCI

IN THE PAST 7 DAYS

1. I have been able to think clearly without extra effort
2. My mind has been as sharp as usual
3. I have been able to remember things as easily as usual without extra effort
4. I have been able to learn new things easily like telephone numbers or instructions
5. My ability to concentrate has been good
6. I have been able to pay attention and keep track of what I was doing without extra effort

NOT AT ALL	A LITTLE BIT	SOME WHAT	QUITE A BIT	VERY MUCH

IN THE PAST 7 DAYS

7. I have had trouble shifting back and forth between different activities that require thinking
8. I had trouble planning out the steps of a task
9. I have had to work harder than usual to express myself clearly
10. I have had trouble finding the right word(s) to express myself

NEVER	RARELY	SOME TIMES	OFTEN	VERY OFTEN

Name _____ Date _____

Spiritual Meaning Scale (SMS)

Directions: Please rate the extent to which you agree/disagree with each statement listed below according to the following scale

1	2	3	4	5
I totally disagree	I partially disagree	I'm in between	I partially agree	I totally agree

_____1. There is no particular reason why I exist.

_____2. We are each meant to make our own special contribution to the world.

_____3. I was meant to actualize my potential.

_____4. Life is inherently meaningful.

_____5. I will never have a spiritual bond with anyone.

_____6. When I look deep within my heart, I see a life I am compelled to pursue.

_____7. My life is meaningful.

_____8. In performing certain tasks, I can feel something higher or transcendent working through me.

_____9. Our flawed and often horrific behavior indicates that there is little or no meaning inherent in our existence.

_____10. I find meaning even in my mistakes and sins.

_____11. I see a special purpose for myself in this world.

_____12. There are certain activities, jobs, or services to which I feel called.

_____13. There is no reason or meaning underlying human existence.

_____14. Something purposeful is at the heart of this world.

_____15. We are all participating in something larger and greater than any of us.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

SF-36 QUESTIONNAIRE

Name:_____ **Ref. Dr:**_____ **Date:** _____

ID#: _____ **Age:** _____ **Gender: M / F**

Please answer the 36 questions of the **Health Survey** completely, honestly, and without interruptions.

GENERAL HEALTH:
In general, would you say your health is:

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

Compared to one year ago, how would you rate your health in general now?

◯ Much better now than one year ago
◯ Somewhat better now than one year ago
◯ About the same
◯ Somewhat worse now than one year ago
◯ Much worse than one year ago

LIMITATIONS OF ACTIVITIES:
The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.
◯ Yes, Limited a lot ◯ Yes, Limited a Little ◯ No, Not Limited at all

Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
◯ Yes, Limited a Lot ◯ Yes, Limited a Little ◯ No, Not Limited at all

Lifting or carrying groceries
◯ Yes, Limited a Lot ◯ Yes, Limited a Little ◯ No, Not Limited at all

Climbing several flights of stairs
◯ Yes, Limited a Lot ◯ Yes, Limited a Little ◯ No, Not Limited at all

Climbing one flight of stairs
◯ Yes, Limited a Lot ◯ Yes, Limited a Little ◯ No, Not Limited at all

Bending, kneeling, or stooping
◯ Yes, Limited a Lot ◯ Yes, Limited a Little ◯ No, Not Limited at all

Walking more than a mile
◯ Yes, Limited a Lot ◯ Yes, Limited a Little ◯ No, Not Limited at all

Walking several blocks
◯ Yes, Limited a Lot ◯ Yes, Limited a Little ◯ No, Not Limited at all

Walking one block
◯ Yes, Limited a Lot ◯ Yes, Limited a Little ◯ No, Not Limited at all

Bathing or dressing yourself

◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

PHYSICAL HEALTH PROBLEMS:

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Cut down the amount of time you spent on work or other activities

◯Yes ◯No

Accomplished less than you would like

◯Yes ◯No

Were limited in the kind of work or other activities

◯Yes ◯No

Had difficulty performing the work or other activities (for example, it took extra effort)

◯Yes ◯No

EMOTIONAL HEALTH PROBLEMS:

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

Cut down the amount of time you spent on work or other activities

◯Yes ◯No

Accomplished less than you would like

◯Yes ◯No

Didn't do work or other activities as carefully as usual

◯Yes ◯No

SOCIAL ACTIVITIES:

Emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

◯Not at all ◯Slightly ◯Moderately ◯Severe ◯Very Severe

PAIN:

How much bodily pain have you had during the past 4 weeks?

◯None ◯Very Mild ◯Mild ◯Moderate ◯Severe ◯Very Severe

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

◯Not at all ◯A little bit ◯Moderately ◯Quite a bit ◯Extremely

ENERGY AND EMOTIONS:
These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling.

Did you feel full of pep?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you been a very nervous person?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you felt so down in the dumps that nothing could cheer you up?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you felt calm and peaceful?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Did you have a lot of energy?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you felt downhearted and blue?

- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Did you feel worn out?

- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you been a happy person?

- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Did you feel tired?

- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

SOCIAL ACTIVITIES:

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ◯ All of the time
- ◯ Most of the time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

GENERAL HEALTH:
How true or false is each of the following statements for you?

I seem to get sick a little easier than other people
○Definitely true ○Mostly true ○Don't know ○Mostly false ○Definitely false

I am as healthy as anybody I know
○Definitely true ○Mostly true ○Don't know ○Mostly false ○Definitely false

I expect my health to get worse
○Definitely true ○Mostly true ○Don't know ○Mostly false ○Definitely false

My health is excellent
○Definitely true ○Mostly true ○Don't know ○Mostly false ○Definitely false

Substance Abuse Screening Instrument (O4/05)

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol.

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

		YES	NO
1.	Have you used drugs other than those required for medical reasons?	___	___
2.	Have you abused prescription drugs?	___	___
3.	Do you abuse more than one drug at a time?	___	___
4.	Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5.	Are you always able to stop using drugs when you want to?	___	___
6.	Do you abuse drugs on a continuous basis?	___	___
7.	Do you try to limit your drug use to certain situations?	___	___
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
9.	Do you ever feel bad about your drug abuse?	___	___
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11.	Do your friends or relatives know or suspect you abuse drugs?	___	___
12.	Has drug abuse ever created problems between you and your spouse?	___	___
13.	Has any family member ever sought help for problems related to your drug use?	___	___
14.	Have you ever lost friends because of your use of drugs?	___	___
15.	Have you ever neglected your family or missed work because of your use of drugs?	___	___
16.	Have you ever been in trouble at work because of drug abuse?	___	___
17.	Have you ever lost a job because of drug abuse?	___	___
18.	Have you gotten into fights when under the influence of drugs?	___	___
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?	___	___
20.	Have you ever been arrested for driving while under the influence of drugs?	___	___
21.	Have you engaged in illegal activities in order to obtain drug?	___	___
22.	Have you ever been arrested for possession of illegal drugs?	___	___
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___
25.	Have you ever gone to anyone for help for a drug problem?	___	___
26.	Have you ever been in a hospital for medical problems related to your drug use?	___	___
27.	Have you ever been involved in a treatment program specifically related to drug use?	___	___
28.	Have you been treated as an outpatient for problems related to drug abuse?	___	___

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of "1." Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16,20, and 22.

Duke–UNC Functional Social Support Questionnaire (FSSQ)

Here is a list of some things that other people do for us or give us that may be helpful or supportive. Please read each statement carefully and place an 'X' in the column that is closest to your situation. Give only 1 answer per row.

	5	4	3	2	1
	As much as I would like	Almost as much as I would like	Some, but would like more	Less than I would like	Much less than I would like
1. I have people who care what happens to me.					
2. I get love and affection.					
3. I get chances to talk to someone about problems at work or with my housework.					
4. I get chances to talk to someone I trust about my personal or family problems.					
5. I get chances to talk about money matters.					
6. I get invitations to go out and do things with other people.					
7. I get useful advice about important things in life.					
8. I get help when I am sick in bed.					

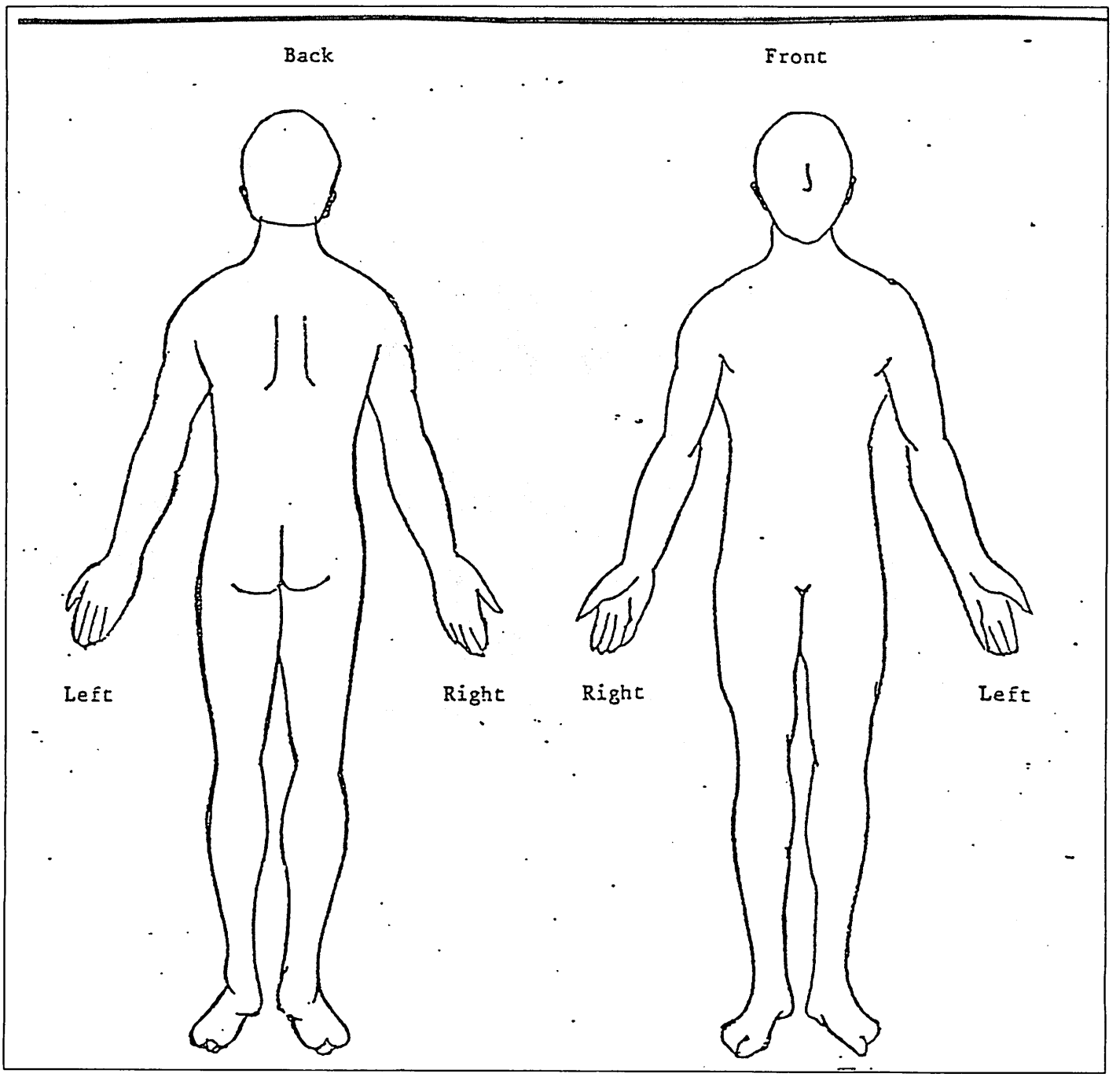
Source: adultmeducation.com

Patient Pain Drawing

Name:_____ Date:_____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in you face.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
^ ^ ^	= = =	o o o	x x x	///	o o o



McGill Pain Questionnaire

There are many words to describe pain. Some of these are grouped below. Check any words that describe the pain that you have right now. (You do not have to check words in every group).

1.	2.	3.	4.
Flickering	Jumping	Pricking	Sharp
Quivering	Flashing	Boring	Cutting
Pulsing	Shooting	Drilling	Lacerating
Throbbing		Stabbing	
Beating			
Pounding			

5.	6.	7.	8.
Pinching	Tugging	Hot	Tingling
Pressing	Pulling	Burning	Itchy
Gnawing	Wrenching	Scalding	Smarting
Cramping		Searing	Stinging
Crushing			

9.	10.	11.	12.
Dull	Tender	Tiring	Sickening
Sore	Taut	Exhausting	Suffocating
Hurting	Rasping		
Aching	Splitting		
Heavy			

13.	14.	15.	16.
Fearful	Punishing	Wretching	Annoying
Frightful	Grueling	Blinding	Troublesome
Terrifying	Cruel		Miserable
	Vicious		Intense
	Killing		Unbearable

17.	18.	19.	20.
Spreading	Tight	Cool	Nagging
Radiating	Numb	Cold	Nauseating
Penetrating	Drawing	Freezing	Agonizing
Piercing	Squeezing		Dreadful
	Tearing		Torturing

Name: _____ **Date:** _____