Patient Demographics

Patient Name:_____

DOB:_____

Address/Mailing Address:_____

State:_____ **City:**_____ **Zip Code:**_____

Parent/Guardian:_____ **Parent/Guardian:**_____

Phone#:_____ **Phone#:**_____

Email:_____

Primary Insurance_____ **Member ID:**_____

Secondary/Supplemental Insurance _____

Please use the space below to explain your complaint/concern and the reason for seeking services. Also, indicate the length of time you have been experiencing these symptoms.

Please report your current medications here (Name and dosage) if any:

- Psychiatric:

- Other Medications:

Family Psychological Services, Inc.
30495 Canwood Street Suite 101
Agoura Hills, CA 91301
Phone: (818) 707-7366 Fax: (818) 306-5836

Disclosure and Consent for Treatment

Dear Patient (Name):_____ **How did you hear about us:** _____

There are a few issues you should understand at the initiation of receiving treatment at this office. If you have any questions about these or any other topics, PLEASE ask our staff or the doctor.

Psychological Services:

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit.
Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have any questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Confidentiality:

In general, we must have your written release to provide information to others. Exceptions in which we may be compelled by law to break confidentiality of your medical records includes serious danger to yourself or others, suspected child abuse or elder abuse, inability to meet basic needs such as food or shelter, or a court order. State law allows clinical information to be exchanged with other doctors without your consent for continuity of ongoing medical care.

Final Report:

Once testing is completed, you will have an opportunity to make an appointment to go over your test results. Please make an appointment to review your test results on the day you finish testing. All balances must be paid in full before we can send the final report out to you; the doctor will review and make any changes as necessary.

Financial Responsibility Agreement

Family Psychological Services, Inc accepts and process insurance payments through a variety of insurance providers and plans.

While we make every effort to collect from your insurance company there are certain instances where you will need to pay a share of cost for services provided.

Many of the insurance companies we work with do not place a restriction on conducting psychological testing and therefore your share of cost would be limited to copays, coinsurance or your deductible.

Unfortunately, there are some insurance companies that do not allow for psychological testing or limit the scope of testing that are allowed to be administered. These limitations often conflict with what is necessary for *Family Psychological Services, Inc* to provide you with a complete and comprehensive report.

This share of cost will be the patients' responsibility and we will inform you of the amount due during your first

visit, the estimated cost of providing services for testing is: ___(**Please Verify with Clinician)**_____.

Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to *Family Psychological Services, Inc.*

Please expect to pay your portion due of copay, coinsurance, deductible, or fee difference at the time of your appointment.

Please Note

Family Psychological Services, Inc ***verifies*** *i*nsurance benefits are active and attempts to inform prospective patients of what the estimated copay and/or deductibles will be according to the information provided by the insurance providers representative. While we hope the information received is 100% correct, we are sometimes provided incorrect information. We encourage our patients to double check their mental health benefits prior to receiving services. It is the patient's responsibility to know their mental health benefits as we would hate for our patients to be stuck with large, unexpected bills.

Family Psychological Services, Inc will submit claims to your insurance for payment, and you (not your insurance company) are ultimately responsible for your bill and any payments. If your insurance company denies a claim filed on your behalf, then you are responsible to pay *Family Psychological Services, Inc* for the difference between the standard rate and the amount previously paid as copay unless approved otherwise by us.

I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy and / or psychological testing are reimbursed by insurance companies.

I agree to pay the amount not covered by my health insurance for psychological testing or therapy.

For our patients who do not want to go through their insurance plans and prefer to pay privately for services, please sign below as an understanding payment is due at the time services are rendered.

Private/Self-Payment for Services

I will self-pay for services at Family Psychological Services, Inc. I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

Credit Card on File

Upon scheduling your first appointment it is mandatory to provide credit card information which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance, deductibles, late cancellations, missed appointments, returned checks, or past due account balances. A receipt will be e-mailed to you at the address you specify below at your request or by email.

Type of card:

☐ Visa / MasterCard ☐ American Express ☐ Discover

Card #: _____-_____-_____-_____

Expiration: _____

Security code: _____

Name on card: _____

Initial here: _____

I authorize Family Psychological Services to charge this credit card as needed according to the terms specified in this Agreement and Policy.

I have read the Agreement and Policy above, and I have been offered a copy for my records. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by Family Psychological Services, Inc. Any and all negotiated exceptions or special arrangements have been discussed.

Cancellation/No Show Policy for Appointments

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call ahead 24 hours prior to your appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. We value your time; hence we ask you to value our time as well; therefore, if you no show or late cancel 3 sessions without a 24-hour cancellation notice we will have to discuss your commitment to therapy. **It is within your providers discretion to remove you from their calendar after 3 no show/late cancellations. If this occurs appropriate steps will be taken to notify you in writing of your discharge date, provide you with options/recommendations for future care and provide emergency care services up to 15 days after your discharge date.**

Once an appointment is scheduled, that time is reserved specifically for you. Although 24 hours is the minimum you need to cancel or reschedule, please give as much notice as possible. You may notify our office of cancellation by phone, text message or email. Late cancellations/no shows will incur a fee of $75.00. We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case-by-case basis. Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

Arriving Late to your Appointment

We understand that sometimes unexpected incidents may occur causing you to be late to your appointment. We typically have patients scheduled right after you, therefore we may not be able to provide you a full session.

No Suicide Contract

I understand that I will not kill myself. I am making a commitment to not harm myself. I understand the consequences of my own actions. I recognize that though I may feel suicidal, I'm competent enough to recognize the finality and consequences of that action. I recognize that suicidal feelings do fluctuate, and I cannot be helped unless I communicate my suicidal feelings/intent to the Doctor. Therefore, if I feel myself losing control over the will to live, I promise to immediately call 911. I acknowledge that I have received a copy of this contract.

No Child Left Behind Contract

Family Psychological Services cannot oversee your children. If you have children under the age of 15 you must remain within the office to provide adult supervision. We cannot administer medication, give them food or water, or take them to the restroom. By signing, you hereby agree to the above stated policy.

(Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Family Psychological Services ("Covered Entity") keeps a record of the health care services we provide you. You may ask to see and copy that record, you may also ask to correct that record, we will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer at (818) 707-7366. Written requests should be made to the Privacy Officer at (818) 707-7366. Written request should be made to the Privacy Officer at the following address:

Family Psychological Services
30495 Canwood Street Suite 101
Agoura Hills, CA, 91301

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

PATIENT ACKNOWLEDGMENT

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.
VERIFICATION OF MEDICAL CONSENT: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity, I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care, I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff, The covered Entity shall not be liable for the acts or omissions of independent contractors.

AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, hereby authorize the Covered Entity and/or its staff to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity's charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patients is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

If the patient is under 18 years of age and the Parents are legally separated, please have both guardians sign below:

Legal Guardian/Patient Signature:

_____ _____

Legal Guardian Signature: **Date**

_____ _____

Relation to Patient

PATIENT NAME: _____

FAMILY PSYCHOLOGICAL SERVICES, INC.
30495 Canwood St., Suite 101 Agoura Hills, CA 91301
818-707-7366 Fax 818-306-5836

Our office is dedicated to providing efficient and effective care. This policy outlines the fees associated with completing certain paperwork and the circumstances under which these fees may apply.

1. Applicable Paperwork
    - Fees may be charged for completing specific forms, including but not limited to:
        - Detailed medical history forms.
        - Disability or insurance claims forms requiring extensive documentation.
        - Specialized reports or evaluations requested by third parties, including accomodations.
2. Fee Structure
    - A fee of between $50-$200 will be applied for each form requiring extensive completion, based on the complexity of the documentation, at the clinicians discretion.
    - Payment must be made prior to the release of the completed paperwork.
3. Payment Methods
    - Payments can be made via:
        - Credit/Debit Card
        - Cash
        - Check
    - Receipts will be provided for all payments.
4. Exceptions
    - No fees will be charged for routine paperwork necessary for ongoing patient care, such as:
        - Standard intake forms.
        - Follow-up appointment reminders.
5. Notification
    - Patients will be notified in advance of any applicable fees before paperwork is completed.
6. Refund Policy
    - Fees are non-refundable once the paperwork has been completed and submitted.
7. Confidentiality
    - All information provided by patients will be kept confidential in accordance with HIPAA regulations.

This policy will be reviewed annually and updated as necessary to reflect changes in practice or regulation.

This policy is effective as of 1/1/2024.

For questions regarding this policy, please contact our office at 818-707-7366.

FAMILY PSYCHOLOGICAL SERVICES, INC.
30495 Canwood Street Suite 101 Agoura Hills, CA 91301
818-707-7366 Fax 818-306-5836

TELETHERAPY CONSENT FORM
Definition of Services:

I,_____, hereby consent to engage in teletherapy with Family Psychological Services. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, psychological testing, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:
1. I, the client, need to be a resident of California. (This is a legal requirement for psychologists practicing in this state under a CA license.)

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the intake packet I received at the start of my treatment with Family Psychological Services.

4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my psychologist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services.

7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not improve, and in some cases may even get worse.

8. I accept that Family Psychological Services does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my psychologist will recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

10. I understand that dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my written consent. I have read, understand and agree to the information provided above regarding telehealth:

Print Name of Patient_____

Patient/Parent or Guardian:'s Signature:_____

Date:_____

Family Psychological Services
30495 Canwood St Ste 101
Agoura Hills, CA 91301

Phone: 818-707-7366
Fax: 818-306-5836
Email: fps4help@fpsca.com

Consent and Agreement for Psychological Testing and Evaluation

I,_____, agree to allow Family Psychological Services to perform the following services:

X Psychological testing, assessment, or evaluation
X Report writing

This agreement concerns _____
Name DOB

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include a clinicians time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, and any other activities to support these services.

I understand that any fee previously discussed for this (these) service(s) will be payable in two parts: a deposit of 50% payable before the start of this (these) service(s), and a second payment of the balance due on the completion and delivery of any report, or reimbursed through my insurance company. Though my health insurance may repay me for some of these fees, I understand that I remain fully responsible for payment for any services not covered by my insurance. I understand that if I am unable to make my scheduled appointment time I am required to notify Family Psychological Services within 24 business hours or I will be charged $75 for the missed session.

I understand that this evaluation is to be done for the purpose(s) of:
1. Diagnostic Determination
2. Recommendations for educational, social, emotional, language, and behavioral planning

I also understand Family Psychological Services agrees to the following:
1. The procedures for selecting, giving, and scoring the tests, interpreting and storing the results, and maintaining my privacy will be carried out in accord with the widely accepted rules and guidelines of organizations (e.g., HIPPA, FERPA, etc.).
2. Tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.) These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a safe place.

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

_____ _____
Signature of patient/parent/guardian Date

This is a strictly confidential patient medical record. Rediscloure or transfer is expressly prohibited by law.

TELL ME ABOUT YOUR CURRENT MENTAL HEALTH SYMPTOMS

☐ Easily distracted	☐ Often bullies, intimidates, or threatens others
☐ Has trouble following directions	☐ Often initiates physical fights
☐ Has trouble organizing tasks	☐ Has used a weapon (bat, brick, gun, knife, broken bottle, other)
☐ Makes careless mistakes	☐ Has been physically cruel to people
☐ Has trouble focusing on tasks	☐ Has been physically cruel to animals
☐ Is forgetful or loses things	☐ Forced someone else into sexual activity
	☐ Mean, threatening with little provocation since childhood
☐ Fidgets, Squirms, restless, bites nails	☐ Has stolen while confronting a victim (mugging, extortion, robbery)
☐ Runs, climbs excessively. On the go	☐ Often initiates physical fights
☐ Talks excessively, can't play quiet	
☐ Leaves or shifts in seat excessively	☐ Has deliberately engaged in fire setting intending to cause serious damage
	☐ Has deliberately destroyed others' property
☐ Has difficulty waiting turn	
☐ Acts without thinking	☐ Has broken into someone else's house
☐ Interrupts Others	☐ Often lies to obtain goods or favors (cons others)
☐ Often loses temper	☐ Often stays out at night defying parents before age 13
☐ Often argues with adults	☐ Has run away overnight 2 or more times (teenager)
☐ Often actively defies, refuses to obey rules or authority	☐ Has been truant at school before age 13
☐ Often deliberately annoys other people	
☐ Often rationalizes and makes excuses	☐ Ever any suicidal thoughts
☐ Often blames others for own mistakes	☐ Ever engage in harming self
☐ Is often touchy or easily annoyed by others	☐ Ever think about harming others
☐ Is often angry, resentful, spiteful, vindictive	☐ Any current plan to commit suicide
☐ Diminished pleasure in activities	☐ Unrealistic, persistent worry about possible harm to parents / loved ones
☐ Marked decrease/increase in appetite	☐ Panic attacks without any known cause
☐ Insomnia or hypersomnia nearly every day	☐ Unrealistic, persistent worry of being separated from parents / loved ones
☐ Psychomotor agitation or retardation	☐ Confused about hearing / seeing things that others do not
☐ Fatigue or loss of energy	☐ Persistent school / work refusal
☐ Excessive feelings of worthlessness/guilt	☐ Persistent avoidance of being alone
☐ Diminished ability to concentrate	☐ Repeated nightmares about separation from parents
☐ Suicidal ideation or attempt	☐ Somatic complaints
	☐ Fears of traumatic memories -abuse / rape / violence / catastrophe
☐ Depressed or irritable mood most of day	☐ Anxious about strange experiences
☐ Poor appetite or overeating	
☐ Insomnia or hypersomnia	☐ Unrealistic fears of future events
☐ Low energy or fatigue	☐ Unrealistic concern about past failures
☐ Low self-esteem	☐ Unrealistic concern about competence
☐ Poor concentration	☐ Marked inability to relax
☐ Feelings or hopelessness	
☐ Never without symptoms of depression more than 2 mo	☐ Are there times when you:
☐ Social isolation	☐ feel so good/hyper, others think you are not yourself
	☐ are so hyper you get into trouble
☐ Fails to react to loud noises	☐ are so irritable you shout, start fights or argue
☐ Stereotyped mannerisms	☐ felt more self-confident than usual

☐	Odd Postures	☐	get much less sleep and don't miss it
☐	Excessive reaction to noise	☐	are more talkative and talk faster than usual
☐	Overreacts to touch	☐	thoughts race through your head
☐	Compulsive rituals	☐	can't slow your mind down
☐	Motor tics	☐	easily distracted so you cannot concentrate
☐	Vocal tics	☐	have much more energy than usual ☐
		☐	do more things in a day than usual
☐	Has trouble falling asleep	☐	more social and outgoing than usual
☐	Wakes up after only 2-3 hours of sleep	☐	more interested in sex than usual
☐	Has trouble going to sleep after waking in night	☐	sex got you into trouble
☐	Feels tired most mornings	☐	do things unusual that are excessive, foolish, or risky
☐	Stays awake for 2+ days at a time	☐	spent money and got yourself or family in trouble
☐	DRUGS OR ALCOHOL PROBLEMS	☐	MARRIAGE / RELATIONSHIP PROBLEMS
☐	ABUSE – PHYSICAL OR SEXUAL	☐	OTHER:
☐	OTHER:	☐	OTHER:

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General

- ☐ Being overweight
- ☐ Recent weight gain or weight loss
- ☐ Poor appetite
- ☐ Increased appetite
- ☐ Abnormal sensitivity to cold
- ☐ Cold sweats during the day
- ☐ Tired or worn out
- ☐ Hot or cold spells
- ☐ Abnormal sensitivity to heat
- ☐ Excessive sleeping
- ☐ Difficulty sleeping
- ☐ Lowered resistance to infection
- ☐ Flu-like or vague sick feeling
- ☐ Sweating excessively at night
- ☐ Urinating excessively
- ☐ Excessive daytime sweating
- ☐ Excessive thirst
- ☐ Other_____

Neurological

- ☐ Seizures: Medication_____
- ☐ Pacing due to muscle restlessness
- ☐ Forgotten periods of time
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Muscle spasms or tremors
- ☐ Impaired ability to remember
- ☐ "Tics"
- ☐ Numbness

Head, Eye, Ear, Nose, & Throat

- ☐ Head Injury, Concussion
- ☐ Were you unconscious
- ☐ Did you have MRI
- ☐ Facial pain
- ☐ Headache
- ☐ Head injury
- ☐ Neck pain or stiffness
- ☐ Frequent sore throat
- ☐ Blurred vision
- ☐ Double vision
- ☐ Overly sensitive to light
- ☐ See spots or shadows
- ☐ Hearing loss in both ears
- ☐ Ear ringing
- ☐ Disturbances in smell
- ☐ Runny nose
- ☐ Dry mouth
- ☐ Sore tongue
- ☐ Other_____

Gastrointestinal and Hepatic

- ☐ Trouble swallowing
- ☐ Nausea or vomiting (throwing up)
- ☐ Abdominal (stomach / belly) pain
- ☐ Anal itching
- ☐ Painful bowel movements
- ☐ Infrequent bowel movements
- ☐ Liquid bowel movements
- ☐ Loss of bowel control
- ☐ Frequent belching or gas
- ☐ Vomiting blood
- ☐ Rectal bleeding (red or black blood)
- ☐ Jaundice (yellowing of skin)
- ☐ Other_____

Genitourinary

- ☐ Itchy privates or genitals
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Difficulty in starting urine
- ☐ Accidental wetting of self
- ☐ Pus or blood in urine
- ☐ Decreased sexual desire
- ☐ Other_____

Females

- ☐ No menses
- ☐ Menstrual irregularity
- ☐ Painful or heavy periods
- ☐ Premenstrual moodiness, irritability, anger, tension, bloating, bre
- ☐ Painful menstrual periods
- ☐ Painful intercourse or sex
- ☐ Sterility infertility
- ☐ Abnormal vaginal discharge

Other_____

Males

- ☐ Impotence (weak male erection)
- ☐ Inability to ejaculate or orgasm
- ☐ Scrotal pain
- ☐ Abnormal penis discharge

Other_____

Explanation

_____

_____

Current Medical Diagnoses:

_____

_____

_____

_____

Learning Disability Screening Questionnaire

Please rate yourself on each of the symptoms listed below using the following scale.

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Reading

_____ ____1. I am a poor reader.
_____ ____2. I do not like reading.
_____ ____3. I make mistakes when reading like skipping words or lines.
_____ ____4. I read the same line twice.
_____ ____5. I have problems remembering what I read even though I have read all the words.
_____ ____6. I reverse letters when I read (such as b/d, p/q).
_____ ____7. I switch letters in words when reading (such as god and dog).
_____ ____8. My eyes hurt or water when I read.
_____ ____9. Words tend to blur when I read.
_____ ____10. Words tend to move around the page when I read.
_____ ____11. When reading I have difficulty understanding the main idea or identifying important details.

Writing

_____ ____12. I have "messy" handwriting.
_____ ____13. My work tends to be messy.
_____ ____14. I prefer print rather than writing in cursive.
_____ ____15. My letters run into each other or there is no space between words.
_____ ____16. I have trouble staying within lines.
_____ ____17. I have problems with grammar or punctuation.
_____ ____18. I am a poor speller.
_____ ____19. I have trouble copying off the board or from a page in a book.
_____ ____20. I have trouble getting thoughts from my brain to the paper.
_____ ____21. I can tell a story but cannot write it.

Body Awareness/ Spatial Relationships

_____ ____22. I have trouble with knowing my left from my right.
_____ ____23. I have trouble keeping things within columns or coloring within lines.
_____ ____24. I tend to be clumsy, uncoordinated.
_____ ____25. I have difficulty with eye hand coordination.
_____ ____26. I have difficulty with concepts such as up, down, over or under.
_____ ____27. I tend to bump into things when walking.

Oral Expressive language

_____ ____28. I have difficulty expressing myself in words.
_____ ____29. I have trouble finding the right word to say in conversations.
_____ ____30. I have trouble talking around a subject or getting to the point in conversations.

Receptive language

_____ ____31. I have trouble keeping up or understanding what is being said in conversations.
_____ ____32. I tend to misunderstand people and give the wrong answers in conversations.
_____ ____33. I have trouble understanding directions people tell me.
_____ ____34. I have trouble telling the direction sound is coming from.
_____ ____35. I have trouble filtering out background noises.

Math

_____ ____36. I am poor at basic math skills for my age (adding, subtracting, multiplying and dividing)
_____ ____37. I make "careless mistakes" in math.
_____ ____38. I tend to switch numbers around.
_____ ____39. I have difficulty with word problems.

Sequencing

_____ ____40. I have trouble getting everything in the right order when I speak.
_____ ____41. I have trouble telling time.
_____ ____42. I have trouble using the alphabet in order.
_____ ____43. I have trouble saying the months of the year in order.

Abstraction

_____ ____44. I have trouble understanding jokes people tell me.

_____ ___ 45. I tend to take things too literally.

Organization

_____ ___ 46. My notebook/paperwork is messy or disorganized.
_____ ___ 47. My room is messy.
_____ ___ 48. I tend to shove everything into my backpack, desk or closet.
_____ ___ 49. I have multiple piles around my room.
_____ ___ 50. I have trouble planning my time.
_____ ___ 51. I am frequently late or in a hurry.
_____ ___ 52. I often do not write down assignments or tasks and end up forgetting what to do.

Memory

_____ ___ 53. I have trouble with my memory.
_____ ___ 54. I remember things from long ago but not recent events.
_____ ___ 55. It is hard for me to memorize things for school or work.
_____ ___ 56. I know something one day but do not remember it to the next.
_____ ___ 57. I forget what I am going to say right in the middle of saying it.
_____ ___ 58. I have trouble following directions that have more than one or two steps.

Social Skills

_____ ___ 59. I have few or no friends.
_____ ___ 60. I have trouble reading body language or facial expressions of others.
_____ ___ 61. My feelings are often or easily hurt.
_____ ___ 62. I tend to get into trouble with friends, teachers, parents or bosses.
_____ ___ 63. I feel uncomfortable around people I do not know well.
_____ ___ 64. I am teased by others.
_____ ___ 65. Friends do not call and ask me to do things with them.
_____ ___ 66. I do not get together with others outside of school or work.

Sensory Integration Issues

_____ ___ 67. I seem to be more sensitive to the environment than others.
_____ ___ 68. I am more sensitive to noise than others.
_____ ___ 69. I am particularly sensitive to touch or very sensitive to certain clothing or tags.
_____ ___ 70. I have unusual senstivity to certain smells.
_____ ___ 71. I have unusual sensitivty to light.
_____ ___ 72. I am sensitive to movement or craves spenning activities.
_____ ___ 73. I tend to be clumsy or accident prone.

Perseveration

_____ ___ 74. I have narrow or unusual interests.
_____ ___ 75. I am highly distressed by change.
_____ ___ 76. I insist on sameness everyday.
_____ ___ 77. I experience unusual repetitive movements (hand flapping, body rocking, finger movements, etc.)

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please indicate your answer with an x in the box.

PHQ-9	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things.	☐	☐	☐	☐
2. Feeling down, depressed, irritable, or hopeless.	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much.	☐	☐	☐	☐
4. Feeling tired or having little energy.	☐	☐	☐	☐
5. Poor appetite or overeating.	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
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.	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	☐	☐	☐	☐
Add the score for each column				

Total Score (add your column scores): _____

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**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please indicate your answer with an x in the box.

GAD-7	Not at all sure (0)	Several days (1)	Over half the days (2)	Nearly every day (3)
1. Feeling nervous, anxious, or on edge.	☐	☐	☐	☐
2. Not being able to stop or control worrying.	☐	☐	☐	☐
3. Worrying too much about different things.	☐	☐	☐	☐
4. Trouble relaxing.	☐	☐	☐	☐
5. Being so restless that it's hard to sit still.	☐	☐	☐	☐
6. Becoming easily annoyed or irritable.	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen.	☐	☐	☐	☐
Add the score for each column				

Total Score (add your column scores): _____

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**

UHS Rev 4/2020

HSS

At different times in their life everyone experiences changes or swings in mood, energy, activity and mood("highs and lows" or "ups and downs"). The aim of this questionnaire is to assess the characteristics of the "high" periods.

1- First of all, how are you today compared to your usual state?

- ☐ **Much worse than usual**
- ☐ **Worse than usual**
- ☐ **A little worse than usual**
- ☐ **Neither better nor worse than usual**
- ☐ **A little better than usual**
- ☐ **Better than usual**
- ☐ **Much better than usual**

2- Compared to other people, my level of activity energy mood:(Not how you feel today, but how you are on average)

- ☐ **Is always rather stable and even**
- ☐ **Is generally higher**
- ☐ **Is generally lower**
- ☐ **Repeatedly shows periods of ups and downs**

3

Please try to remember a period when you were in a "high" state (while not using drugs or alcohol). In such state you felt like (circle each one that applies):

1	☐	**I need less sleep**
2	☐	**I feel more energetic and more active**
3	☐	**I am more self-confident**
4	☐	**I enjoy my work more**
5	☐	**I am more sociable (make more phone calls, go out more)**
6	☐	**I want to travel and/or do travel more**
7	☐	**I tend to drive faster or take more risks when driving**
8	☐	**I spend more money/too much money**
9	☐	**I take more risks in my daily life (in my work and/or other activities)**
10	☐	**I am physically more active (sport etc.)**
11	☐	**I plan more activities or projects**
12	☐	**I have more ideas, I am more creative**
13	☐	**I am less shy or inhibited**
14	☐	**I wear more colorful and more extravagant clothes/make-up**
15	☐	**I want to meet or actually do meet more people**
16	☐	**I am more interested in sex, and/or have increased sexual desire**
17	☐	**I am more flirtatious and/or am more sexually active**
18	☐	**I talk more**
19	☐	**I think faster**
20	☐	**I make more jokes or puns when I am talking**
21	☐	**I am more easily distracted**
22	☐	**I engage in lots of new things**
23	☐	**My thoughts jump from topic to topic**
24	☐	**I do things more quickly and/or more easily**
25	☐	**I am more impatient and /or get irritable more easily**
26	☐	**I can be exhausting or irritating for others**
27	☐	**I get into more quarrels**
28	☐	**My mood is higher, more optimistic**
29	☐	**I drink more coffee**
30	☐	**I smoke more cigarettes**
31	☐	**I drink more alcohol**
32	☐	**I take more drugs(sedatives, anti-anxiety pills, stimulants)**

Primary Care *Mood Questionnaire*

		Yes	No
1.	**Has there ever been a period of time when you were not your usual self and (while not using drugs or alcohol):**	☐	☐
	You felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble? *(circle yes or no for each line please)*	☐	☐
	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 usual 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 you 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 more than one of the above, have several of these ever happened during the same period of time?**	☐	☐
3-	**Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?**	☐	☐

4- **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?**

☐ **No Problem** ☐ **Minor Problem** ☐ **Moderate Problem** ☐ **Serious Problem**

5- **Draw a line connecting any (blood) relative to any problem (this doesn't have to be neat):**

Grandparents	**Mom**	**Dad**	**Aunts/Uncles**	**Brother/Sisters**	**Children**
Suicide	**Alcohol/drug problems**		**Mental Hospital**	**Manic or bipolar**	

BSDT

Read the following paragraph all the way through first. Check the statements that apply to you; then follow the instructions which appear below it:

- ☐ **Some individuals noticed that their mood and/or energy levels shift drastically from time to time**
- ☐ **These individuals notice that, at times, they are moody and/or energy level is very low, and at other times, and very high**
- ☐ **During their "low" phases, these individuals often feel a lack of energy, a need to stay in bed or get extra sleep, and little or no motivation to do things they need to do**
- ☐ **They often put on weight during these periods**
- ☐ **During their low phases, these individuals often feel "blue", sad all the time, or depressed**
- ☐ **Sometimes, during the low phases, they feel helpless or even suicidal**
- ☐ **Their ability to function at work or socially is impaired**
- ☐ **Typically, the low phases last for a few weeks, but sometimes they last only a few days**
- ☐ **Individuals with this type of pattern may experience a periods of "normal" mood in between mood swings, during which their mood and energy level feels "right" and their ability to function is not disturbed**
- ☐ **They may then noticed they marked shift or "switch" in the way they feel**
- ☐ **Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do**
- ☐ **Sometimes during those "high" periods, these individuals feel as if they had too much energy or feel "hyper"**
- ☐ **Some individuals, during these high periods, may feel irritable, "on edge", or aggressive**
- ☐ **Some individuals, during these high periods, take on too many activities at once**
- ☐ **During the high periods, some individuals may spend money in ways that cause them trouble**
- ☐ **They may be more talkative, outgoing or sexual during these high periods**
- ☐ **Sometimes, their behavior during the high periods seems strange or annoying to others**
- ☐ **Sometimes, these individuals get into difficulty with co-workers or police during these high periods**
- ☐ **Sometimes, they increase their alcohol or nonprescription drug use during the high periods**

- ○ **TOTAL THE NUMBER OF CHECK MARKS_____.**

Please decide which of the following is most accurate:

- ○ **This story fits me very well, or almost perfectly** ☐
- ○ **This story fits me fairly well** ☐
- ○ **This story fits me to some degree, but not in most respects** ☐
- ○ **This story doesn't really describe me at all** ☐

PTSD CheckList – (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that clients sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?	☐	☐	☐	☐	☐
2.	Repeated, disturbing *dreams* of a stressful experience from the past?	☐	☐	☐	☐	☐
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?	☐	☐	☐	☐	☐
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?	☐	☐	☐	☐	☐
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?	☐	☐	☐	☐	☐
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?	☐	☐	☐	☐	☐
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?	☐	☐	☐	☐	☐
8.	Trouble *remembering important parts* of a stressful experience from the past?	☐	☐	☐	☐	☐
9.	Loss of *interest in things that you used to enjoy?*	☐	☐	☐	☐	☐
10.	Feeling *distant* or *cut* off from other people?	☐	☐	☐	☐	☐
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	☐	☐	☐	☐	☐
12.	Feeling as if your *future* will somehow be *cut short*?	☐	☐	☐	☐	☐
13.	Trouble *falling* or *staying asleep*?	☐	☐	☐	☐	☐
14.	Feeling *irritable* or having *angry outbursts*?	☐	☐	☐	☐	☐
15.	Having *difficulty concentrating*?	☐	☐	☐	☐	☐
16.	Being *"super alert"* or watchful on guard?	☐	☐	☐	☐	☐
17.	Feeling *jumpy* or easily startled?	☐	☐	☐	☐	☐

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division