Registration

to be completed by applicant, parent, guardian or assistant

Applicant _____ age___ sex___ birth date _____

address _____ city, state, zip _____

cell _____ work _____ home _____

eMail _____ fax _____ best time to call: home _____ work _____

preferences: ☐**any** contact is OK *-or-* ***HOME*** ☐no calls ☐no messages ☐no faxes ***WORK*** ☐no calls ☐no messages ☐no faxes

employer/school _____ job/grade _____

street address _____ city, state, zip _____

referred by _____ phone _____

personal physician _____ phone _____

Primary contact _____ relationship _____

address ☐ check if same as above: _____ city, state, zip _____

cell _____ work _____ home _____

eMail _____ fax _____ best time to call: home _____ work _____

preferences: ☐**any** contact is OK *-or-* ***HOME*** ☐no calls ☐no messages ☐no faxes ***WORK*** ☐no calls ☐no messages ☐no faxes

employer/school _____ job/grade _____

address _____ city, state, zip _____

Secondary contact _____ relationship _____

address ☐ check if same as above: _____ city, state, zip _____

cell _____ work _____ home _____

eMail _____ fax _____ best time to call: home _____ work _____

preferences: ☐**any** contact is OK *-or-* ***HOME*** ☐no calls ☐no messages ☐no faxes ***WORK*** ☐no calls ☐no messages ☐no faxes

employer/school _____ job/grade _____

address _____ city, state, zip _____

- I request initial consultative services for myself, my family, my client and/or my dependent. I understand that this consultation does not initiate a doctor/patient relationship and may result in a referral, report, discharge or consultation with a third party.
- If applying for a minor, I certify that I have the legal right to obtain consultation, evaluation and/or treatment.
- My permission for this service and/or release of information can be revoked at any time.
- I understand that I am responsible for the charges incurred for these services unless a specific payor (person, third party or agency) arranged for payment in advance. (Designate agency below). We do not accept assignment of benefits from private insurers.
- I read and understood the Privacy Policy and Practice Information documents provided.

Please specify payor: ☐ myself ☐ third party _____

Responsible party _____ date _____

Applicant _____ Age _____ Date of Evaluation _____

Filled out by [_] applicant [_] other _____ clinician _____

Please answer from the point of view of the adolescent.

Use the lines below each section or the back of the page to explain your answers. Although some questions may be difficult to answer in the space provided, do your best to be brief and to the point. During the interview you can ask questions, explain your answers, discuss whatever you like.

1. **What is the purpose of your interview?** Do you, or other people, think you are having any problems?

Problem list: _____ _____

_____ _____

_____ _____

_____ _____

2. When did these problems start? _____ How long do you think it will take to take care of them? _____
3. What do you think caused them? _____

Treatment

4. Did you have counseling for depression, addiction or emotional or behavioral problems? [_] yes [_] no

Age	Where	Who treated you	What for	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Did you take medication in the past? [_] yes [_] no *(List current medications on page 4, past meds below)*

If so What kind	What for	How much/how often	Doctor	I took it for (how long)	How long ago
Example: ZOLOFT	social phobia	25 mgs/ 2 times a day	Jones	2 years	4 yrs ago
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

6. Were you hospitalized for these or other problems? [_] yes [_] no If so, how many times? _____

Age	Where	Your doctor	What for (diagnosis, if any)	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Did you have any BAD REACTIONS to medications? [_] no [_] yes _____

Was any treatment helpful? [_] yes [_] no [_] sort of Explain: _____

7. Placements Other than treatment centers, list the places you lived when you did not stay with your mother and/or father.

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

Growing up

8. Did you have any MEDICAL problems [_] at birth [_] birth to age 3 [_] 3 to 5 [_] 5 to 12 [_] 12 to 18? [_] no

Please explain: *(put recent and current conditions on page 4)* _____

_____

9. Did you have DELAYS or problems with: [_] don't know

[_] crawling/walking [_] coordination [_] eating _____

[_] ear infections [_] growing [_] weaning _____

[_] learning to talk [_] toileting [_] attention _____

[_] staying alone [_] playing [_] learning _____

10. What words fit your early PERSONALITY best: [_] social [_] leader [_] loner [_] joiner [_] fearful [_] temperamental [_] self-absorbed

[_] shy [_] careful [_] serious [_] scattered [_] fighter [_] withdrawn [_] impulsive [_] aggressive [_] thoughtless [_] gothic [_] stoner

[_] rigid [_] fearless [_] angry [_] fun [_] easy going [_] defiant [_] weird [_] studious [_] other _____

11. Did you have trouble GETTING ALONG _____ [_] no

with [_] other kids [_] brothers/sisters [_] parents _____

[_] teachers [_] other authority figures? _____

starting in [_] preschool [_] KG [_] grade ___ _____

Any past trouble with the law? [_] no [_] yes _____

[_] vandalism/theft [_] fires [_] drugs [_] truant _____

[_] hurt animals [_] gang activity [_] violence _____

12. Did you have WORRIES about [_] leaving home [_] going to school [_] safety/heath [_] being around people? [_] no

When worried, did you have [_] stomach pains [_] trouble sleeping [_] nightmares [_] panic attacks? Other: _____ [_] no

_____

[_] Did you ever try to harm yourself? Explain: _____ [_] no

_____

13. Did you undergo TRAUMA such as [_] DEATHS, illness or losses [_] parents DIVORCED [_] witness ABUSE? [_] no

Were you abused, mistreated or abandoned? [_] yes [_] no <u>Explain this section below</u>

How were you PUNISHED? [_] not _____

[_] timed out [_] grounded [_] points _____

[_] natural consequences [_] belted _____

[_] lectured [_] chores [_] other _____

_____

Were you [_] poorly accepted or _____

[_] rejected by your parents _____

[_] raised by foster parents? _____

_____

[_] Did your parents lose control? _____

[_] Did either use drugs or alcohol? _____

[_] Were they in trouble with the law? _____

Your everyday life

14. Your school ________________________________ [] none. What grade are you in? _____ What grade should you be in?____

Learning disability [] no [] yes: [] reading [] math [] written language [] verbal [] receptive [] expressive [] processing [] speech Other _______

Special classes: [] none [] resource [] self-contained [] other: __________ Were you [] RPC'd [] Suspended [] Expelled [] Special schooled: ____________

15. Do you work? Where ____________________________ position _________________________ # mo/yrs at this job ______

Longest employment at _________________________________ position __________________________ how long? ____

Other notable work or experience ____

16. Your educational/vocational plan _______________________ [] none Spiritual practice ____________________ [] none

17. Problems and stress. Check all areas of concern. Other ____

[] **PERSONAL**	[] self-control	[] motivation	[] concentration	[] fatigue	[] mood	[] organization	[] grief
	[] family illness	[] health	[] accident	[] adoption	[] parenting	[] home/household/move(s)	
[] **RELATIONSHIP**	[] friend(s)	[] supervisor	[] roommate	[] coworker	[] spouse	[] girl/boyfriend	
[] **FAMILY**	[] fighting	[] conflicts/divorce	[] custody	[] child problems	[] parents	[] other relatives	
[] **SCHOOL**	[] performance	[] concentration	[] behavioral	[] disability	[] accommodation		
[] **WORK**	[] conflicts	[] fitness for duty	[] disability	[] financial/loss	[] vocational direction		
[] **HABIT**	[] alcohol/drug	[] gambling	[] sexual	[] obsession	[] impulsivity	[] other behavioral	
[] **LEGAL**	[] probation	[] parental fitness	[] competency	[] drug/alcohol	[] community safety	[] criminal allegation	
	[] personal injury/workman compensation [] other ____________________________						

18. Explain how you cope with stress: ____

____

How well do you think you are doing? [] poorly [] could be better [] varies [] very well [] I feel great

19. What are your strengths and interests? []reading []writing []music (what kind) ____________ []play sports (which one) ______________

[]faith/prayer []community/church []building/mechanics/computer []work []shopping []collections []video/computer games []play instrument

[]movies/TV []art/photo []travel []friends/social []blogs/chat/online []gamble []journal [] design /fashion []coach/volunteer [] other: ________

You and your family

20. Did you go through divorce? [] parents divorced [] my divorced [] none Was it difficult? [] yes [] no Is it still? [] yes [] no
Are/were there problems with [] legal custody [] physical custody [] visitation [] alimony/child support [] parental differences [] abuse allegations

21. Have any of your blood relatives had EMOTIONAL, BEHAVIORAL or ADDICTION problems? [] yes [] no
[]addiction []drugs []alcohol [] learning disability [] ADHD [] Manic depression/bipolar [] depression [] anxiety [] panic [] autism
[] obsessive/compulsions [] psychosis/schizophrenia [] diagnosis unknown [] needed medication [] hospitalized [] other:__________

22. List your family members living in your home(s) and elsewhere. Use an "[s]" in the box to indicate step-relative.
Example SUSAN SAMPLER . age 35 .[S]mother []father []spouse/partner --->[] Lives with you [x] other home New Jersey

Name ________________________ . age____. []mother []father []spouse/partner --->[] Lives with you [] other home _____________

Name ________________________ . age____. []mother []father []spouse/partner --->[] Lives with you [] other home _____________

Name ________________________ . age____. []sister []brother []daughter []son []other--->[] Lives at home [] other home _______________

Name ________________________ . age____. []sister []brother []daughter []son []other--->[] Lives at home [] other home _______________

Name ________________________ . age____. []sister []brother []daughter []son []other--->[] Lives at home [] other home _______________

Name ________________________ . age____. []sister []brother []daughter []son []other--->[] Lives at home [] other home _______________

Name ________________________ . age____. []sister []brother []daughter []son []other--->[] Lives at home [] other home _______________

Name ________________________ . age____. []sister []brother []daughter []son []other--->[] Lives at home [] other home _______________

Your health

23. Past and current MEDICAL PROBLEMS. Write in your age (approximate) when you were first diagnosed.

Medical condition(s) and/or check below _____ [_] no medical problems

_____asthma/emphysema/lung disease _____uterus, ovaries, breast _____polycystic ovaries _____genital

_____serious injury to arms, legs, back _____thyroid/pituitary/hormone _____chronic fatigue _____Tourette's/tics

_____blood pressure/anemia/valve _____urinary/bladder _____skin cancer/disease _____other cancer

_____ulcers/colitis/rectal/colon/esophagus _____prostate cancer/disease _____shaking/Parkinson's _____AIDS/HIV/STD

_____jaundice/hepatitis/liver disease _____heart attack/heart disease _____paralysis/sensory _____kidney/renal

_____black-outs/epilepsy/seizures _____head injury/stroke/migraine _____infectious disease _____diabetes

_____eyes/ears/nose/throat _____lymphoma/leukemia/blood _____arthritis/ lupus _____self-injury

Other_____

24. Check any persistent or bothersome symptoms:

[_]back problems [_]headaches [_]allergies [_]gastrointestinal symptoms [_]stomach aches [_]nausea [_]vomiting [_]diarrhea
[_]bloody/black stools [_]unusual weight gain or loss [_]bladder control [_]leg swelling [_]excessive coughing or coughing blood
[_]chest pain [_]wheezing [_]fatigue [_]joint pain [_]muscular pain [_]visual problems [_]changes in sexual functioning [_]sleeping
[_]rash/abnormal itching [_]persistent fever [_]shortness of breath [_]drug problems Other _____

Last physical exam by doctor _____Month/year _____

25. For women: Are you having monthly periods? [_] yes [_] no Using birth control? [_] yes [_] no Could you be pregnant? [_] yes [_] no

26. List below accidents or work injuries involving workman's compensation or insurance claims.

Date	Type of Injury	Location of accident	case pending?
_____	_____	_____	[_] yes [_] no
_____	_____	_____	[_] yes [_] no
_____	_____	_____	[_] yes [_] no

27. Have you had an EKG (heart monitor)? [_] yes [_] no Was it abnormal? [_] yes [_] no

28. Ever have a head injury, an EEG (brain wave test) or seen a neurologist (brain specialist)? [_] yes [_] no

29. List the medications you are allergic to: [_] penicillin [_] sulfa [_] others _____

30. Do you have a poor DIET? [_] yes In what way?_____ [_] no

31. CAFFEINATED beverages (energy drinks, colas, tea, coffee) each day?____ Tobacco [_] chew [_] smoke_____

32. On average, how many cigarette packs have you smoked for how many years? [_] none [_] quit __packs/day __years

33. **CURRENT MEDICATIONS** and TREATMENTS you are taking still. Also list herbal remedies and supplements.

	What kind	**What for**	**How much/how often**	**Prescribing doctor**	**How long**
Example:	DOXYCYCLINE	acne	100 mgs/ twice a day	Dr. Smith	1 year

Drug and Alcohol Profile

Check here if this section is [_] Not Applicable

Has anyone told you they were concerned about your drug or alcohol use? [_] yes [_] no
Does it annoy you when others tell you how they feel about your drinking or use? [_] yes [_] no
Have you ever felt guilty about drinking? [_] yes [_] no
Did you ever drink to get the day started when you first woke up (had an eye-opener)? [_] yes [_] no

Did you ever: have a seizure while withdrawing from alcohol or drugs? [_] yes [_] no
hallucinate, shake, be anxious, agitated or have physical craving after stopping? [_] yes [_] no
go to two or more, or switch doctors to get more prescriptions? [_] yes [_] no

Did you ever lose your memory due to alcohol or drugs? [_] temporarily [_] permanently [_] Ever blacked out?
Ever overdose [_] on purpose? [_] by accident? [_] go to the hospital? [_] stomach pumped? [_] admitted overnight?
If you no longer drink or use drugs, why did you stop?._____

Ever go to [_] AA [_] NA [_] CA [_] ACOA [_] Al-anon [_] Ever have a sponsor? [_] Are you familiar with the 12 steps?

Check all the substances you have tried and circle your favorites.

	When did you start? Age	How much and how often do/did you use? Cost per week.	Did you stop?	When
[X] EXAMPLE (weed)	10	One or two blunts every day, $50 to $300 per week	[X] yes [_] no	2 months ago
[_] alcohol	_____	_____	[_] yes [_] no	_____
[_] weed/marijuana	_____	_____	[_] yes [_] no	_____
[_] crystal meth/speed	_____	_____	[_] yes [_] no	_____
[_] cocaine/ crack	_____	_____	[_] yes [_] no	_____
[_] XTC/ecstasy/MDMA/X	_____	_____	[_] yes [_] no	_____
[_] heroin	_____	_____	[_] yes [_] no	_____
[_] mushrooms/peyote	_____	_____	[_] yes [_] no	_____
[_] LSD/ PCP	_____	_____	[_] yes [_] no	_____
[_] GHB/ DXM/ K	_____	_____	[_] yes [_] no	_____
[_] sherm	_____	_____	[_] yes [_] no	_____
[_] Xanax/Valium/Ativan	_____	_____	[_] yes [_] no	_____
[_] barbiturates	_____	_____	[_] yes [_] no	_____
[_] other prescriptions	_____	_____	[_] yes [_] no	_____
[_] huffing paint, glue, etc.	_____	_____	[_] yes [_] no	_____
[_] other _____	_____	_____	[_] yes [_] no	_____

[_] I mixed them as follows _____

_____

[_] Did you get into legal or other trouble in any way due to your substance use? Please explain:

_____

_____

List any other addiction you think you might have. _____

Adult Psych Symptoms Checklist

Name _____ Date _____ Filled out by _____ Relationship _____

This questionnaire defines your problem areas. Many of these questions may not apply. Some may sound strange or be inappropriate but please do your best. You can ask questions and explain your answers during the interview.

Check NOW, PAST, or N/A (Not Applicable/appropriate) for each line as it applies to you NOW, in the past only, both or neither.

For example:

NOW	PAST	N/A	
[x]	[x]	[ ]	Do you like to watch television?
[ ]	[ ]	[x]	Do you play baseball?
[x]	[ ]	[ ]	Do you have allergies?
[ ]	[x]	[ ]	Do you wet your bed?

If you have DEPRESSION, please describe what it is like for you: (If not, check [ ] here, and move on to page 2)

NOW	PAST	N/A	
[ ]	[ ]	[ ]	Does your depression or sadness COME AND GO frequently?
[ ]	[ ]	[ ]	Do your moods come OUT of the BLUE?
[ ]	[ ]	[ ]	Is your depression triggered by things that HAPPEN?
[ ]	[ ]	[ ]	Do you stay depressed for 2 WEEKS or more with little if any relief?

When you are depressed, do you:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	… lose your ENERGY?
[ ]	[ ]	[ ]	… have a "WHATEVER" attitude *only* when you are depressed?
[ ]	[ ]	[ ]	… lose INTEREST in everything? … [ ] slow down … [ ] become RESTLESS?
[ ]	[ ]	[ ]	… lose your APPETITE? … [ ] LOSE weight … [ ] GAIN weight?
[ ]	[ ]	[ ]	Do you have trouble FALLING ASLEEP?
[ ]	[ ]	[ ]	… wake up in the [ ] MIDDLE of the night, or [ ] EARLY in the morning? [ ] wake up IN A PANIC?
[ ]	[ ]	[ ]	… need a lot of NAP TIME?
[ ]	[ ]	[ ]	Do you wake GASPING for breath? [ ] SNORE?

During periods of depression, do you:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	… get very ANGRY AT yourself? … [ ] all the time? … [ ] only when very depressed?
[ ]	[ ]	[ ]	… feel GUILTY for things that are not your fault?
[ ]	[ ]	[ ]	… STAY ALONE … [ ] MOPE around?
[ ]	[ ]	[ ]	… have trouble THINKING or CONCENTRATING?
[ ]	[ ]	[ ]	… CRY easily … [ ] feel DESPERATE?

If you have thoughts about hurting yourself:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	Have you INJURED yourself on purpose?
[ ]	[ ]	[ ]	Do you have THOUGHTS about taking your life?
[ ]	[ ]	[ ]	Do you have PLANS to do it?
[ ]	[ ]	[ ]	Have you ever TRIED to end your life?

[ ] Do you have any such thoughts or plans NOW?

Are you ever ON EDGE (anxiety or panic) to an extreme? (If not, check [ ] here, and move on to the next section.)

NOW	PAST	N/A	
[ ]	[ ]	[ ]	Do your nerves effect EVERY PART of your life?
[ ]	[ ]	[ ]	Do you have sudden ATTACKS …[ ] MINUTES or … [ ] HOURS that go away quickly?
[ ]	[ ]	[ ]	…do you stay nervous for a …[ ] FEW DAYS, or … is it [ ] ALWAYS THERE?
[ ]	[ ]	[ ]	Do you have FEELINGS IN YOUR BODY when you get upset, such as…
[ ]	[ ]	[ ]	PAINS in your …[ ] CHEST, …[ ] HEAD or …[ ] STOMACH?
[ ]	[ ]	[ ]	When nervous, do you have trouble BREATHING?
[ ]	[ ]	[ ]	… your …[ ] HEART POUNDS? …[ ] LOSES FEELING in your hands, head or feet?
[ ]	[ ]	[ ]	Do you feel SHAKY, SWEATY, FLUSHED or DIZZY when you get nervous?
[ ]	[ ]	[ ]	Do you AVOID PEOPLE or …[ ] THINGS? _____ (For instance)
[ ]	[ ]	[ ]	Do you have extreme NIGHTMARES?
[ ]	[ ]	[ ]	Do you have memories that are so real, it's like you are actually LIVING them?
[ ]	[ ]	[ ]	Do you ever feel OUT OF TOUCH like you are OUTSIDE OF YOUR BODY as though you are watching a movie of your life instead of living it?

Do you have abnormal MOVEMENTS of your face or other parts of your body?
(If not, check [ ] here, and move on to the next section below.)

NOW	PAST	N/A	
[ ]	[ ]	[ ]	Do you get movements or irritations in your THROAT or MOUTH such as throat clearing or sniffing?
[ ]	[ ]	[ ]	Do your hands SHAKE a lot of the time?
[ ]	[ ]	[ ]	Do other parts of your body JERK uncontrollably?
[ ]	[ ]	[ ]	Does this happen only when you are nervous?
[ ]	[ ]	[ ]	Does it happen at BEDTIME when you are trying to fall asleep?
[ ]	[ ]	[ ]	Do you call out FOUL LANGUAGE out of the blue as though you have no control?
[ ]	[ ]	[ ]	Do you have severe HEADACHES?
[ ]	[ ]	[ ]	… have you ever …[ ] BLACKED-OUT … [ ] have FITS … [ ] FAINTED … [ ] SEIZURE(S)?
[ ]	[ ]	[ ]	Have you WET or SOILED your clothes? … [ ] DURING BLACKOUTS?

Do you have:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	THOUGHTS that just WON'T GO AWAY?
[ ]	[ ]	[ ]	… the need to DO THINGS OVER AND OVER almost unable to stop?
[ ]	[ ]	[ ]	… uncontrollable urges such as CHECKING your body, locking the door over and over again, washing, counting, or having to have everything … [ ] "JUST SO"?
[ ]	[ ]	[ ]	If you try to control these, is it extremely UNCOMFORTABLE?

Do you take things very SERIOUSLY to the point that you performs:

[ ]	[ ]	[ ]	RITUALS, ROUTINES or HABITS that don't make sense?
[ ]	[ ]	[ ]	Would you or others describe you as RIGID?
[ ]	[ ]	[ ]	Do you ever think that "trying to be PERFECT" gets out of hand?

Do you:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	BINGE eat or PURGE food?
[ ]	[ ]	[ ]	Use LAXATIVES or make himself VOMIT?
[ ]	[ ]	[ ]	Do you think you or you are over-weight whiles others see you as just fine?

Have you done things OUT OF CHARACTER such as:

NOW PAST N/A

[ ] [ ] [ ] Gone SEVERAL NIGHTS WITH LITTLE IF ANY SLEEP?
[ ] [ ] [ ] SPENT a lot? … [ ] GAVE away THINGS you treasured?
[ ] [ ] [ ] Shown a lot of … [ ] ENERGY? Acted exceptionally … [ ] STRONG or… [ ] SMART?
[ ] [ ] [ ] Treated OTHERS POORLY, acted RUDE, HOSTILE or ARGUMENTATIVE out of character?
[ ] [ ] [ ] Did you feel SHAME or regret LATER about unusual things you did?
[ ] [ ] [ ] Has your SEXUAL DRIVE or behavior ever been a concern to you?
[ ] [ ] [ ] Do you get very, very focused on HORROR films, PAIN or REVENGE?
[ ] [ ] [ ] Do you suffer from EXTREME JEALOUSY?
[ ] [ ] [ ] Do these characteristics come and go together in episodes?
[ ] [ ] [ ] Are they part of your EVERYDAY behavior?
[ ] [ ] [ ] Do you think these out of character reactions are due only to drug use?
[ ] Are you in one of these episodes right now?

Did you ever feel like BIZARRE things were happening, such as:

NOW PAST N/A

[ ] [ ] [ ] VOICES whispering, talking, calling your name or swearing at you?
[ ] [ ] [ ] SMELLING things no one else does?
[ ] [ ] [ ] … heard or saw THINGS or PEOPLE that no one else does?
[ ] [ ] [ ] … lost your sense of DIRECTION … [ ] MEMORY?
[ ] [ ] [ ] Have you ever seen things breathing, shrinking or growing?

Have you:

NOW PAST N/A

[ ] [ ] [ ] stopped TAKING CARE of yourself?
[ ] [ ] [ ] become ill at ease WITH PEOPLE?
[ ] [ ] [ ] … lost your SENSE OF HUMOR?
[ ] [ ] [ ] … thought the RADIO or TV was TALKING to you?
[ ] [ ] [ ] … thought that your THOUGHTS WERE BEING READ or CONTROLLED?
[ ] [ ] [ ] Do you have thoughts or beliefs that are IRRATIONAL or hard for others to follow, understand or believe?
[ ] [ ] [ ] Do you think ALCOHOL or DRUGS were responsible for these reactions?

Would you use any of the following terms to described your USUAL behavior when you were young?

[ ] Selfish	[ ] Steals	[ ] Inattentive	[ ] Stubborn	[ ] Hurts animals
[ ] Fidgety	[ ] Sets fires	[ ] Destructive	[ ] Anti-authority	[ ] Lacks conscience
[ ] Lies	[ ] Fights	[ ] Restless	[ ] Distractible	[ ] Insensitive to pain
[ ] Willful	[ ] Argues	[ ] Irresponsible	[ ] Calls out in class	[ ] Can't wait turn
[ ] Bullies	[ ] Cheats	[ ] Disrespectful	[ ] Short attention	[ ] Acts without thinking
[ ] Hateful	[ ] Whines	[ ] Demanding	[ ] Takes risks	[ ] Uncaring about others
[ ] Abusive	[ ] Defiant	[ ] Out of control	[ ] Manipulative	[ ] Other:

Describe any illegal or other activities not covered elsewhere that you are concerned about below or on the back.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Privacy Practices

This document describes the information processes and protections of this practice. You should know how we conduct our practice and assure your privacy.

Prescribing

Certain prescriptions require an original for each fill, such as most ADD medications. Others require a new prescription after the 6 refills, such as antianxiety medications. Some can be filled, after shown to be safe and effective, for up to a year. We prepare your original prescription on a word processor and hand it to you, usually with prescribing and risk information attached. For refills, you pharmacy will fax us a form to complete. We receive and return these forms to them through by fax by way of gmail and HelloFax, a paperless method that replaces a fax machine. Prescriptions and protected pharmacy information on paper does not float around this office. Prescribing and all medical information are digitalized and are stored in password protected computers on a dedicated password protected network.

Invoices and payments

The practice uses QuickBooks in a dedicated local cloud server to track services and prepare invoices. We send invoices by email (gmail) to the payor. We produce diagnostic and service codes for you on the invoice for you to submit for insurance reimbursement, but we don't accept assignments of payments the insurance companies. The invoice should help you to get the benefit allowed by your insurance. Payment at time of service is expected unless other arrangements are made and approved by Dr. Roitman. We accept cash, checks, Amex, MasterCard or Visa.

Communications

We ask your permission to phone, text, email, fax, FaceTime or (when prearranged) Skype you or your family member with the understanding that Skype, and metadata on emails, may not be 100% secure. The degree of security is just like that you have for your private home operations.

Medical records

We produce your record on an Apple Word processor (Pages) that most computers can't open, so if they are sent accidentally, almost never able to be opened. They are produced and stored in a cloud server (Dropbox) which has encrypted storage. Although the metadata (file names) could theoretically detected during transmission to storage, no contents is at risk. This is similar to gmail. We have looked at alternative sites and dedicated servers, but the degree of risk is so small, and the advantage of using universal digital tools and software like these, the decision was to stick with these services. We send record requests by converting the word processing document to PDFs and then send by HelloFax.

Storage and Archives

There are no paper records in the office. The server keeps an archive of every document produced including changes and additions over time. In addition, we use Time Machine backs up for files on a hard drive at a distant location that refreshes on an hourly basis. This drive is encrypted and password protected so it can't be stolen and broken into. Time Machine archives the original and versions of each file. All paper records received or produced elsewhere are scanned. Hard copies are retained for a month under lock and key, and then shredded. We don't destroy digitalized files so your medical record is accessible in case you need it in the future. Old records have been scanned and stored in PDF format.

Medical record content

Proper medical records only track the diagnostic information necessary to guide treatment, such as observations about the effect of medications and their side effects, assessment of other interventions, referrals, labs and future planning. They should document a doctor's reasoning underlying the choice of treatments. The greatest protection against invasion of privacy is selective recording of information, eliminating that which is not relevant to the medical treatment. The practice avoids documenting the names of other people in a patient's file or complicated interpersonal issues. We don't record particulars about conflicts such as who said what to whom. Wishes and fears are recorded only about their pertinence to treatment. Other desires or other personal, private thoughts do not get recorded unless it is necessary to document risks or benefits of treatment.

Routinely information in the records contain whether the patient showed up, what their feeling tone has been in general, examples of improvement or set backs, target behaviors and observations related to medical and psychiatric treatments. Results to date, plans, side effects, prescriptions and informed consents are what they contain. Personal, libelous or embarrassing content not relevant to treatment, especially that which could harm a party, are not recorded. Just as a surgeon records the size, depth and complications of a laceration, and does not describe the person who stabbed them or what the fight was about, psychiatry, as any medical speciality, is concerned with signs and symptoms of disorders. It is not be necessary to record beyond the psychiatric injury except concerning how it was produced and how it can be mitigated.

information releases

The government has a right to records under conditions such as terrorism threat, emergencies, etc and the Board of Medical Examiners may request records to determine whether a doctor is conducting their practice appropriately. Records are be released in case of medical emergencies. Courts can order the release for a variety of reasons, and your insurer will ask to review them if you use your insurance. You may request a release to another provider or ask for a copy yourself at any time. Unless the record is judged to possibly psychologically injure you, it will be released. We think that your record should be accountable and transparent and every entry is chosen with forethought and your privacy in mind.

Online services

Gmail is our email program and is SSL secure and HIPAA compliant. Skype is not complaint and we would need your permission to use it for distant services. We have access to Apple's FaceTime which is HIPAA complaint. Phone sessions are an option. Phones have their limits too, but have always been accepted, as have faxes. Texting is convenient for recording instructions for medication use and provides both parties with a written record about risk and benefit and in this way is superior to voice communications for certain communications. The practices uses an iPhone that is password protected as are all 5 computers on the network. If there is frequent or extensive use of online services, the practice may issue a charge commensurate with the time spent, inconvenience, the urgency of a service or the delivery of therapeutic services off hours. Normally a simple communication or required task is not a chargeable item. When the online service is substituting for outpatient, in office service a charge may be issued.

In summary

HIPAA privacy regulations and standard electronic health records are mostly designed for major health care organizations with many personnel and employee turnover, who could be targets from a variety of sources. They are major financial targets as well. They have complicated computers systems and billing software. Healthcare companies are require to have compliance offices, audits and signed forms, and quality assurance systems. As a small solo practitioner, it is not possible to keep up with changing rules and multilayered requirements. We don't think it is feasible a very small private practice like ours to be compliant the way major health care organizations have to be. If any party is intent on invading your privacy they will find a way around the basic HIPAA regulation anyway. In our estimation, this disclosure meets meet the intent of HIPAA privacy regulations and we are confident in our safety and privacy protection. The practice has always been respectful and based its processes on traditional medical values of total privacy. If you need additional safeguards please let us know and we will accommodate you.

I have read this Privacy Practices document regarding communications, privacy standards, medical records, information storage, prescribing and invoicing. By signing below I signify that I've had the opportunity to discuss them and I accept the Privacy Practices above. I am informed about how this office manages practice information systems and give my consent.

Responsible party date

Witness date

Release of information

Filled out by applicant, parent or guardian, completed by assistant..

Today's date _____

Applicant _____ Age ____ Sex _____ Date of Birth: _____

I hereby authorize Dr. Roitman and his staff to (check all that are applicable):

- ❒ exchange information with:
- ❒ only request information from:
- ❒ only release information to:

Name _____ Title _____

Street _____

City, State and Zip Code _____

Phone _____ fax _____ cell _____ **Initial** _____

Name _____ Title _____

Street _____

City, State and Zip Code _____

Phone _____ fax _____ cell _____ **Initial** _____

Name _____ Title _____

Street _____

City, State and Zip Code _____

Phone _____ fax _____ cell _____ **Initial** _____

NORTON A. ROITMAN, MD
2340 PASEO DEL PRADO #D 307
LAS VEGAS, NEVADA 89102
Phone 702-222-1812 Fax 702-297-6561 eMail: NRoitmanMD@gmail.com

The purpose of this release of information is to

- ❒ Coordinate treatment with other providers
- ❒ Verify attendance
- ❒ Evaluate status
- ❒ Obtain assistance
- ❒ Other _____

I release Norton A. Roitman, MD and his staff from any legal liability resulting from the release of this information with the understanding that reasonable professional safeguards will be taken. Unless otherwise specified, release authorization will expire in one year. Release of information is subject to revocation at any time.

Responsible party _____ Staff _____