AMIGO FAMILY COUNSELING, LLC

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NEW CLIENT WELCOME STATEMENT

Dr. Amigo and the staff at Amigo Family Counseling, LLC (AFC) would like to review some important information with you regarding our procedures and mutual responsibilities.

OFFICE HOURS

Amigo Family Counseling, LLC is open Monday through Friday, 11:00 am to 8:00 pm. Saturday appointments depend upon therapist availability. Appointments with Dr. Amigo are arranged by AFC administrative staff. All other appointments should be scheduled directly with your therapist or service provider. Our phone number is **614-310-1234**.

All incoming phone calls are received and routed by an automated voice mail attendant. For all **general** inquiries you may leave a message on extension "0" for the Front Desk Confidential staff voice mailboxes are available 24 hours a day.

EMERGENCIES

Because we are not a 24-hour emergency facility, please contact these Emergency Centers should the need arise:

OSU Medical Center	1-614-293-8333	Netcare: 1-614-276-2273
North Central M.H.	1-614-299-6600	Suicide Prevention of Franklin County: 1-614-221-5448

SERVICES AND FEES

Most sessions are 45 or 60 minutes. Sessions of shorter or longer duration depend upon therapist availability. We will attempt to start and finish sessions in a timely manner. If your session does not begin on time, we ask for your understanding. Rarely would your therapist be unable to meet for the full time agreed to.

Note that once the required insurance information leaves our office, we have no control over who has access to it or how that information is used. For reasons of privacy, you may decide to pay out-of-pocket and not file with your insurance plan. If you choose to file with your insurance, we ask that you pay your co-payment or required percentage at the time of each session. We suggest that you keep track of such things as your deductible, required pre-certifications and/or the number of authorized sessions. Important information regarding your mental health benefits are available directly from your insurance provider. **Confirmation of benefits is your responsibility and if AFC is unfamiliar with the benefit plan, you will pay full fee and credit will be applied once benefits are confirmed.** As a courtesy to our clients, our billing department will file claims to your primary insurance provider. We do not file to secondary insurance. If you have any insurance or billing questions, please call Carol at MedComm Billing Consultants, 614-761-1533.

LEGAL PROCEEDINGS

If your therapist is required to become involved in legal proceedings involving your therapy (or your child's therapy), you agree to pay for the therapist's time in preparing for such legal action, including, but not necessarily limited to traveling to and attending a deposition, hearing, or trial, including any time spent waiting to tetify, responding to a subpoena, in addition to any legal fees my therapist may incur as part of your involvement in such legal action.

CANCELLATION POLICY

Occasionally you may need to cancel or change your scheduled appointment time because of illness or scheduling conflicts. However, unlike medical practices which often double or triple book, we reserve our clinical time exclusively for you. When you can't make your scheduled appointment, we require at least a 24-hour notice. For Group Therapy, notification by 12:00 pm noon that day is required. **If you cancel your scheduled appointment with less than the required notice, for whatever reason, it is a "Late Cancellation." Because your appointment time is reserved, late cancellations and missed appointments are charged 1/2 the scheduled session fee.**

BENEFITS AND RISKS

The services we offer can have benefits and risks. Since treatment 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, mental health services have also been shown to have many benefits. Treatment may often lead to better relationships, solutions to specific problems and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

CHILDREN AND COUNSELING

Sessions may involve just the child, parent(s) or the child and family, depending on your particular situation and therapist's clinical preference. If you have important weekly information to share with your child's therapist, please fill out the "**Parent Feedback Form**" located next to the front desk window and hand it to your therapist. This is especially helpful for children involved in group therapy.

WAITING ROOM

Please understand that all of us appreciate a quiet and peaceful waiting room. Therefore, adult clients and/or parents are not to leave their young children without parental supervision in the waiting room. Also please refrain from unnecessarily sharing personal confidential information at the front desk with AFC staff.

COMMUNICATION POLICY

We will use any of the contact information you have provided in the intake process or as part of our New Client Packet which you will complete today and/or that currently is available in your file. This includes home phone number(s), cell phone number(s), work phone number(s) and e-mail addresses.

Please note that we use our sole AFC e-mail address primarily for appointment notifications and for the exchange of appointment related information of AFC service event reminders. Be aware that not all AFC clinical staff choose to communicate via e-mail.

Therefore, please refrain from e-mailing us (AFC staff) personal health information (PHI) related to your therapy sessions, as e-mail is not completely secure or confidential. Be aware that all e-mails are retained in the logs of your and our Internet Service Providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet Service Provider.

You should also know that any e-mails we receive from you are seen and handled by designated AFC administrative staff and then delivered to the named recipient in paper form. Any e-mails we receive from you and any responses we send you become a part of your legal and clinical record. Therefore we prefer that clinical information (PHI) be discussed or addressed via e-mail as little as possible.

It is important to clarify that any and all e-mail correspondence from AFC is not encrypted. Additionally, unencrypted e-mails carry with them certain levels of risk, for example, the information in the e-mail could be read by an unintended third party. So as a covered entity, AFC cannot be responsible for any unauthorized access. Please read and sign the AFC Informed Consent Sheet on bottom of page 3.

AMIGO FAMILY COUNSELING, LLC

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NEW CLIENT INFORMED CONSENT SHEET

I, _____ have read Amigo Family Counseling's **NEW CLIENT WELCOME STATEMENT.** I understand I will have opportunity to ask the Amigo Family Counseling staff questions regarding any and all matters addressed in each of these documents. Therefore, I accept, understand and agree to abide by all portions of them.

_____ _____

SIGNATURE OF CLIENT/RESPONSIBLE PARTY DATE

_____ _____

WITNESS DATE

355 E. Campus View Blvd., Suite 105, Columbus, OH 43235 ♦ Phone: 614-310-1234 ♦ Fax: 614-310-1237
Email: amigofamcounsel105@gmail.com ♦ Website: amigofamilycounseling.com

AMIGO FAMILY COUNSELING, LLC

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NEW CLIENT INFORMATION SHEET – CHILD

CLIENT INFORMATION

Name: Last_____ First _____ Middle _____
Address_____
City_____ State _____Zip_____
Phone: Home _____ Work _____
Cell _____ OK to Call? (H) _____ (W) _____ (C)_____
E-Mail Address: _____ OK to carbon copy? _____
Age _____ Date of Birth _____ Gender: M_____ F_____
Fulltime Student? Yes / No Grade: _____ School Name: _____

RESPONSIBLE PARTY INFORMATION (Note: If parents are separated or divorced, the parent bringing the child is considered the responsible party.)

Name: Last_____ First _____ Middle _____
Address_____
City_____ State _____Zip_____
Phone: Home _____ Work _____
Cell _____ OK to Call? (H) _____ (W) _____ (C)_____
E-Mail Address: _____ OK to carbon copy? _____
Age _____ Date of Birth _____ Gender: M_____ F_____
Single _____ Married _____ Divorced _____ Separated _____ Other, Specify: _____
Employer _____ Occupation _____
If married, Spouse's Name: _____ Employer: _____

EMERGENCY CONTACT PERSON

Name: Last_____ First _____ Middle _____
Address_____
City_____ State _____Zip_____
Phone: Home _____ Work _____
Cell _____ E-Mail Address: _____
Relationship to Client_____
Primary Insurance Company_____
Who referred you to Amigo Family Counseling?_____

OFFICE USE ONLY BELOW:

Therapist _____ **Today's date_____**
DSM 1V _____ **FA _____**
DSM 1V _____ **CA _____**
CLIENT COPAYMENT _____

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NOTICE OF PRIVACY PRACTICES FOR NEW CLIENTS

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), and regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in the following situations. As mental health professionals licensed in this state it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with our professional codes of ethics and HIPAA.

Serious Threat to Health or Safety: If we believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). We will inform you about these notices and obtain your written consent, if we deem it appropriate under the circumstances**.**

Abuse, Neglect, and Domestic Violence: If we know or have reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child or developmentally disabled individual under 21, the law requires that we file a report with the appropriate government agency, usually the County Children Services Agency. Once such a report is filed, we may be required to provide additional information. If we have reasonable cause to believe that a developmentally disabled adult, or an elderly adult in an independent living setting or in a nursing home is being abused, neglected, or exploited, the law requires that we report such belief to the appropriate governmental agency. Once such a report is filed, we may be required to provide additional information. If we know or have reasonable cause to believe that an adult client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the client's record.

Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by law. We cannot provide any information without your (or your personal or legal representative's) written authorization. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

To Coroners and Medical Examiners: We may disclose PHI to coroners and medical examiners to assist in the identification of a deceased person and to determine a cause of death.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices. Examples of disclosures requiring an authorization include disclosures to your partner, your spouse, your children and your legal counsel. Any disclosure involving psychotherapy notes will require your signed authorization, unless we are otherwise allowed or required by law to release them.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, **Dr. Emilio Amigo** (see page 4).

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer and we'll consider how best to resolve your complaint. In the event that you aren't satisfied with our response to your complaint, or don't want to first file a complaint with us, then you may send a written complaint to or contact either of the following:

Director
Office for Civil Rights
U.S. Department of Health and Human Services 200
Independence Avenue, S.W. Room 509F HHH Bldg.
Washington, D.C. 20201

Region V, Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601. Ph. (800) 368-1019, Fax (312) 886-1807, TDD (800) 537-7697.

We will not retaliate against you for filing a complaint.

PRIVACY AND SECURITY OFFICER

The Privacy and Security Officer for the practice is Dr. Emilio Amigo whose contact information is listed at the bottom of page one of this form. You may contact him if you have any questions about any privacy or Security Policies or if you wish to file a complaint with the practice.

The effective date of this Notice is September 2013.

AMIGO FAMILY COUNSELING, LLC

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NOTICE OF PRIVACY PRACTICES RECEIPT & ACKNOWLEDGEMENT OF NOTICE FOR NEW CLIENTS

Client Name:_____
DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Amigo Family Counseling LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer Emilio Amigo at the address listed above.

_____

Signature of Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

355 E. Campus View Blvd., Suite 105, Columbus, OH 43235 ♦ Phone: 614-310-1234 ♦ Fax: 614-310-1237
Email: amigofamcounsel105@gmail.com ♦ Website: amigofamilycounseling.com

AMIGO FAMILY COUNSELING, LLC

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NEW CLIENT FINANCIAL AGREEMENT TO PAY FOR SERVICES

I, The Undersigned, request that AMIGO FAMILY COUNSELING (AFC) provide professional services to me _____
(Name of Client)
or to _____ as a Client, and I agree to
(Other)
pay Amigo Family Counseling's fees as stated on the "Welcome Statement" I received. I understand that I am required to give at least 24 hours notice prior to canceling any appointment. For missed appointments and late cancellations, I will be billed and responsible for 50% of the session fee, which is non-reimbursable by Insurance, and shall be paid at the time of my next appointment.

If at any time, I am dissatisfied with the services provided at Amigo Family Counseling, I agree to discuss my views, reasons and plans with my therapist, and if necessary with Dr. Amigo, the Director of AFC.

I agree that this Financial Agreement will remain in effect with Amigo Family Counseling as long as professional services are being provided for me, my minor children or the above named client for which I am assuming financial responsibility, until such time that I inform my therapist in person, by telephone or by certified mail, that I wish to discontinue my therapy. I agree to pay in full for all services provided for me, my minor children, or the above named client, until I have paid the balance in full.

I understand that I am responsible for any and all charges assessed for services provided by Amigo Family Counseling, although other persons or insurance companies may make payments on my or this client's account.

I hereby authorize my insurance benefits to be paid directly to Amigo Family Counseling whenever I have not already paid for services in full. I also authorize Amigo Family Counseling to release any information required to process any claims. I acknowledge that I am responsible for any non-covered services.

I agree to pay a $25.00 service charge on all returned checks. Also, in the event that this account goes to Collections, I agree to pay a 20% collection fee added to the balance.

I have read this financial agreement and agree to cooperate with and abide by all of its provisions as indicated by my signature below.

Signature_____ Date:_____

Printed Name:_____

Relationship to Client: Self_____ Parent/Guardian_____ Other_____

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LIMITS OF CONFIDENTIALITY NOTICE FOR NEW CLIENTS

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harms to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under 18) and reports suspected child abuse, including but not limited to, physical beatings and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports abuse of adult who is developmentally disabled.
6. The client reports sexual exploitation by a licensed professional.
7. Felony activities may be reported.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

Having read and understood the above, I agree to these limits of confidentiality.

_____

Name of Client or Guardian Date

_____

Signature of Client or Guardian Date

_____

Signature of Clinician Date

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NEW CLIENT MEDICAL & SURGICAL BACKGROUND SHEET

Date: _____ **Client Name:** _____ **Physician Name:** _____

MEDICAL & SURGERY HISTORY: (Check (x) if answer is Yes)

A. Has your child EVER had:

( ) High Blood Pressure
( ) Diabetes
( ) Stomach Ulcers
( ) Gout
( ) Heart Attack
( ) Arthritis
( ) Allergies
( ) Varicose Veins
( ) Heart Surgery
( ) Hospitalizations *
( ) Lung Disease
( ) Other Operations *
( ) Cardiac Catheterization
( ) Medication Sensitivities *
( ) Injuries to Back, etc.
( ) Kidney Disease
( ) Heart Murmur
( ) Epilepsy
( ) Overweight
( ) Asthma

If you indicated Yes for any of the above that has an asterisk (*) next to it, please explain:

_____
_____
_____

B. Has your child RECENTLY had:

( ) Accidents
( ) Cough on Exertion
( ) Difficulty Sleeping
( ) Skin Changes
( ) Heart Palpitations
( ) Back Pain
( ) Nervousness
( ) Tightness in chest (particularly during exercise)
( ) Swollen, Stiff or Painful Joints
( ) Calf Pain or Cramps with Exercise
( ) Chest Pains
( ) Shortness of Breath
( ) Fatigue
( ) Other Problems

If you indicated Yes for ANY of the above, please explain:

_____
_____
_____

C. Medication Name **Dosage** **Reason:**

_____
_____
_____
_____
_____
_____
_____

D. If you have allergies to medications, please list all allergies and explain specifically:

_____
_____
_____

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Email: amigofamcounsel105@gmail.com ♦ Website: amigofamilycounseling.com

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6—17

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Relationship with the child: _____

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

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No		☐ Don't Know		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No		☐ Don't Know		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No		☐ Don't Know		
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No		☐ Don't Know		
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No		☐ Don't Know		
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No		☐ Don't Know		

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11—17

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

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…	**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.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes		❑ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes		❑ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes		❑ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	❑ Yes		❑ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	❑ Yes		❑ No			
	25.	Have you EVER tried to kill yourself?	❑ Yes		❑ No			