Fieldston
Counseling & Wellness

REGISTRATION FORM & AGREEMENT

CLIENT INFORMATION

Last Name:	First Name:	Preferred Pronouns: ☐She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐Other/Prefer not to say	
Address:			Apt #:
City/State/Zip:			
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: ☐Voice ☐Text		If voice, select preferred number: ☐Home ☐Cell ☐Work	
Can we leave a message regarding your mental health care? ☐Yes ☐No	Email Address:		

Date of Birth: / /	Gender: ☐Male ☐Female ☐Trans ☐Non-binary ☐Other/Prefer not to say	Sexual Orientation: ☐Heterosexual ☐Bisexual ☐Gay ☐ Lesbian ☐Pansexual ☐ Other/Prefer not to say	Social Security#: ___-__-____	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership ☐ Other

Employer Name:	Employer Address:	
Emergency Contact Name:	Emergency Contact Phone #: ( ) -	Relationship to Client:

CHILDREN (UNDER 18)

Mother's Name:	Phone Number: ( ) -		
Father's Name:	Phone Number: ( ) -		
Pediatrician Name:	Pediatrician Phone Number: ( ) -		
Does child have any medical problems? ☐Yes ☐No	If yes, please specify:	Last Physical Date:	
Has child ever been diagnosed with developmental disability? ☐Yes ☐No	Has child ever received early intervention (including speech or occupational therapy? ☐Yes ☐No		
Does child have an IEP? ☐Yes ☐No	If yes, ☐Emotional Disturbance? ☐Learning Disability?		
Is child currently in special education setting? ☐Yes ☐No	Where does child attend school?	Grade?	
ACS involvement? ☐Current ☐Past	Caseworker Name:	Caseworker Phone Number: ( ) -	
Reason for ACS involvement:			

INSURANCE INFORMATION

Insurance Provider:	Member ID:		
Employer Name:	Group ID:		
Insurance Provider Address:	Insurance Provider Phone Number: ( ) -		
Responsible Party (Primary Insured):	Date of Birth (of responsible party/primary insured):		
Address of responsible party:	Apt #:	City/State/Zip:	
Phone Number of responsible party: ( ) -			

INTERNAL USE

Intake Date:	
Dx:	
Date Submitted:	
Co-Pay / Fee:	

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PERSONAL HISTORY

Have you previously been seen for mental health treatment? ☐Yes ☐No	If yes, where?	If yes, when?
Are you currently taking psychotropic medications? ☐Yes ☐No	If yes, which?	
Do you have a current supply? ☐Yes ☐No	Prescribing Doctor?	
Have you had a recent psychiatric hospitalization? ☐Yes ☐No	Have you had a psychiatric hospitalization in the last 2 years? ☐Yes ☐No	
Are you currently experiencing suicidal ideation or thoughts of self-harm? ☐Yes ☐No	Have you ever self-harmed? ☐Yes ☐No	
Are you a victim, perpetrator or witness of domestic violence? ☐Yes ☐No	If yes, please specify:	
Do you have legal problems (including history of arrests)? ☐Yes ☐No	If yes, please specify?	
Primary Care Physician Name:	Physician Phone Number: ( ) -	Last Physical Date:
Do you have medical problems? ☐Yes ☐No	If yes, please specify:	
Do you take medications for medical conditions? ☐Yes ☐No	If yes, what medication do you take?	
Do you smoke cigarettes? ☐Yes ☐No	If yes, how many cigarettes a day?	
Do you drink alcohol? ☐Yes ☐No	If yes, how often? ☐Daily ☐Weekly ☐Monthly	
When was the last time you drank?	How many drinks do you typically have?	
Do you use drugs? ☐Yes ☐No ☐Marijuana ☐Cocaine ☐Heroin ☐Prescription Medication ☐Other: Specify:		
Do you feel you have a problem with alcohol or drugs? ☐Yes ☐No		

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SELF PAY FEES	Initial intake assessment (60 minute): $450 Individual session (45 – 60 minutes): $275 Family Session (60 – 90 minutes): $350 - $450 Couples Session (60 – 90 minutes): $350 - $450	Sliding Scale Agreement: ☐Yes ☐No Amount per session: $ _____ Type of session: Individual / Family / Couples Length of session: 30 / 45 / 60 minutes

AGREEMENT	**PLEASE BE MINDFUL THAT THERE IS A 24-HOUR ADVANCE NOTICE POLICY. IF YOU CANCEL LESS THAN 24 HOURS IN ADVANCE, AND WE ARE NOT ABLE TO RE-SCHEDULE WITHIN THE SAME WEEK YOU WILL BE CHARGED THE ENTIRE SESSION FEE. THIS POLICY IS STRICTLY ENFORCED.** *Your signature below indicates that you received notice of privacy practices have read the information in Informed Consent document and agree to abide by its terms during our professional relationship, including cancellation policy and payment agreement.*		
	Client Name:		
	Client Signature:		Date:
	(For children & Adolescents-under age 18) Parent/Guardian Name:		Relationship to minor:
	Parent/Guardian Signature:		Date:
	All efforts will be made to bill your insurance company for your services. If payment is denied, please be advised that you will be responsible for payment in full. You may be eligible for a scale payment arrangement depending on your income. We require a credit card on file for no show and late cancellation fees, co-payments and billing.		
	Name on Credit Card:	Credit Card #:	
	Credit Card Expiration:	CDV #:	Billing Zip Code:
	Authorization Signature:		

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

(Please initial next to each line)

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*

- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*

- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

_____

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between Ingrid Nunez, LCSW *(Healthcare provider's name)* and staff and

_____ *(Patient's name)*

_____ _____

Patient or Legal Representative Signature/Date/Time Relationship to Patient

_____ _____

Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the *patient/legal representative (circle one)* fully understands what I have explained.

_____

Healthcare Provider Signature/Date/Time

_____ copy given to patient _____ original placed in chart

initial initial

Fieldston
Counseling & Wellness

OFFICE POLICIES & INFORMED CONSENT

Welcome to Fieldston Counseling & Wellness. This document contains important information about our professional services and business policies. When you sign this document, it will represent an agreement between you and your assigned counselor. Please keep a copy of this agreement for your reference.

ABOUT COUNSELING

Counseling is not easily described in general statements. It varies depending on personalities of the counselor and client, and the particular objectives you bring forward. There are various methods we may use to address the issues that you hope to work on. You and your counselor will agree on a specific plan tailored to your particular needs and goals. Counseling calls for a very active approach on your part, success will depend on the effort you put forward during and outside of your sessions. Progress also depends on good communication between client and counselor. If at any time during counseling you have any questions or concerns, feelings about something your counselor has said or suggested, or need clarification regarding our process, do not hesitate to discuss.

Counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings and the process may, at times, feel quite difficult. On the other hand, counseling has also been shown to have benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress.

MEETING

Initial assessment session lasts 45 to 60 minutes. Thereafter, a regular individual counseling session runs between 30 to 60 minutes and a family (client plus collateral) counseling sessions last 45 to 75 minutes. During your initial consultation meeting(s) you and your counselor will mutually decide if they are the best person to provide the services you need. If either of you decide for any reason that you would be better helped by another professional or method of intervention, you will be offered referrals for alternative services or providers. If you decide to continue with ongoing counseling, you will schedule sessions at a mutually agreed upon time. Any and all sessions may take place in person, over through tele-health via phone or via video chat based on mutual agreement.

CANCELLATIONS & MISSED APPOINTMENTS

Because the success of counseling depends on the regularity and continuity of your meetings, the expectation is that you and your counselor will meet regularly at the time mutually decided upon. Once you have an agreed upon regular time or times to meet, that time will be reserved for you. It is understandable that on occasion you will need to cancel or reschedule a session. If it is necessary to reschedule or cancel an appointment, we require that you provide at least 24 hours advance notice in order to avoid being charged for the session. If notice is less than 24 hours in advance and you or your counselor are not able to reschedule your session during the same week, or you miss a session with no advance notice, you will be charged for the missed session in full.

FEES FOR SERVICE (SELF-PAY)

During your initial consultation meeting we will jointly agree to a fee and payment schedule. Unless we make other specific arrangements, payment by cash, credit card, ZELLE, VENMO or IVY PAY is due at the beginning or end of each session. We do offer a few sliding scale slots for patients who are unable to afford the regular fee. We charge the same fee for other professional services you may need. Other services might include, but are not limited to, telephone consultations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, and preparation of records or counseling summaries or reports. We will pro-rate the cost if the work lasts for periods less than one hour. We periodically raise my fees with reasonable advance notice.

INSURANCE

Current accepted insurances: Aetna, CIGNA, Blue Cross Blue Shield, Magnacare, Oxford, and United Health, Oscar, Emblem HIP, Medicaid and Medicare. If you do not have these insurances, you may be able to be reimbursed if you have out of network benefits (you can call your insurance carrier to confirm your benefits).

**Not all counselors may accept insurance at this time (your individual counselor will confirm their participation or non-participation).*

CONTACTING YOUR COUNSELOR

By Phone: You may contact your counselor at (646) 204-6755. Although we are not always immediately available by telephone, a message can be left at this number at any time of day or night. We check voicemail frequently during business hours and we will always attempt to return your call within 24 hours. We will give you advance notice of any vacations or other planned absences. Another therapist will provide emergency coverage when your counselor is away. This person's contact information will be available to you when plans are discussed with you.

By Email: Because the security of email communications cannot be guaranteed, it is recommended that email be limited to requests for phone contact, appointment arrangements, or requests for information. Please only include general information about yourself. Any communication that requires immediate attention or a timely response should be made by phone.

EMERGENCIES

Although you can leave a message at any time, we are often not available to call you back immediately. If you have an urgent matter, please call, and we will return your call as quickly as possible. However, if you have an **emergency** requiring immediate attention, please call 911 or LIFENET (800) 543-3638 or go to your nearest emergency room.

ENDING TREATMENT

You have the right to end or take a break from your counseling at any time without their permission or agreement. However, if you decide to exercise this option we encourage you to talk with your counselor about the reason for your decision in a counseling session so that we can bring sufficient closure to your work together. We can also discuss any referrals you may need at that time.

Counselors are ethically required to continue therapeutic relationships only as long as it is reasonably clear that patients are benefiting from the relationship. Therefore, if your counselor believes that you need additional treatment, or if they believe that they can no longer be of help to you, they will discuss this with you and make an appropriate referral.

CONFIDENTIALITY

In general, the privacy of all communications between a client and counselor, and all written counseling records, are protected by law. We may only release information about our work to others with your written permission. There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's counseling. For example, if it is believed that a child, elderly person, or disabled person is being abused, a report must be filed with the appropriate state agency. If it is believed that a client is threatening serious bodily harm to another, your counselor is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalizations for the client. If the client threatens to harm himself/herself, your counselor may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. These situations have rarely occurred. If such a situation occurs, we will make every effort to fully disclose with you before taking any action. Your counselor participates in regular professional consultations. In such cases, neither your name, or any other identifying information about you will be revealed.

TREATMENT TERMINATION

If at any time during the course of your counseling, your counselor determines that they cannot continue, we will terminate counseling and explain why this is necessary. Ideally, counseling ends when you and your counselor agree that you have reached your personal goals. Other situations that warrant termination include: regularly becoming enraged or threatening during session; bringing a weapon into the premises; persistent drug abuse; arriving under the influence of drugs or alcohol; disclosing illegal intentions or actions.

NOTICE OF PRIVACY PRACTICES

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

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

- We participate in one or more **Health Information Exchanges (HIE),** which allows disclosure of your electronic health record via electronic transfer to other facilities and providers for your treatment purposes. Your health information and basic identifying information regarding your visits to our facilities may be shared with the HIEs for the purposes of diagnosis and treatment.

This includes health information for your continuing care, as well as care you may seek at other locations. Other providers participating in these HIEs may access this information as part of your treatment.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below**.**

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:
Privacy Officer: Ingrid Nunez
Phone: 646-945-0639
Address: 3265 Johnson Avenue, Suite 105
Bronx, NY 10463
E-mail: info@fieldstoncounseling@gmail.com

This notice is effective May 1, 2020

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Fieldston Counseling & Wellness, 3265 Johnson Avenue, Bronx, NY 10463

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

□ Medical Record form (insert date) _____to (insert date)_____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

□ Other:_____ Include: (*Indicate by Initialing*)

_____ _____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

_____ **Genetic Testing**

Authorization to Discuss Health Information

(b). □ By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm or Governmental Agency Name)

10. Reason for release of information: □ At request of individual □ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of Patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
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 _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PCL-5

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

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

D3 **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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HE0350

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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