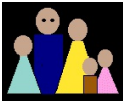
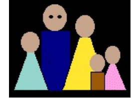


ADOLESCENT CLIENT INFORMATION FORM

Today's Date:					
Presenting Problem:					
CLIENT'S INFORMATION				**PARENT'S OR GUARDIAN'S INFORMATION**	
Client's Name:				**Non-Custodial Parent:**	
Date of Birth:		**Age:**		**Address:**	
School:				**City/State/Zip**	
Grade				**Non-Custodial Parent's Cell Phone:**	
Custodial Parent's Name:				**Non-Custodial Parent's E-Mail:**	
Home Address:				**Non-Custodial Parent's Occupation:**	
City/State/Zip				**Step Mother:**	
Custodial Parent's Cell Phone:				**Step Father:**	
Custodial Parent's E-Mail:				**Non-Custodial Parent's E-Mail:**	
Custodial Parent's Occupation:				**Non-Custodial Parent's Occupation:**	
Siblings': Names/Ages:					
Pediatrician's Name:				**Phone Number:**	



OFFICE POLICIES AND PSYCHOLOGICAL SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. The law requires that I obtain your signature acknowledging that I have provided you with this information at or before the end of the first meeting. Although these documents are long and sometimes complex, it is very important that you read them carefully. I can discuss any questions you have about the procedures during the first meeting. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Under Dr. Kovner's supervision, I provide assessment, diagnosis and treatment of learning, relationship, psychological, and some neuropsychological disorders. By signing this agreement, you are giving consent for yourself and/or your child/to undergo psychological evaluation and/or treatment.

Psychological Testing

A psychological evaluation is a comprehensive assessment of cognitive, educational, and social/emotional functioning. Over a period of 4 to 8 hours, standard testing procedures assess various abilities that relate to cognition, learning, memory, problem solving and critical thinking. The evaluation also measures psychological dimensions relating to social and emotional functioning. The evaluation may also be used to procure public school or college classroom/teaching accommodations for you or your child in order to obtain more effective learning experiences. Also, psychological testing may be used to provide medical clearance, fitness for duty to return to work, or parental competence in a court of law. If you have further questions about the purpose and potential benefits of a psychological evaluation, I will be happy to provide additional information.

Psychotherapy

Psychotherapy, or mental health counseling, is a complex array of many activities that serve to build a trusting relationship between the client and their therapist. This array of activities may consist of play, dance or movement, physical exercise, education, learning, application and practice of that learning, assimilation of learning into behavior and integration of what is learned and practiced into ethical, morally mature, socially responsible and healthy personality functioning. The transformation that occurs through this complex array of activities with the therapist involves easing of personal defense mechanisms that permit insight into one’s own emotional life and habitual ways of behaving socially.

Self-control and improved social and moral functioning comes through the development of self-awareness, rational thought, appropriate expression of emotions, planning, anticipation of consequences, mental flexibility, self-acceptance, genuine regard for others’ feelings, beliefs, and opinions, and capitalizing on one’s existing strengths and resources. By forming a therapeutic alliance with me, we will work to improve your chances of success in achieving the goals of emotional stability, personal and interpersonal growth, occupational and educational satisfaction and social responsibility. Furthermore, research has shown that improvement in mental health can have a beneficial affect on your physical health.

CONTACT INFORMATION AND EMERGENCY PROCEDURES

Often I am not available immediately by telephone. I do not answer the phone when I am in a meeting with a client. On days that I am not in the office, I check voice mail frequently. When I am unavailable, the telephone is answered by the office manager or an answering machine. I will try to return your call within one business day of receiving it, with the exception of holidays and vacations.

If you are difficult to reach, please inform us of some times when you will be available. My practice does not have 24 hour crisis availability, support staff, or a psychiatrist. If it is possible you will need crisis services over the course of treatment it is important that you discuss this point with me as soon as possible. I may recommend that you seek services with a provider who can offer more crisis coverage than can be provided by mye.

In case of an emergency, this is the protocol I follow. In an emergency, you may try to reach me at the office number. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. In a situation where serious harm may occur, call 911 or get safe transportation to the nearest hospital emergency room. If you are able to wait for a return call, clients with life-threatening emergencies will be seen immediately, or directed to emergency care. Clients with non-life threatening urgent needs will be seen within 24 hours or be directed to emergency care.

If I will be unavailable for an extended time and you provide me with a written request I will provide you with the name of a colleague to contact.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in a Clinical Record. Except in unusual circumstances where that disclosure would physically or emotionally endanger you and/or others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. In most circumstances, I am allowed to charge a copying fee and charge for certain other expenses such as postage and envelopes.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

You also may add information to your records when I review them with you if you believe they contain inaccurate or incomplete information.

It is my office policy to retain clients' records for seven years after the end of our therapy.

Children and Adolescent Clinical Records

With regards to your child or adolescent, the review of the clinical record would violate the client's confidentiality. Without privacy, most children and adolescents would not talk or disclose matters of true concern and therapy would not be effective. There may be general discussion with you about the goals, progress and effectiveness of therapy at your therapist's discretion. However, if during the course of treatment, if I were to become concerned that your child's life or safety was endangered your child's confidentiality privileges would be waived. Therefore, before I would agree to treat your child (or adolescent) I request that you consent to waive your right to have a copy of or review the details of the clinical record by signing in the space below.

I, ______________________________, the parent or legal guardian of ____________________________________
(Print Parent'sr Legal Guardian's Name)

whose date of birth is _______________, waive my right to read, review or own a copy of the clinical record.

Please note that in some cases your files may include information from other treatment providers that clients have given me written permission to obtain. If you have given me permission to obtain such records, I cannot provide them to you if you ask to review your files. Instead, I would ask for you to contact the provider who created the records and obtain copies directly from her or him.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. I are happy to discuss any of these rights with you.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about you or your child's treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Georgia law. However, in the following situations, no authorization is required: Disclosures required by health insurers or to collect overdue fees; if you are involved in a court proceeding and a judge waives your privilege to confidentiality. Generally, I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. In the case of suspected child abuse, the privilege is waived because all psychologists are mandated court reporters of child abuse.

Additionally, I would not need authorization to disclose your records under the following circumstances:

1. If a you file a complaint or lawsuit against me, I may disclose relevant information regarding you and your treatment in order to defend myself.

2. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of a client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.

3. You should be aware that I practice with other mental health professionals and that I occasionally employ administrative staff. In some cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations in which we are legally obligated to take actions where your confidentiality privileges are waived. These situations include instances where we believe it is necessary to attempt to protect others from harm. Under such circumstances, I may have to reveal some information about a patient's treatment. These situations are unusual in our practice, and include:

4. If I know or have reasonable cause to suspect that a child under 18 has been or is likely to be abused or neglected or that a disabled person has been abused, neglected or exploited, the law requires that I file a report with the appropriate government agency, usually the Georgia Department of Child Protective Services. Once such a report is filed, I may be required to provide additional information.

5. If I determine that the patient poses a direct threat of imminent harm to the health or safety of any individual, including himself/herself, I may be required to disclose information in order to take protective action(s). These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can assist in providing protection.

6. If you have filed a worker's compensation claim and I are being compensated for your treatment by your employer or its insurance company as a result of that claim, I must provide, upon appropriate request, legally required reports and other information related to your condition.

FEE FOR SERVICES

Your fee per session is based on income. You will need to bring a pay stub and your last 1040 tax return to prove your income.

Sliding Scale

- **If your yearly income is between $35,000 and $50,000, sessions will be charged at $50 per session.**

- **If your yearly income is between $25,000 and $34,000, sessions will be charged at $35 per session.**
- **If your yearly income is below $25,000, your sessions will be charged at $25 per session.**
- **If you are unemployed and not collecting unemployment, your sessions will be charged at $20 per session.**

Payment by cash or credit/debit card must be made at the time you make the appointment.

I also charge my session rate for other services including:

- Psychological Testing
- Report Writing
- Telephone consultations lasting longer than 10 minutes
- Consultations with other professionals
- Preparing records or treatment summaries for court

It may be helpful to keep your credit card on file to make your payments. If so, please fill out the form below.

CREDIT CARD AND AUTHORIZATION FORM

Credit Card Number		**Expirations Date**	/	**Security Code**	
    ____________________ **Authorizing Signature** ________ **Date**		**The services rendered are checked below.** ( ) Diagnostic Interview ( ) Psychotherapy 50-60 Min. ( ) Psychological Evaluation ( ) Court Testimony ( ) Two-Day Couples Retreat ( ) Written Correspondence ( ) Test Results Feedback ( ) School Board, IEP or Tribunal Hearing ( ) Phone Consultations greater than 10 minutes			

CANCELLATION POLICY AND RESCHEDULING APPOINTMENTS

When you schedule an appointment you will be asked to pay for the session at that time. If you cannot keep your appointment, we require a 48 hour advanced notice of your cancellation or else you forfeit your session fee. We refer to this as the ***Cancelation Fee***. The fee may be waived at Ms. Deragon's discretion if you were unable to attend due to circumstances beyond your control.

Your will need to pay for your next appointment at the time you schedule it.

RETURNED CHECK FEES

There will be a $35.00 charge for each returned check to cover all of the expenses involved in paying bank fees and other resulting insufficient funds charges.

EATING OR SMOKING

No Eating or Smoking is permitted in the Building. If you smoke outside, please throw your used cigarette into the plastic receptacle out front. Children are to wait quietly in the waiting room. Parents must accompany young children to the bathroom and make sure all doors are closed and the facilities are left clean. Do not leave children unsupervised in or outside of the office.

THE WAITING AREA

Clients are to wait quietly in the waiting room. Please be courteous and turn your cell phones to vibrate. Please use ear buds to listen to music and voices down to a whisper if you talk on your cell phone. We use the radio to provide the Office Manager privacy. She has limited time. Please respect her time and privacy.

All clinical information is to be presented ***in therapy sessions by appointment***.

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICES OF PRIVACY PRACTICES, OFFICE AND CANCELLATION POLICIES

A summary of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules is available for you to read on line at your-psychologist.com or in the office on the credenza in the waiting room. A paper copy of your HIPAA rights is available to you upon request. The entire privacy rule, as well as guidelines and additional materials may be found on the government website at http//: www.hhs.gov/ocr/hipaa.

By signing below, I acknowledge that I have been provided information about Ms. Deragon's and Dr. Kovner's privacy practices, made the HIPAA information available to read in detail and have therefore been advised of how health information about me may be used and disclosed and how you may obtain access to and control this information according to law; and I have been informed of and agree to their Office Policies and financial agreements.

____
Client or Parent's Signature

1. Please list who you want to have access to your pertinent medical information?
(i.e.: family member, spouse, significant other)

______________________ ______________________
______________________ ______________________
______________________ ______________________

2. May we leave a message on your phone or answering machine? YES __ NO__
3. Preferred method of contact?
Email ______________________________
Home #__________ Cell #__________ Work #__________
....

Having read Ms. Deragon's and Dr . Kovner's office policies, I consent to have my child in assessment and/or treatment.

X______________________________
Parent's Signature

PARENT'S QUESTIONNAIRE

Today's Date:_______________

Child's Name:		Date of Birth:		Age:	
Referred By:					
Presenting problem:					
Has child failed any grades?					

Family Relationships			
Biological Mother's Name:		Biological Father's Name:	
Education:		Education:	
Occupation:		Occupation:	
Stepfather:		Stepmother:	
Guardian:		Siblings:	
How does child get along with siblings?			

CHILD'S BIRTH AND EARLY DEVELOPMENT
Was pregnancy planned?
Premature? If yes, how weeks?
Adopted?
Birth Weight
How was mother's health during pregnancy?
Any problems at birth?
Any feeding difficulties?
Any sleep difficulties?
Approximate age when child: Sat alone
Walked alone
Correctly used "mama" & "dada"
Used "yes" & "no"
3 word sentences
Any trouble with eyesight?

Anything unusual about speech development?			
Was child over or under active?			
Was child excessively aggressive?			
How did child react to new situations and changes in routine?			
Please check any of the problems below that your child has:			
Fingernail biting	Thumb sucking	Body rocking	Sleep walking
Fire setting	Temper tantrums	Stealing	Truancy

Accident proneness	Concerns about eating	Concerns about sleep habits
Self-injury	Unusual perceptions	Night terrors of nightmares

EDUCATIONAL HISTORY List in chronological order all schools your child has attended.

Name of School	Dates Attended				Grade Level	GPA	Conduct
	From		To				
	From		To				
	From		To				
	From		To				
	From		To				
	From		To				

Name of current teachers ____

______________________________________Child's favorite subjects ______________________

____Child's least favorite subjects ____

______________________Has your child ever repeated a grade? _______ If so, which? ______________________

____Has your child ever skipped a grade? ______ If so, which? ____

________Has your child ever received tutoring? ______ If so, in which subject(s)?______________________

____Has your child ever been in a Special Education Program? ______ If so, during which years? ____What type of Program? (Gifted, LD, BD/EH, MR?) ____

____________________________Child's attitude toward school ______________________________________

____How well does your child get along with other children? ____

_______________Please describe your child's strengths ____

____and weaknesses ______________

____

Child's extracurricular activities including sports, hobbies, clubs, lessons, etc.

Baseball	________	Karate	____________	Dance	___________
Football	________	Piano	____________	(type)	___________
Basketball	________	Cheerleading	____________	Music	___________
Soccer	________	Scouts	____________	(Type)	___________
Other	________	Other	____________		

List any additional special abilities, skills, strengths your child has.______________________

____

____

PSYCHOLOGICAL/PSYCHIATRIC HISTORY

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings? ___________________________

____

Has your child been hospitalized for a psychiatric condition? If yes, when and where? __________

____

____

____

______________Is your child taking medication? If yes, what medications are they, what dose, and for what condition?

For what Condition Medication is Prescribed for?	Date Prescribed?	Name of Medication?	Dose?

Are there any family members on either side of the family who have ever been treated for mental or emotional problems? If yes, specify. ____

Parents' Self-Descriptions

How would you rate your overall level of happiness on a scale from 1 (Happy) to 10 (Unhappy).

Mother _____ Father _____

On a scale from 1 (Low) to 10 (High), how would you rate your stress in the following areas ?

	Mother's Ratings	Father's Ratings
Job		
Home Life		
Parenting		
Friends/Social Life		
Day to day hassles		
Your marriage		
Finances		
Intimacy		
Communication		
Time Together		
Overall Stress		

DISCIPLINE

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed by circling the appropriate number from 1 (Unlike) to 5 (Likely). Also, please indicate how effective each of the discipline strategies is for your child by circling them from 1 (Ineffective) to 5 (Effective).

Strategy	Unlikely — Likely	Ineffective — Effective
Let situation go	1 2 3 4 5	1 2 3 4 5
Use token system	1 2 3 4 5	1 2 3 4 5
Take away a privilege (e.g., T.V.)	1 2 3 4 5	1 2 3 4 5
Use charts & stickers	1 2 3 4 5	1 2 3 4 5
Earn privileges	1 2 3 4 5	1 2 3 4 5
Earn time with friends	1 2 3 4 5	1 2 3 4 5
Take away something material (e.g., no dessert)	1 2 3 4 5	1 2 3 4 5
Earn special time with parents	1 2 3 4 5	1 2 3 4 5
Send to room	1 2 3 4 5	1 2 3 4 5
Give verbal praise	1 2 3 4 5	1 2 3 4 5
Physical punishment	1 2 3 4 5	1 2 3 4 5
Reason with child	1 2 3 4 5	1 2 3 4 5
Earns material or food reward	1 2 3 4 5	1 2 3 4 5
Teach desired behavior by discussion	1 2 3 4 5	1 2 3 4 5
Ground child	1 2 3 4 5	1 2 3 4 5
Teach appropriate behavior by modeling	1 2 3 4 5	1 2 3 4 5
Yell at child	1 2 3 4 5	1 2 3 4 5
Teach desired behavior by role-playing	1 2 3 4 5	1 2 3 4 5
Earn participation in social activities	1 2 3 4 5	1 2 3 4 5
Send to time-out	1 2 3 4 5	1 2 3 4 5
Reward positive behavior	1 2 3 4 5	1 2 3 4 5
List anything else you may do: ______________	1 2 3 4 5	1 2 3 4 5
______________	1 2 3 4 5	1 2 3 4 5
______________	1 2 3 4 5	1 2 3 4 5
______________	1 2 3 4 5	1 2 3 4 5
______________	1 2 3 4 5	1 2 3 4 5

ACKNOWLEDGMENT OF REVIEW OF OUR OFFICE, FINANCIAL AND CANCELLATION POLICIES & AGREEMENTS, AND PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with, understand and accept the policies in the "HIPAA Notice of Privacy Practices" as well as Dr. Kovner's "Office Policies, Cancellation Requirements" and Financial Obligations. I have been advised of how health information about me may be used and disclosed by Ms. Deragon and Dr. Kovner, how I may obtain access to and control this information and my responsibilities to pay all fees and costs for services.

X____ ____________________

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *DATE*

____

PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE

1. Please list who you want to have access to your pertinent medical information? (i.e.: family member, spouse, significant other):

Name	*Relationship to Client*	*Phone Number*

2. May we leave a message on your answering machine? YES NO

3. Preferred method of contacting you:

*Home #*____________________*Cell #*____________________*Work #*____________________

SK SYMPTOM CHECKLIST: ADOLESCENT©

by Steven Kovner, Ph.D.

Adolescent's Name:____Today's Date: __________________

Date of Birth: _____________________ Age:___________

DIRECTIONS: (To be filled out by the adolescent.) This inventory is designed to get a picture of the presenting symptoms you are experiencing. Read each item carefully and don't spend too much time on any one item. If you are displaying the symptoms at all, place a check before that item.

ADD

Fails to give close attention to details or makes _ careless mistakes
Has difficulty sustaining attention
Does not appear to listen
Struggle to follow through on instructions
Has difficulty with organization
Avoids or dislike tasks requiring sustained me effort
Is easily distracted
Is forgetful in daily activities
Fidgets with hands or feet or squirms in the chair
Has difficulty remaining seated
Runs around or climb excessively
Has difficulty engaging in activities quietly
Acts as if driven by a motor
Talk excessively
Blurts out answers before questions have been completed
Has difficulty waiting or taking turns
Interrupts or intrude upon others

CD

Negativity
Defiance
Disobedience
Hostile feelings toward authority figures
Temper tantrums
Argumentative with adults
Refuses to comply with adult requests or rules
Deliberately annoys other people
Blames others for own mistakes or misbehavior
Acts touchy and easily annoyed
Is angry and resentful
Acts spitefully or vindictively
Is aggressive toward peers
Has difficulty maintaining friendships
Has academic problems
Displays aggressive behavior that harms or threatens other people or animals
Has destructive behavior that damages or destroys property
Lies
Is truant from school or work or has other serious rule violations
Has tobacco, alcohol, or substance use and abuse
Is sexually active
Exhibits physical acts of cruelty to people or animals
Frequently involved in fights, bullying intimidation
Will use a weapon in fights
Steals
Runs away from home
Ignores set curfew times
Is planning an attack on others

DEP

- Has persistent sad, anxious or "empty" feelings
- Has feelings of hopelessness and/or pessimism
- Has feelings of guilt, worthlessness and/or helplessness
- Is irritable and restlessness
- Has lost interest in activities or hobbies once pleasurable
- Fatigue and decreased energy making decisions
- Difficulty concentrating, remembering details and making decisions
- Insomnia
- Early–morning wakefulness
- Excessive sleeping
- Overeating, or appetite loss
- Thoughts of suicide, suicide attempts
- Persistent aches or pains,
- Headaches
- Cramps
- Digestive problems that do not ease even with treatment

ANX

- Shyness
- Compulsions
- Phobias
- Stress
- Anorexia
- Fear of heights
- Negative self image
- Fear of spiders
- Insomnia
- Fear of needles
- Has morbid thoughts
- Obsessions
- Thumb sucking
- Blushing
- Excessive Gaming, TV Watching, or Internet
- Fear of being sick
- Migraines
- Lack of confidence
- Fatigue
- Fear of flying
- Panic attacks

SEP

- An unrealistic and lasting worry that something bad will happen to my parent or caregiver if I leave.
- An unrealistic and lasting worry that something bad will happen to me if I leave my parent.
- Refusal to go to school in order to stay with your parent.
- Refusal to go to sleep without your parent being nearby or discomfort sleeping away from home.
- Fear of being alone.
- Nightmares about being separated.
- Bed wetting
- Complaints of physical symptoms, such as headaches and stomachaches, on school days.

PSY

- Seeing or hearing things that don't exist (hallucinations), especially voices
- Having beliefs not based on reality (delusions)
- Lack of emotion Emotions inappropriate for the situation
- Social withdrawal Poor school performance
- Decreased ability to practice self-care
- Strange eating rituals Incoherent speech
- Illogical thinking Agitation

ED

Refusing to eat and denying hunger
An intense fear of gaining weight
Negative or distorted self-image
Excessively exercising
Flat mood or lack of emotion
Preoccupation with food Social withdrawal
Thin appearance
Dizziness or fainting
Soft, downy hair present on the body (lanugo)
Menstrual irregularities or loss of menstruation (amenorrhea)
Constipation
Abdominal pain
Dry skin
Frequently being cold Irregular heart rhythms
Low blood pressure
Dehydration

1. Have you used drugs other than those required for medical reasons? Y N
2. Have you abused prescription drugs? Y N___
3. Do you abuse more than one drug at a time? Y N
4. Can you get through the week without using drugs?Y N
(other than those required for medical reasons)? Y N
5. Are you always able to stop using drugs when you want to? Y N
6. Do you abuse drugs on a continuous basis? Y N
7. Do you try to limit your drug use to certain situations? Y N
8. Have you had "blackouts" or "flashbacks" as a result of drug use? Y N
9. Do you ever feel bad about your drug abuse? Y N
10. Does your spouse (or parents) ever complain about your involvement with drugs? Y N
11. Do your friends or relatives know or suspect you abuse drugs? Y N
12. Has drug abuse ever created problems between you and your spouse? Y N
13. Has any family member ever sought help for problems related to your drug use? Y N
14. Have you ever lost friends because of your use of drugs? Y N
15. Have you ever neglected your family or missed work because of your use of drugs? Y N
16. Have you ever been in trouble at work because of drug abuse? Y N
17. Have you ever lost a job because of drug abuse? Y N
18. Have you gotten into fights when under the influence of drugs? Y N
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?Y N
20. Have you ever been arrested for driving while under the influence of drugs? Y N
21. Have you engaged in illegal activities in order to obtain drug? Y N
22. Have you ever been arrested for possession of illegal drugs? Y N
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake? Y N
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? Y N
25. Have you ever gone to anyone for help for a drug problem? Y N ___
26. Have you ever been in a hospital for medical problems related to your drug use? Y N
27. Have you ever been involved in a treatment program specifically related to drug use? Y N
28. Have you been treated as an outpatient for problems related to drug abuse? Y N

A SHORT QUESTIONNAIRE ABOUT YOUR ALCOHOL USE

C - Have you ever thought you should CUT DOWN on your drinking? ☐*Y* ☐ *N*
A - Have you ever felt ANNOYED by others' criticism of your drinking? ☐*Y* ☐ *N*
G - Have you ever felt GUILTY about your drinking? ☐*Y* ☐ *N*
E - Do you have a morning EYE OPENER? ☐*Y* ☐ *N*

ADVERSE CHILDHOOD EXPERIENCES

1. Did a parent or other adult in the household often or very often swear at you, insult you, or put you down? ☐*Y* ☐ *N*

2. Did one of your parents often or very often push, grab, slap or throw something at you? ☐*Y* ☐ *N*

3. Did one of your parents often or very often hit you so hard that you had marks or were injured? ☐*Y* ☐ *N*

4. Did an adult or person at least 5 years older ever have you touch their body in a sexual way? ☐*Y* ☐ *N*

5. Did an adult or perosn at least 5 years older ever attempt oral, anal, or vaginal intercourse with you? ☐*Y* ☐ *N*

6. As a child, did you witness your mother sometimes, often , or very often pushed, grabbed, slapped, or had something thrown at her? ☐*Y* ☐ *N*

7. As a child, did you witness your mother sometimes, often , or very often kicked, bitten, hit with a fist, or hit with something hard? ☐*Y* ☐ *N*