A Better Way Counseling Center
818 NW 17th Avenue, Suite 3
Portland, Oregon 97209
(503) 226-9061

Please use a pen (not pencil) to fill out the following forms. They take about one hour to complete.

The questions you will find on the next few pages are helpful in your treatment. The more we understand about your history and your personal situation, the more we will be able to help you. However, if you find some of them too uncomfortable, feel free not to answer them.

These forms take time and effort on your part. Completing them outside of your appointment time will enable you to talk about your more immediate concerns during your appointment.

INTAKE FORM

Today's Date: _____/_____/_____

Personal Information

Name:			Age:	Sex:
Date of Birth: / /	Marital Status:		Cell Phone #:	
Address:			Work Phone #: ( ) -	
City:	State:	Zip:	Message Phone #: ( ) -	
# of Children:	Their Ages:		Home Phone #: ( ) -	
Nearest Relative Living Separately:			Their Phone #: ( ) -	
Partner's Name:			Their Phone #: ( ) -	

Education / Employment Information

Last grade completed in school:	Are you employed now? _____Yes _____No
Present Occupation:	Company Name:
Main occupation during past 5 years:	

Medical Insurance

Insurance Name:			Phone #: ( ) -
Address:			ID #:
City:	State:	Zip:	Group #:

General Information

How did you hear about us? _____

Problems you want help with: _____

_____

_____

How much have you worked during the past two years?_____

Describe your education (# of years of school, special training, etc.):_____

_____

Describe any psychological problems you have or have had (e.g. periods of depression, anxiety, fears, phobias, problems with anger, confusion, etc.): _____

_____

_____Describe your living situation:_____

_____Did anyone in your family die before you were 18 years old? _____ Yes _____ No

Who? _____ How old were you? _____

Other family deaths? _____

PLEASE FILL OUT ALL THREE PAGES

When were you last examined by a physician? _____ Name_____

Present physician's name _____ Phone number _____

List any major health problems for which you have received treatment:

_____

_____

Do you or your family members currently have or have ever had any of the following: (Please check all that apply)

	SELF	FAMILY
HEART PROBLEMS	_____	_____
CANCER	_____	_____
NERVOUS BREAKDOWN	_____	_____
STROKE	_____	_____
CHRONIC ILLNESS _____	_____	_____
ALCOHOL OR DRUG ABUSE	_____	_____
LEGAL PROBLEMS	_____	_____
LEARNING DISABILITY	_____	_____
DEPRESSION	_____	_____
OTHER _____	_____	_____

List any medications you are now taking (prescription and non-prescription): _____

_____

_____

Have you been abused or assaulted? (Circle One) YES NO DON'T REMEMBER

Did you witness abuse between your parents? YES NO DON'T REMEMBER

Did you witness abuse between parent and child? YES NO DON'T REMEMBER

List everyone currently living in your home, including family and other:

NAME	AGE	BIRTHDATE	RELATIONSHIP	OCCUPATION

Have you ever received psychiatric or psychological help or counseling of any kind before? _____ YES _____ NO

If you have, please explain: _____

_____

PLEASE TURN TO PAGE THREE

Please circle any of the following which concern you:

NERVOUSNESS	DEPRESSION	FEARS	SHYNESS
SEXUAL PROBLEMS	SUICIDAL THOUGHT	SEPARATION	DIVORCE
FINANCES	ANGER	SELF-CONTROL	FRIENDS
SLEEP PROBLEMS	STRESS	WORK/SCHOOL	RELAXATION
HEADACHES	TIREDNESS	LEGAL MATTERS	MEMORY
AMBITION	ENERGY	INSOMNIA	MAKING DECISIONS
LONELINESS	INFERIORITY FEELINGS	CONCENTRATION	EDUCATION
CAREER CHOICES	MARRIAGE/RELATIONSHIPS	HEALTH PROBLEMS	TEMPER
NIGHTMARES	CHILDREN	EATING PROBLEMS	UNHAPPINESS
SEXUAL ABUSE	PHYSICAL ABUSE	BOWEL TROUBLES	BEING A PARENT
MY THOUGHTS	STOMACH PROBLEMS	GAMBLING	BINGE EATING
EATING TOO LITTLE	TOO HEAVY OR THIN		

Please circle any of the following strengths you have:

CONFIDENT	HARD WORKER	ORGANIZED	SYMPATHETIC	GOOD LISTENER
DEPENDABLE	SENSITIVE	LOGICAL	LOYAL	
DECISIVE	RESPONSIBLE	UNDERSTANDING	SENSE OF HUMOR	

OTHER _____

Please use the chart below to describe your use of drugs. Complete the "yes" or "no" lines for each drug listed, and if "yes", answer the remaining questions on the line.

	No, I Never Used	Yes, I Used	If yes, age at first use	When using, frequency of use (daily, weekly, etc.)	How long since last used?
Tobacco					
Alcohol					
Marijuana/Hashish					
Cocaine					
Crack					
Crank					
Amphetamine/Speed					
Hallucinogens (LSD, Mushrooms, Mescaline, etc.)					
Coffee					
Other					

Please add any additional information which you feel may be helpful to us:

_____

_____

THANK YOU FOR FILLING OUT THIS FORM

Name _____ Date _____

Please answer the following questions. Feel free to use additional paper. If there are some you don't feel comfortable answering, leave them blank and circle them.

What was the highest grade level you achieved? (For example, you completed high school, or you completed 2 years of college, etc.) _____

Have you attended any specialized educational institutions? (For example, a culinary institute, acupuncture college, etc.) _____
_____
_____

What companies have you worked for and what type of work did you do at each?
_____
_____
_____
_____
_____
_____

Have you had any medical problems? Did you receive treatment for them, such as medications, hospitalization, etc.? Please list the different problems you've had and what treatment you've had for each, starting from childhood.

Age Problem Treatment

_____
_____
_____
_____
_____

When was the last time you had a complete physical exam? What was the outcome? When was the last time you saw a physician for any reason? What was the outcome?
_____
_____
_____
_____

What is the name of your physician? _____

Have you ever had any psychological problems before? Please describe what problems you have had in the past and at what age. Also please describe any treatment, if any, you had for these problems - including counseling, medication, hospitalization etc. and for how long you were treated.

Age Problem Treatment

_____
_____
_____
_____
_____

Have you had suicidal thoughts in the past 2 months? Yes ___ No ___

Have you considered suicide as an option in the past 2 months? Yes ___ No ___
Do you have a suicide plan? _____ If "yes," what is it? _____
_____
Have you ever attempted suicide? Yes ____ No ____ How many times? _____
When and how? _____
_____
_____
Has anyone in your family ever attempted or succeeded at suicide? Yes ____ No ___
Who? _____

Have you ever had any legal issues (criminal or civil)? If so, please explain what the issue was and when you had it. (For example, DUII, divorce, identity theft, etc.)

_____
_____
_____
_____

Do you have any friends or family with whom you discuss your deepest problems?
Yes ___ No ___ Who? _____
How many friends or family members do you have with whom you talk on a regular basis:
Daily (or nearly daily) _____ Weekly _____ Monthly _____ ?

If you drink alcohol, how often do you drink two drinks in one day (where one drink means one oz. of hard liquor, one six oz. glass of wine, or one twelve oz. bottle of beer)? _____ three drinks in one day? _____ four drinks in one day? _____ more than four drinks in one day? _____

Please use the space provided to write a short history of your birth family and your present family. Include examples of major positive or negative events:

PSYCHOLOGICAL/SOCIAL HISTORY

Instructions: Answer the following questions as they apply to you. On some questions no answers will apply so do not mark anything. Circle the right answers. Some questions will have more than one answer, so circle all that apply. Put a check mark by any answers you want to discuss.

NAME:_____ AGE_____ DATE_____ SEX _____
OCCUPATION _____

What is your cultural heritage? (1 answer)
1. Asian
2. African-American
3. Caucasian (white)
5. Hispanic
6. Native American
8. Other

1. Who primarily raised you? (1 answer)
1. Natural Parents
2. Father Only
3. Mother Only
4. Father and Stepmother
5. Mother and Stepfather
6. Adoptive Parents
7. Foster Parents
8. Institutional Caretakers
9. Aunt and/or Uncle
10. Brother and/or Sister
11. Maternal Grandparent(s)
12. Paternal Grandparent(s)
13. Other

2. How would you characterize your cbildhood? (Answer all that apply)
1. Happy
2. Frightening
3. Unhappy
4. Dull
5. Hard to Remember
6. Secure
7. Painful
8. Regimented

3. Which descriptor(s) characterize your mother (maternal caretaker)? (answer all that apply)
1. Warm
2. Distant
3. Uncaring
4. Strict
5. Unpleasant
6. Rejecting
7. Overprotective
8. Domineering
9. Abusive
10. Faultfinding
11. Understanding
12. Perfect
13. Affectionate

4. Which (descriptor(s) characterize your father (paternal caretaker)? (answer all that apply)
1. Warm
2. Distant
3. Uncaring
4. Strict
5. Unpleasant
6. Rejecting
7. Overprotective
8. Domineering
9. Abusive
10. Faultfinding
11. Understanding
12. Perfect
13. Affectionate

5. How would you describe your parents' (or parent substitutes') relationship? (answer all that apply)
1. Warm
2. Distant
3. Uncaring
4. Strict
5. Unpleasant
6. Rejecting
7. Overprotective
8. Domineering
9. Abusive
10. Faultfinding
11. Understanding
12. Perfect
13. Affectionate

6. How many brother and sisters did you have? (1 answer)
1. One
2. Two
3. Three
4. Four
5. Five
6. Six
7. Seven
8. More than seven
9. None

7. Which descriptors characterize you as a child (0 to 12 years of age)? (Answer all that apply)
1. Outgoing
2. Shy
3. Active
4. Aggressive
5. Awkward
6. Happy
7. Friendly
8. Emotional
9. Irresponsible
10. Nervous
11. Rebellious
12. Serious
13. Stubborn

8. What was your order of birth? (1 answer)
1. Oldest
2. Middle
3. Youngest
4. Only Child

9. What were problems for you as a child (0 to 12 years of age)? (Answer all that apply)
1. None
2. Getting along with mother
3. Getting along with father
4. Getting along with sibling(s)
5. Getting along with peers
6. Getting along with teacher
7. Bed-wetting
8. Nightmares
9. Excessive fears or worries
10. Academic
11. Physical/medical problems
12. Nerves
13. Felt I was a burden to my parents
14. Overweight
15. Underweight
16. Having my feelings hurt
17. Fear of failure

10. What did your parents (parent caretakers) argue about? (Answer all that apply)
1. Money
2. Discipline of children
3. Relatives interfering
4. Drinking
5. Sex
6. Jealousy
7. Not taking care of the home
8. Not being a good provider
9. Never argued

11. What was your father's (paternal caretaker's) occupation)? (1 answer)
1. Homemaker
2. Professional
3. Owner of Business
4. Skilled Craftsman
5. Office Worker
6. Salesperson
7. Skilled Laborer
8. Unskilled Laborer
9. Unemployed
10. Disabled
11. Government Service
12. Personal Service (e.g. Hair Stylist, Maid)
13. Military Service
14. Executive
15. Does Not Apply

12. What was your mother's (maternal caretaker's) occupation? (1 answer)
1. Homemaker
2. Professional
3. Owner of Business
4. Skilled Craftsman
5. Office Worker
6. Salesperson
7. Skilled Laborer
8. Unskilled Laborer
9. Unemployed
10. Disabled
11. Government Service
12. Personal Service (e.g. Hair Stylist, Maid)
13. Military Service
14. Executive
15. Does Not Apply

13. How would you describe your mother's method of discipline? (1 answer)
    1. Strict
    2. Fairly Strict
    3. Fair
    4. Lenient
    5. Inconsistent

13. How would you describe your father's method of discipline? (1 answer)
    1. Strict
    2. Fairly Strict
    3. Fair
    4. Lenient
    5. Inconsistent

14. What fears did you have as a child (0 to 12 years of age)? (Answer all that apply)
    1. No significant fears
    2. Death
    3. Might Fail
    4. Might be seriously injured or become ill
    5. Strangers
    6. Might be laughed at
    7. Might be abandoned - lose my parents
    8. Animals
    9. Other children

15. How far did you go in school? (1 answer)
    1. Completed less than 6 grades
    2. Completed elementary school
    3. Completed junior high (9th grade)
    4. Attended high school but did not receive a diploma
    5. Received a G.E.D.
    6. Graduated from high school
    7. Vocational or Business school training beyond high school
    8. Attended college but did not graduate
    9. Graduated from college - four year degree
    10. Completed college course work at the graduate level
    11. Earned a Master's Degree
    12. Earned a Doctoral Degree

16. How would you rate your intellectual ability? (1 answer)
    1. Below average
    2. Average
    3. Above average
    4. Superior/gifted

17. Were you ever held back in school? (1 answer)
    1. No
    2. Yes

19. In general, what grades did you make in school? (1 answer)
    1. Many D's and F's
    2. Mostly C's
    3. Mostly A's and B's
    4. Mostly A's

20. Did you ever get in trouble while in school? (1 answer)
    1. No
    2. Occasionally
    3. Often

21. Did you have any problems learning to read? (1 answer)
    1. No
    2. Yes

22. Did you have any problems learning math? (1 answer)
    1. No
    2. Yes

23. Did your peers ridicule, tease or make fun of you more than other kids? (1 answer)
    1. No
    2. Yes

24. Rate your family's economic status during childhood and adolescence: (1 answer)
    1. Poverty level (received welfare)
    2. Working Class
    3. Middle Class
    4. Upper Middle Class
    5. Wealthy

25. Who provided the main source of income for your family? (1 answer)
    1. Mother
    2. Father
    3. A Relative
    4. Social Service (Welfare, Unemployment, Disability)
    5. A Friend of the Family
    6. Other

26. Did your parents agree on how money should be spent? (1 answer)
    1. Agreed most of the time
    2. Disagreed
    3. Disagreed frequently

27. Did your family experience any financial problems? (1 answer)
    1. No
    2. Occasionally
    3. Often

28. Currently, how much money does the household earn that you now live in? (1 answer)
    1. Less than $8,000
    2. $8,000 - $20,000
    3. $20,000 - $40,000
    4. $40,000 - $75,000
    5. $75,000 - $125,000
    6. $125,000 - $200,000
    7. More than $200,000

29. Have you had any major changes in income during the last 2 years? (1 answer)
    1. No
    2. Decreased significantly
    3. Increased significantly

30. What is your family's primary source of income? (1 answer)
    1. My Earnings
    2. My Partner's Earnings
    3. Relatives
    4. Disability Payments
    5. Unemployment
    6. Welfare
    7. Investments
    8. Other

31. Is providing enough income for your family a big stress in your life? (1 answer)
    1. No
    2. Yes

32. Are you presently employed? (1 answer)
    1. No
    2. Yes

33. How long have you been working at this job? (1 answer)
    1. Less than 6 months
    2. 6 months to one year
    3. 1 to 3 years
    4. 3 to 5 years
    5. 5 to 10 years
    6. 10 to 15 years
    7. 15 to 20 years
    8. More than 20 years
    9. Does not apply

34. How many hours per week do you work? (1 answer)
    1. Less than 10
    2. 10 to 20
    3. 20 to 30
    4. 30 to 45
    5. More than 45
    6. Does not apply

35. In general, how do you enjoy your work? (1 answer)
    1. Enjoyable
    2. Neutral
    3. Unenjoyable
    4. Does not apply

36. Have you ever been fired? (1 answer)
    1. No
    2. Yes

37. Have you ever been laid off? (1 answer)
    1. No
    2. Yes

38. What is the longest period of time you held one job? (1 answer)
    1. Less than 1 year
    2. 1 to 3 years
    3. 3 to 5 years
    4. 5 to 10 years
    5. More than 10 years

39. Since starting full-time work, what is your longest non-work period? (1 answer)
    1. Less than 1 month
    2. 1 to 6 months
    3. 6 months to 1 years
    4. 1 to 3 years
    5. 3 to 5 years
    6. 5 to 10 years
    7. More than 10 years

40. Do you have any problems at work? (1 answer)
    1. No
    2. Yes
41. What kinds of work have you performed in the past? (Answer all that apply)
    1. A Homemaker
    2. A Professional
    3. An Owner of Business
    4. A Skilled Craftsman
    5. An Office Worker
    6. A Salesperson
    7. A Skilled Laborer
    8. An Unskilled Laborer
    9. Have Never Worked
    10. In Government Service
    11. Personal Service (e.g. Hair Stylist, Maid)
    12. An Executive
    13. Other
42. Have you ever served in the military? (1 answer)
    1. No
    2. Yes
43. Which branch did you serve in? (1 answer)
    1. Does not apply
    2. Air Force
    3. Army
    4. Navy
    5. Marines
    6. Coast Guard
44. How long did you serve? (1 answer)
    1. Does not apply
    2. Less than 3 months
    3. Less than 1 year
    4. 1 to 2 years
    5. 2 to 4 years
    6. 4 to 6 years
    7. 6 to 10 years
    8. 10 to 15 years
    9. More than 15 years
45. What kinds of problems did you experience while in the military? (Answer all that apply)
    1. Getting used to following rules and regulations
    2. Taking orders
    3. Nerves
    4. Began using drugs
    5. Began using alcohol to excess
    6. Was reprimanded by my superiors for my conduct
    7. Had to perform special duty because of my conduct (K.P., Latrine, etc)
    8. Did time in the stockade/brig
    9. Was court marshaled
    10. Went AWOL
    11. Other
    12. Does not apply/none
46. Were you stationed in a combat zone? (1 answer)
    1. Does not apply
    2. No
    3. Yes, for less than 3 months
    4. Yes, for 3 to 6 months
    5. Yes, for 6 months to 1 years
    6. Yes, for 1 to 2 years
    7. Yes, for 2 to 3 years
    8. Yes, for 3 to 4 years
    9. Yes, for longer than 4 years
47. What was the highest rank you attained? (1 answer)
    1. Does not apply
    2. Enlisted person
    3. Noncommissioned Officer
    4. Officer
48. What were the terms of your discharge? (1 answer)
    1. Does not apply
    2. Still on active duty
    3. Honorably discharged due to mental problems
    4. Honorably discharged due to physical problems
    5. Honorable discharge
    6. Dishonorably discharged
49. Did you ever see a psychologist or psychiatrist while in the military? (1 answer)
    1. Does not apply
    2. No
    3. Was hospitalized for mental problems
    4. For evaluation and treatment (outpatient)
    5. For evaluation only
50. Do you have a service-connected disability? (1 answer)
    1. Does not apply
    2. No
    3. Physical
    4. Mental
    5. Physical and Mental
51. Which of the following have you used? (Answer all that apply)
    1. None
    2. Cocaine
    3. Barbiturates
    4. Amphetamines
    5. Hallucinogenics
    6. Opium
    7. Qualludes
    8. Heroin
    9. Marijuana
    10. Tranquilizers without prescription
    11. Pain pills without prescription
    12. PCP
52. Have you ever felt there was a time you drank too much alcohol? (1 answer)
    1. No
    2. Yes, on one occasion
    3. Yes, on several occasions
    4. Yes, on more than several occasions
53. On the average, how often do you drink alcohol? (1 answer)
    1. Never
    2. Once or twice a year
    3. Once a month
    4. Once a week
    5. Several times a week
    6. Daily
54. How would you describe your illegal drug usage? (1 answer)
    1. Never used drugs
    2. Once or twice a year
    3. Once or twice a month
    4. Once a week
    5. A couple of time a week
    6. Daily
55. Have you ever been involved in an alcoholism or drug treatment program? (1 answer)
    1. No
    2. Yes
56. Did your parents have a problem with alcohol when you were a child? (1 answer)
    1. No
    2. Mother only
    3. Father only
    4. Both parents did
    5. The person who raised me did
57. Do you smoke cigarettes? (1 answer)
    1. No, never have
    2. No, I quit smoking
    3. Yes, a pack a week or less
    4. Yes, approximately one-half pack a day
    5. Yes, a pack a day
    6. Yes, more than a pack a day
58. Have any family members ever experienced mental illness? (Answer all that apply)
    1. No
    2. I have
    3. Mother
    4. Father
    5. Sibling(s) [brother(s) and sister(s)]
    6. Grandparents
    7. Outside the immediate family (uncle, aunt, etc.)
59. Did you have any bad illnesses as a child (e.g., hospitalizations)? (1 answer)
    1. No
    2. Yes
60. Have you had any significant accidents in the past 3 years? (1 answer)
    1. No
    2. Yes
61. Have you had any major illnesses or hospitalizations in the past 3 years? (1 answer)
    1. No
    2. Yes
62. Rate your general level of health. (1 answer)
    1. Excellent
    2. Good
    3. Fair
    4. Poor
    5. Extremely Poor
63. Are you currently under the care of a physician? (1 answer)
    1. No
    2. Yes

64. What medications are you currently taking? (Answer all that apply)
    1. None
    2. Pain pills
    3. Antibiotics
    4. Anti-inflammatory pills
    5. Anticonvulsant pills
    6. Hear pills
    7. High blood pressure pills
    8. Tranquilizers
    9. Antidepressants
    10. Vitamins
    11. Insulin
    12. Allergy Pills
    13. Stomach pills
    14. Other
65. What is your marital status? (1 answer)
    1. Single, but involved in an intimate relationship
    2. Single
    3. Divorced
    4. Separated
    5. Married
    6. Widowed
66. Have you ever been divorced? (1 answer)
    1. No
    2. Yes
67. How long have you been with your current partner? (1 answer)
    1. Not involved in an intimate relationship at this time
    2. Less than 1 year
    3. 1 year
    4. 2 years
    5. 3 years
    6. 4 years
    7. 5 years
    8. More than 5 years
    9. More than 10 years
    10. More than 15 years
    11. More than 20 years
    12. More than 25 years
    13. More than 30 years
68. How many children do you have? (1 answer)
    1. 1
    2. 2
    3. 3
    4. 4
    5. 5
    6. 6
    7. 7
    8. More than 7
    9. None
69. How would you describe your partner? (Answer all that apply)
    1. Warm
    2. Unhappy
    3. Distant
    4. Uncaring
    5. Happy
    6. Unpleasant
    7. Enjoyable
    8. Abusive
    9. Faultfinding
    10. Understanding
    11. Perfect
    12. Indifferent
    13. Argumentative
    14. Boring
    15. Stimulating
    16. Unforgiving
    17. Tense
    18. Affectionate
    19. Does not apply
70. Are you having problems with your child(ren)'s behavior? (1 answer)
    1. No
    2. Yes
    3. Does not apply
71. Is the frequency of sex a problem? (1 answer)
    1. No
    2. Yes
72. What are your living arrangements? (1 answer)
    1. Living with relatives in their home
    2. Living with friends in their home
    3. Renting a home
    4. Renting an apartment
    5. Buying a home
    6. Own my own home
    7. Boarder
    8. Living in a dorm
    9. Other
73. How often do you and your partner argue? (1 answer)
    1. Never
    2. Rarely
    3. Once a month
    4. Once a week
    5. Several times a week
    6. Daily
    7. Several times a day
    8. Does not apply
74. Has your relationship ever been threatened by an affair? (1 answer)
    1. No
    2. Yes, my affair
    3. Yes, my partner's affair
    4. Does not apply
75. What interests do you and your partner share? (Answer all that apply)
    1. None
    2. Children
    3. Work-related
    4. Sports
    5. Hobbies or crafts
    6. Movies
    7. Theater
    8. Music
    9. Politics
    10. Socializing with friends
    11. Television
    12. Religious activities
    13. Club activities
    14. Talking
    15. Games
    16. Camping
    17. Hunting/fishing
    18. Other
    19. Does not apply
76. How well do you feel your partner fulfills his/her role with you? (1 answer)
    1. Very well
    2. Fairly Well
    3. Poorly
    4. Very poorly
    5. Does not apply
77. Do you eat a balanced diet? (1 answer)
    1. No
    2. Yes
78. Do you participate in a regular exercise program? (1 answer)
    1. No
    2. Yes
79. How would you characterize your size? (1 answer)
    1. Very thin
    2. Thin
    3. About average
    4. A little heavy
    5. Heavy
    6. Very heavy
80. Which of the following have you experienced in the past two years? (Answer all that apply)
    1. Marital reconciliation
    2. Jail term
    3. Retirement
    4. Fired at work
    5. Change in health of family member
    6. Marital separation
    7. Divorce
    8. Death of spouse/ partner
    9. Pregnancy
    10. More or less arguments with partner
    11. None
81. Which of the following have you experienced in the past two years? (Answer all that apply)
    1. Death of a close friend
    2. Marriage
    3. Death of a close family member
    4. Change in financial state
    5. Personal injury or illness
    6. Change to different line of work
    7. Business readjustment
    8. Gain a new family member
    9. Sexual worries
82. How would you rate your ability to cope with life? (1 answer)
    1. Very good
    2. Good
    3. Fair
    4. Poor
83. How would you describe yourself? (Answer all that apply)
    1. Quiet
    2. Outgoing
    3. Talkative
    4. Shy
    5. Active
    6. Aggressive
    7. Temperamental
    8. Self-confident
    9. Wild
    10. Carefree
    11. Stubborn
    12. Easygoing
    13. Friendly
    14. Smart
    15. Impatient
    16. Responsible
    17. Rebellious
    18. Unassertive

84. How would you describe your mental state? (Answer all that apply)
    1. Tense
    2. Depressed
    3. Forgetful
    4. Sad
    5. Worried
    6. Fearful
    7. Angry
    8. Unenthusiastic
    9. Confused
    10. Disappointed
    11. Regretful
    12. Irritable
    13. Calm
    14. Scared
    15. Hyperactive
    16. Nervous
    17. Happy
    18. None of the above
85. Have you ever had legal problems? (Answer all that apply)
    1. No
    2. Civil (e.g., Divorce)
    3. Arrested
    4. Convicted
86. What is the primary problem bothering you? (1 answer)
    1. Marriage
    2. Family
    3. Loneliness
    4. Moodiness
    5. Depression
    6. Anxiety
    7. Low self-confidence
    8. Physical (ill/tired)
    9. Alcohol
    10. Drugs
    11. Sex
    12. Memory
    13. Work
    14. Other
87. How long ago did you begin to be troubled by this problem? (1 answer)
    1. Within the past month
    2. Between 1 and 6 months
    3. Between 6 and 12 months
    4. Between 1 and 2 years
    5. Between 2 and 5 years
    6. Between 5 and 10 years
    7. Over 10 years
    8. All my life
    9. Does not apply
88. Rate the degree to which this problem has affected your life. (1 answer)
    1. Very little
    2. A little
    3. A fair amount
    4. A good deal
    5. A great deal
    6. Does not apply
89. How often do you experience this problem? (1 answer)
    1. Many times a day
    2. Several times a day
    3. Daily
    4. Several times a week
    5. Once a week
    6. Several times a month
    7. Monthly
    8. Several times a year
    9. Less than once a year
    10. Does not apply
90. What other kinds of problems are bothering you? (Answer all that apply)
    1. Marriage
    2. Family
    3. Loneliness
    4. Moodiness
    5. Depression
    6. Anxiety
    7. Low self-confidence
    8. Physical (ill/tired)
    9. Alcohol
    10. Drugs
    11. Sex
    12. Memory
    13. Work
    14. Other
    15. Does not apply

THE TRAUMA SYMPTOM CHECKLIST (TSC-40)

How often have you experienced each of the following in the last two months?

		NEVER	1	2	OFTEN
1.	Headaches	0	1	2	3
2.	Insomnia (trouble getting to sleep)	0	1	2	3
3.	Weight loss (without dieting)	0	1	2	3
4.	Stomach problems	0	1	2	3
5.	Sexual problems	0	1	2	3
6.	Feeling isolated from others	0	1	2	3
7.	"Flashbacks" (sudden, vivid, distracting memories)	0	1	2	3
8.	Restless sleep	0	1	2	3
9.	Low sex drive	0	1	2	3
10.	Anxiety attacks	0	1	2	3
11.	Sexual overactivity	0	1	2	3
12.	Loneliness	0	1	2	3
13.	Nightmares	0	1	2	3
14.	"Spacing out" (going away in your mind)	0	1	2	3
15.	Sadness	0	1	2	3
16.	Dizziness	0	1	2	3
17.	Not feeling satisfied with your sex life	0	1	2	3
18.	Trouble controlling your temper	0	1	2	3
19.	Waking up early in the morning and can't get back to sleep	0	1	2	3
20.	Uncontrollable crying	0	1	2	3
21.	Fear of men	0	1	2	3
22.	Not feeling rested in the morning	0	1	2	3
23.	Having sex that you didn't enjoy	0	1	2	3
24.	Trouble getting along with others	0	1	2	3
25.	Memory problems	0	1	2	3
26.	Desire to physically hurt yourself	0	1	2	3
27.	Fear of women	0	1	2	3
28.	Waking up in the middle of the night	0	1	2	3
29.	Bad thoughts or feelings during sex	0	1	2	3
30.	Passing out	0	1	2	3
31.	Feeling that things are "unreal"	0	1	2	3
32.	Unnecessary or over-frequent washing	0	1	2	3
33.	Feelings of inferiority	0	1	2	3
34.	Feeling tense all the time	0	1	2	3
35.	Being confused about your sexual feelings	0	1	2	3
36.	Desire to physically hurt others	0	1	2	3
37.	Feelings of guilt	0	1	2	3
38.	Feeling that you are not always in your body	0	1	2	3
39.	Having trouble breathing	0	1	2	3
40.	Sexual feelings when you shouldn't have them	0	1	2	3

Fear Inventory

This questionnaire is designed to help your therapist understand what kinds of things you are afraid of. After each item, check the one box that best describes how much you are disturbed by it these days.

	Not at All	A Little	A Fair Amount	Very Much
Noise of vacuum cleaners	☐	☐	☐	☐
Open wounds	☐	☐	☐	☐
Being alone	☐	☐	☐	☐
Being in a strange place	☐	☐	☐	☐
Loud voices	☐	☐	☐	☐
Dead people	☐	☐	☐	☐
Speaking in public	☐	☐	☐	☐
Crossing streets	☐	☐	☐	☐
People who seem insane	☐	☐	☐	☐
Falling	☐	☐	☐	☐
Automobiles	☐	☐	☐	☐
Being teased	☐	☐	☐	☐
Dentists	☐	☐	☐	☐
Thunder	☐	☐	☐	☐
Sirens	☐	☐	☐	☐
Failure	☐	☐	☐	☐
Entering a room where other people are already seated	☐	☐	☐	☐
High places on land	☐	☐	☐	☐
Looking down from high buildings	☐	☐	☐	☐
Worms	☐	☐	☐	☐
Imaginary creatures	☐	☐	☐	☐
Strangers	☐	☐	☐	☐
Receiving injections	☐	☐	☐	☐
Bats	☐	☐	☐	☐
Journeys by train	☐	☐	☐	☐
Journeys by bus	☐	☐	☐	☐
Journeys by car	☐	☐	☐	☐
Feeling angry	☐	☐	☐	☐
People in authority	☐	☐	☐	☐
Flying insects	☐	☐	☐	☐
Seeing other people injected	☐	☐	☐	☐
Sudden noises	☐	☐	☐	☐
Dull weather	☐	☐	☐	☐
Crowds	☐	☐	☐	☐
Large open spaces	☐	☐	☐	☐
Cats	☐	☐	☐	☐
One person bullying another	☐	☐	☐	☐
Tough looking people	☐	☐	☐	☐
Birds	☐	☐	☐	☐
Sight of deep water	☐	☐	☐	☐
Being watched working	☐	☐	☐	☐
Dead animals	☐	☐	☐	☐
Weapons	☐	☐	☐	☐

OVER

Dirt	☐	☐	☐	☐
Crawling insects	☐	☐	☐	☐
Sight of fighting	☐	☐	☐	☐
Fire	☐	☐	☐	☐
Sick people	☐	☐	☐	☐
Dogs	☐	☐	☐	☐
Being criticized	☐	☐	☐	☐
Strange shapes	☐	☐	☐	☐
Being in an elevator	☐	☐	☐	☐
Witnessing surgical operations	☐	☐	☐	☐
Angry people	☐	☐	☐	☐
Mice	☐	☐	☐	☐
Human blood	☐	☐	☐	☐
Animal blood	☐	☐	☐	☐
Parting from friends	☐	☐	☐	☐
Enclosed places	☐	☐	☐	☐
Prospect of a surgical operation	☐	☐	☐	☐
Feeling rejected by others	☐	☐	☐	☐
Airplanes	☐	☐	☐	☐
Medical odors	☐	☐	☐	☐
Feeling disapproved of	☐	☐	☐	☐
Harmless snakes	☐	☐	☐	☐
Cemeteries	☐	☐	☐	☐
Being ignored	☐	☐	☐	☐
Darkness	☐	☐	☐	☐
Premature heartbeats (missing a beat)	☐	☐	☐	☐
Nude men	☐	☐	☐	☐
Nude women	☐	☐	☐	☐
Fighting	☐	☐	☐	☐
Doctors	☐	☐	☐	☐
People with deformities	☐	☐	☐	☐
Making mistakes	☐	☐	☐	☐
Looking foolish	☐	☐	☐	☐
Losing control	☐	☐	☐	☐
Fainting	☐	☐	☐	☐
Becoming nauseous	☐	☐	☐	☐
Spiders	☐	☐	☐	☐
Being in charge or responsible for decisions	☐	☐	☐	☐
Sight of knives or sharp objects	☐	☐	☐	☐
Becoming mentally ill	☐	☐	☐	☐
Being with a member of the opposite sex	☐	☐	☐	☐
Taking written tests	☐	☐	☐	☐
Being touched by others	☐	☐	☐	☐
Feeling different from others	☐	☐	☐	☐
A lull in conversation	☐	☐	☐	☐
Rape	☐	☐	☐	☐
Being overpowered	☐	☐	☐	☐
Suffocating	☐	☐	☐	☐
Confined spaces	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

INSTRUCTIONS FOR COMPLETING THIS ACTIVITY ASSESSMENT FORM

On the next page is a form that helps your therapist understand how you use your time. Fill it out using the last seven days' activities. So, for instance, if today were Monday, you would start with the day before, Sunday, and work your way backwards until all seven days are filled in. Fill in as much as you can remember.

Time	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1:00 am							
2:00 am							
3:00 am							
4:00 am							
5:00 am							
6:00 am							
7:00 am							
8:00 am							
9:00 am							
10:00 am							
11:00 am							
12:00 pm							
1:00 pm							
2:00 pm							
3:00 pm							
4:00 pm							
5:00 pm							
6:00 pm							
7:00 pm							
8:00 pm							
9:00 pm							
10:00 pm							
11:00 pm							
12:00 pm							

THE MICHIGAN ALCOHOLISM SCREENING TEST

1.	Do you feel you are a normal drinker?	Yes	No
2.	Have you ever awakened in the morning after some drinking the night before and found that you could not remember part of the evening?	Yes	No
3.	Does your wife/husband or parents ever worry or complain about your drinking?	Yes	No
4.	Can you stop drinking without a struggle after one or two drinks?	Yes	No
5.	Do you ever fell badly about your drinking?	Yes	No
6.	Do you ever try to limit your drinking to certain times of the day or to certain places?	Yes	No
7.	Do your friends or relatives think that you are a normal drinker?	Yes	No
8.	Are you always able to stop when you want to?	Yes	No
9.	Have you ever attended a meeting of Alcoholics Anonymous?	Yes	No
10.	Have you gotten into fights when drinking?	Yes	No
11.	Has drinking ever created problems with you and your wife/husband?	Yes	No
12.	Has your wife/husband or other family members ever gone to anyone for help about your drinking?	Yes	No
13.	Have you ever lost friends or girlfriends/boyfriends because of your drinking?	Yes	No
14.	Have you ever gotten into trouble at work because of drinking?	Yes	No
15.	Have you ever lost a job because of drinking?	Yes	No
16.	Have you ever neglected your obligations, your family or work for two days or more in a row because of drinking?	Yes	No
17.	Do you ever drink before noon?	Yes	No
18.	Have you ever been told you have liver trouble?	Yes	No
19.	Have you ever had DT's (delirium tremens), severe shaking, heard voices or seen things that weren't there after heavy drinking?	Yes	No
20.	Have you ever gone to anyone for help about your drinking?	Yes	No
21.	Have you ever been in a hospital because of drinking?	Yes	No
22.	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem?	Yes	No
23.	Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor or clergyman for help with an emotional problem in which drinking played a part?	Yes	No
24.	Have you ever been arrested, even for a few hours, because of drunken behavior?	Yes	No
25.	Have you ever been arrested for drunken driving or driving after drinking?	Yes	No

Instructions for Health Insurance Claim Form

Please fill out all sections that apply to you on the top portion of this form. Generally this means you will need to answer questions #1 through #13. Leave #14 through #33 blank.

The term "patient," as in section #2, means you. "Insured" means the employee whose job provides the insurance for the employee and additional family members. Therefore you might be both the "insured" and the "patient," or you might be the "patient" and your spouse the "insured."

Fill out section #9 only if you are covered under a second insurance policy. For instance, you might be insured through your work and also be covered under your spouse's policy. You would fill out **your** information in section #**11**, and your **spouse's** insurance information in section #**9**. If you are not an employee yourself with insurance, but you are covered under your spouse's or parent's insurance, the "insured" would be your spouse or parent.

Please be sure to sign in both places - sections #12 and #13.

Thank You.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items caption in "insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision ; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is recieved as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872, and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Addition disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed, Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vo. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USES(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquireies made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency of Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

EATING ATTITUDES TEST (EAT-26)

Name: _____ Date: _____ Age: _____

Present Weight: _____ (lbs) Height: _____ Sex: _____

Highest Past Weight: _____ (lbs) How Long Ago? _____

Lowest Past Adult Weight: _____ (lbs) How Long Ago? _____

INSTRUCTIONS

Please place an (X) under the column which applies best to each of the numbered statements. All of the results will be strictly confidential. Most of the questions directly relate to food or eating, although other types of questions have been included. Please answer each question carefully. Thank you.

Always	Usually	Often	Sometimes	Rarely	Never		
						1.	Am terrified about being overweight
						2.	Avoid eating when I am hungry.
						3.	Find myself preoccupied with food.
						4.	Have gone on eating binges where I feel that I may not be able to stop.
						5.	Cut my food into small pieces.
						6.	Aware of the calorie content of foods that I eat.
						7.	Particularly avoid foods with a high carbohydrate content (e.g., bread, rice, potatoes, etc.).
						8.	Feel that others would prefer if I ate more.
						9.	Vomit after I have eaten.
						10.	Feel extremely guilty after eating.
						11.	Am preoccupied with a desire to be thinner.
						12.	Think about burning up calories when I exercise.
						13.	Other people think that I am too thin.
						14.	Am preoccupied with the thought of having fat on my body.
						15.	Take longer than others to eat my meals
						16.	Avoid foods with sugar in them.
						17.	Eat diet foods.
						18.	Feel that food controls my life.
						19.	Display self-control around food.
						20.	Feel that others pressure me to eat.
						21.	Give too much time and thought to food.
						22.	Feel uncomfortable after eating sweets.
						23.	Engage in dieting behavior.
						24.	Like my stomach to be empty.
						25.	Enjoy trying new rich foods.
						26.	Have the impulse to vomit after meals.

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Your Name _____

Eating Disorder History and Treatment

These questions are designed to help you obtain the best possible treatment specific to your needs. Please answer each question as best you can using the bottom of the page when you need more room.

The following terminology is specific to the treatment at A Better Way Counseling Center. Please take a moment to familiarize yourself with these specific terms.

Eating disorder behaviors consist of the following activities:

***Binge eating**: feeling out of control eating large amounts of food rapidly in a brief time period.*
***Compulsive eating**: feeling out of control eating large amounts of food over an extended period (i.e. throughout the day) instead of all at once.*
***Purging**: ridding the body of unwanted food through artificial means such as vomiting or the use of laxatives.*

People engage in these behaviors in different patterns. Some will do them frequently and consistently, others do them only occasionally and randomly, and still others do them on a regular basis but not frequently. The following questions will help us understand your pattern.

Binge Eating

Number of days you binged in the past month: _____
Average number of times per day you binged: _____
Approximate age when you first binged: _____

For the following, check the statement that best applies. How would you describe your episodes of binge eating in the past year?

____ Frequent and regular episodes (averaging _____ times per week)

____ Episodes lasting:
_____days or _____ weeks or _____ months.

with periods of normal eating in between. During these episodes you binged:
_____ times per day or _____ times per week.

____ Infrequent episodes (please describe length of time and number of occurrences in the past year):
_____
_____
_____
_____
_____
_____

What do you eat on a typical binge?

_____
_____
_____
_____
_____

Please provide any additional information you believe is important, using the bottom of the page if necessary.

Compulsive Eating

Number of days you ate compulsively in the past month: _____
Approximate age when you first ate compulsively: _____

For the following, check the statement that best applies. How would you describe your episodes of compulsive eating in the past year?

____ Frequent and regular episodes (averaging _____ times per week)

____ Episodes lasting:
_____days or _____ weeks or _____ months.

with periods of normal eating in between. During these episodes you ate compulsively:
_____ times per day or _____ times per week.

____ Infrequent episodes (please describe length of time and number of occurrences in the past year):

_____
_____
_____
_____
_____
_____

What do you eat during a typical episode in which you eat compulsively?

_____
_____
_____
_____
_____

Please provide any additional information you believe is important, using the back page if necessary.

Purging

Number of days you purged in the past month: ____
Average number of times per day you purged: ____
Type of purging (e.g., vomiting, laxatives, etc.): _____
Approximate age when you first purged: _____ What type? _____

For the following, check the statement that best applies. How would you describe your episodes of purging in the past year?

____ Frequent and regular episodes (averaging _____ times per week)

____ Episodes lasting:
_____days or _____ weeks or _____ months

with periods of normal eating in between. During these episodes you purged:
_____ times per day or _____ times per week.

____ Infrequent episodes (please describe length of time and number of occurrences in the past year):
_____
_____
_____
_____
_____

Please provide any additional information you believe is important, using the back page if necessary.

Exercise

How many hours per day have you exercised over the past month? _____
Per day over the past year (on average)? _____
Approximately how many days have you exercised over the past month? _____
How many days, on average, have you exercised per month over the past year? _____
Was there a time you exercised more or less? _____ When and how much did you exercise?
_____
_____

Weight History

Please use this space to describe your weight history. Include your lowest and highest adult weights and when you were at them. Also describe your weight fluctuations over the course of your life.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

General Information

When did your eating disorder behavior first start? _____
_____

What behavior? _____

For women:
When was your last period? _____
How many have you missed since then, if any? _____
Are your periods irregular? _____ If so, describe: _____
_____
In the past two years, have you missed three or more periods? _____
When and how many did you miss? _____
_____
List any health problems you have that may have been caused by your eating disordered behavior:

_____
_____
_____
_____
_____
_____
_____

Treatment

Please list:
(A) any treatment you have had for your eating disorder, or in which your eating disorder was discussed (with therapists, physicians, nurses, etc.),
(B) what kind of treatment you received (medical care, hospitalization, individual, family or group psychotherapy, etc.),
(C) when you were treated,
(D) who you saw for treatment,
(E) and for how long:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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HOME EATING PROFILE: "Bad Day"

Name: _____ Date: _____

Explanation: Please record the foods eaten on a typical "**BAD**" day prior to entering the program. Please fill out accurately and with as much detail as possible. Bring completed form with you to your initial appointment.

Waking Time: _____ Bed Time: _____

Beginning Time	Place	Item	Quantity	Ending Time

HOME EATING PROFILE: "Good Day"

Name: _____ Date: _____

Explanation: Please record the foods eaten on a typical "**GOOD**" day prior to entering the program. Please fill out accurately and with as much detail as possible. Bring completed form with you to your initial appointment.

Waking Time: _____ Bed Time: _____

Beginning Time	Place	Item	Quantity	Ending Time