

Date: _____

CLIENT CONTACT FORM

Client Name: _____ Date of Birth: _____ Age: _____
Gender: Male/ Female/Other Preferred pronoun: _____ Marital Status: M S D
Social Security: _____
Address: _____
City, State, Zip: _____
Cell Phone: (____) _____ Cell Phone Carrier: _____
May I leave a message? YES NO Restrictions: _____
Email address: _____ PCP: _____
Employer: _____ How did you hear about us? _____

Family/Emergency Contact Data

Parent/Spouse/ Guardian: _____
Address: _____ City, State, Zip: _____
Email for parent/spouse/guardian: _____
Parent/ Spouse Employer: _____ Phone: (____) _____
Parent/ Spouse Social Security Number: _____ DOB: _____
Name of nearest relative not living with you: _____
Address: _____ City, State, Zip: _____
Phone: (____) _____

Description of why you are seeking services:

Insurance Information

We will need a copy of your insurance card and photo ID

Client Name _____

Insurance Company _____

Insurance ID _____ Group number _____

Policy Holder Full Name: _____ DOB: _____ Sex: _____

SSN: _____ *(Insured person's social security is required)*

Client's relationship to insured: **Self Spouse Child Other:** _____

Insured's Employer: _____

Insured's Phone: (____) _____ *(circle)* cell home other

Is there a second insurance policy *(circle)* **YES NO I don't know** *(if yes a copy of the card is required and ask office staff for an additional form for insurance)*

Therapy Charges

<u>Initial Evaluations</u>	60 min	\$225.00
<u>Individual Sessions</u>	60 min	\$180.00
	45 min	\$160.00 (individual)
<u>Initial Family/Couples Evaluation</u>	60 min	\$225.00
<u>Family/Couples/Group Therapy</u>	45/60 min	\$190.00 (family)

**** LPC-A's Intake/Sessions \$175.00 /\$150.00 and \$175.00 for couples Intake/Sessions.**

*I hereby give New Braunfels Counseling Center permission to file with my insurance company to receive reimbursement for services rendered. I understand that I am totally liable for my bill and although NBCC will file with my insurance, **I am liable for charges accrued while I am receiving therapeutic services. Missed appointments, and those canceled with less than 24 hours notice will be billed to me at the standard rate. If more than two therapy sessions are NO SHOW's and/or Late Cancellations in a two month period of time, the account must be made current before any additional sessions will be scheduled.** I acknowledge I will need to speak with my provider before additional sessions will be scheduled. I ACKNOWLEDGE THAT I HAVE BEEN ADVISED ON THE NOTICE OF PRIVACY PRACTICES explaining how my medical information will be used and disclosed. I may request a copy for my records at any time. A \$50.00 fee may be associated with the copy of records.*

Patient (parent/guardian if minor) Signature: _____

Informed Consent

By signing this document, I, _____, am indicating that I agree to participate in the following services with New Braunfels Counseling Center (hereafter NBCC):

_____ CLINICAL ASSESSMENT	_____ INDIVIDUAL THERAPY
_____ CLINICAL ASSESSMENT FOR MY CHILD	_____ THERAPY FOR MY CHILD
_____ FAMILY THERAPY OR COUPLES THERAPY	
_____ OTHER _____	

I understand in order to develop the therapist-patient relationship plan necessary to meet my needs, an initial assessment will be completed and a joint decision made to either proceed with the recommended treatment plan or continue the assessment over additional visits. The limitations and benefits of all therapy or services I may receive will be discussed with me. I understand that while the long term goal of therapy is to feel better. I may experience a period of feeling worse before I begin to feel better and I also understand that there is no guarantee of success. I understand that there may be alternative methods of therapy for my consideration and I am encouraged to ask questions regarding my treatment or other methods at any time.

Notice of Privacy Practices

I ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES (HIPAA): (PROVIDED

UPON REQUEST) _____ Notice of Privacy Practices received (initial)

_____ Notice of Privacy Practices declined (initial)

Signature: _____ Date: _____

Relationship to Client: _____

Client Responsibilities

As a patient, you have some important responsibilities. Please keep all scheduled appointments with your counselor and be prompt. Being on time is an indication of your commitment to your own progress in therapy. Please remember that once an appointment is made, your provider has set that time aside. Late cancellations or "No Shows" not only disrupt your provider's schedule, but are discourteous as well. If some occurrence prevents you from keeping a scheduled appointment, contact the office as soon as possible. You will be charged the standard rate for a full session if you miss a session, if 24 hours notice is not given to cancel your appointment. **The 24 hour notice must be during the Monday through Friday work week, not over a weekend or the standard fee will be charged to you (not insurance).** If the initial appointment is a NO SHOW, a fee of \$50 will be charged once paperwork is completed to reserve the rescheduled initial appointment. The fee will be applied to the cost of the initial session. If insurance is used, the fee will be applied to the copay or coinsurance after the session is billed to the insurance company. If there is no fee associated with the insurance, the amount will be refundable. We also reserve the right to terminate therapy if there are excessive cancellations or "No Shows", as the client is not likely to benefit from treatment.

Phone Messages

If a situation arises that you feel the provider needs to know about before your next scheduled appointment, please feel free to contact the office and leave a message for your provider. Your message will be confidential, and your provider will review your message before your scheduled therapy session. The rate per hour for phone support is determined by session, prorated in 15 minute increments. If an emergency arises, please contact 911 or go to the nearest emergency room.

New Braunfels Counseling Center
790 Generations Dr Ste 410
New Braunfels, TX 78130-6720
Phone: (830)625-0599
Fax: (830)625-5877

Darla Lane, LCSW-S
Angela McCree LMFT-A
Sher MCKelvie, LPC, LCDC.
Susan Greco, LPC
Randall Chavez, LPC
Melanie Blank, LCSW
Kelvin McCoy, LCSW, LCDC
Tifarah Canion, LPC-A
Mike Allen, LPC-A
Ulysees Cantero, LPC, LPL, AMFT
Ivonne Mouser, LPC
Stephanie Donnell, LPC

Financial Responsibility

We accept most insurance and will file your claim for you; however, it is important for you to understand that you are responsible for your bill. We expect payment of any deductibles and/or copayments as services are rendered. Payment may be made by cash, check, debit and credit card in the office. Flexible spending account /HRA cards are also accepted.

NBCC does not extend credit. NBCC would rather communicate with our clients to find solutions to overdue accounts. I will contact the office if payment arrangements need to be made. I hereby consent to the delegation of collection activity to an outside collection service, including the release of necessary information by the collection agency. A delinquency fee of 40% of the outstanding balance will be added if a collection agency is required.

I am aware that there is a **returned check fee of \$35** in addition to the reimbursement of the charges assessed by NBCC's bank. **Statements, receipts, or other documents will not be issued to any delinquent account until paid in full.** Payment by credit cards will be in accordance with the Informed Consent form provided by NBCC. I agree that NBCC reserves the right to amend this agreement and may provide me with written notice of any amendment, at which time I have 30 days to decide to continue treatment with my provider at NBCC under the amended agreement. I authorize payment of benefits to my provider at NBCC for any/all services rendered by that provider.

I am aware that State and Federal laws require NBCC to collect copayments, coinsurance and deductibles in full. I am responsible for paying my copayments, coinsurance, and deductibles at the time services are rendered. **I am aware that I am fully responsible for all fees not covered by my insurance company and that there is no guarantee that my insurance company will cover services.** NBCC will file with my insurance company and will bill me for coinsurance and deductibles that are due upon receiving an explanation of benefits. If my balance exceeds \$200.00, after explanation of benefits from my insurance company, or if I am paying privately; my provider may stop providing services until my balance is decreased to a reasonable amount. I will be contacted by my provider to address payment issues and possible referral to a lower fee service provider.

Fees

Initial Assessment		\$225.00
LPC-A sessions		\$175.00/\$150.00
LPC-A Family/Marriage		\$175.00/\$175.00
Individual Session	45 min	\$160.00
Individual Session	60 min	\$180.00
Family/Marital Session		\$190.00
Phone Session		Rate: Determined per scheduled session
Cancellation W/O 24 Hr Notice		Rate: Determined per scheduled session
No Show		Rate: Determined per scheduled session
Complete File Copy		\$50.00 (1-20 pages/ \$.50 per page thereafter)
Other Services Rendered		\$180.00 per hr

Letters, Disability forms, or other forms completed by therapists (per occurrence): \$50.00

Divorce/Child Custody Cases/CPS Cases

The parent/guardian who accompanies the child to our center is responsible for payment. This includes co-pays, co-insurance, fee for service, and non participating insurance balances. **Regardless of which parent carries the insurance on the child, we will collect from the parent that brings the child. WE DO NOT ACCEPT ANY ONGOING OR OPEN CPS CASES.** If we discover an open CPS case we will immediately terminate services. We cannot get involved in custody specifics, e.g., one parent pays 80% and the other pays 20% towards medical expenses; as we are not a party to the court agreement. It is the parents' obligation to work out an arrangement themselves or through the court systems. In addition, a copy of the custody agreement must also be placed in each child's chart before the initial session.

Court Appearances

We are **NOT FORENSIC THERAPISTS**, but if we are subpoenaed for court for any reasons fees are:
\$500.00 per hr

Minimum retainer fee for legal services: \$2,000.00.

If you become involved in legal proceedings that require a provider's participation, you will be expected to pay for the time, **even if the provider is called to testify by another party.** Due to the difficulty of legal involvement, **a charge of \$400.00 per hour** will be assessed for **any preparation and attendance at any legal proceeding, including research of the client's previous therapy sessions. Professional fees for court appearances, depositions and attorney consultations including travel and waiting time, are non-refundable, are payable in advance only, and are not prorated as we have to block out time to be at court; thus preventing your provider from being able to see other clients during that time. A minimum of \$2,000.00 is required and must be paid prior to any response to attorneys via telephone, provisions of clinical opinions, subpoenas, report preparation for either litigating party, or testimony.** The providers at NBCC will not agree to court appearances or other legal involvement unless they have discussed the matter thoroughly and both provider and the client agree to such involvement. The provider will also decide whether involvement is within the range of provider's competence and whether or not the court will interfere with the treatment relationship. I understand that if report preparation is required or requested, the rate for the preparation will be charged at the standard rate of a therapy session. Frequent and/or extended telephone will also be charged for at the standard phone session rate. These services are not reimbursed by insurance.

Your signature below means that you have read and understand the information contained in this form:

Signature: _____ Date: _____

Relationship to client: _____

I understand that this agreement is valid for the duration of time that I am participating in services with NBCC. By signing below, I acknowledge that I have read the **Informed Consent** and I understand and agree to the entire contents of these documents. I acknowledge that I have had an opportunity to have answered any questions, comments or concerns that I might have had prior to signing this consent and participation in services. I am aware that I can stop counseling at any time. NBCC reserves the right to amend the **Informed Consent** at any time and copies will be available at the office of NBCC. I can request a copy of changes at any time, at no charge. Any changes that NBCC makes are effective immediately unless otherwise indicated.

Signature of patient: _____ Date: _____

Signature of Parent (if patient is a minor): _____

Patients are responsible for updating any and all insurance information with the front desk. If insurance denies a claim due to patients' not informing the front desk of new/updated information, the patient is held responsible for any and all charges assessed and unpaid by the insurance company.

PATIENTS' RIGHTS AND RESPONSIBILITIES

✓ I understand that I will see a Licensed Clinical Social Worker/ Licensed Professional Counselor/ Licensed Professional Counselor- Associate/Licensed Chemical Dependency Counselor/Licensed Marriage and Family Therapist in the State of Texas. (please circle the correct License).

✓ I understand that NBCC works with children, adolescents, and adults in individual, family/marriage counseling.

✓ I understand that as my provider, or the provider working on my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

✓ I understand that if I am concerned about slow progress or lack of progress, I have the right to speak to my provider at NBCC about this concern.

✓ I understand that if any assignment is given that I disagree with morally, emotionally or ethically, I have the right to not proceed with the assignment.

✓ I understand that counseling can improve, as well as upset the equilibrium in any person or family.

✓ I understand that any LPC-A/LPC/LCSW/LMFT/LCDC at NBCC, are not psychiatrists and as such cannot recommend or prescribe medications, but can encourage clients to see an MD for a medical evaluation.

✓ I understand that my provider at NBCC does not perform formal testing; however I may be referred to a psychologist who can perform formal testing.

✓ I understand that there are occasions when confidentiality can/must be breached. those occasions are: 1) the client request the provider to tell someone else in writing or verbally; 2) the provider determines that the client is a threat to themselves or others; 3) the provider is ordered by court to disclose information; 4) the provider suspects that child abuse has taken place, at which time he/she will notify Child Protective Services.

✓ I understand the providers and clients paths may cross in social situations, but the therapeutic relationship comes first, along with the protections of confidentiality.

✓ I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to therapists at NBCC.

✓ I understand that there is a \$35 returned check fee and that if a returned check is not cleared within 30 days of receipt, NBCC will file suit with the Comal County District Attorney's Office.

✓ I understand that if I have a complaint I cannot resolve with the provider at NBCC and I wish to file a formal complaint, I may contact the Texas Behavioral Health Executive Council online at bhec.texas.gov or call (800)821-3205.

✓ Emergencies: I understand that although NBCC does not provide formal emergency services, my provider will try to be available to every extent possible. I may call the office number at any time and leave a message. If during the business day, the call will be returned before the end of the business day, in most circumstances. If the call is received overnight or on the weekends, it will be returned within 48 hours of receipt. If I find myself in an urgent situation, I have the choice of waiting for the return call, calling 911, or going to the nearest emergency room for immediate care.

By signing below, I confirm that I have read, agreed to, and received the above information.

Signature: _____ **Date:** _____

Credit Card Information and Authorization

If you need to cancel or reschedule an appointment, **please give 24 hours advance notice**, otherwise you will be charged **\$150.00** and this will not be covered by your insurance. If the office does not hear from you before your missed/no show appointment, your credit card will be charged. If you need to cancel or are going to be late, please call the office at (830)625-0599. If you arrive late, the session will still end at the scheduled time. If you are going to be late and you still have not appeared within 15 minutes of your scheduled time, it will be considered a missed appointment and will be charged accordingly.

Credit Card Authorization Form

I, _____, hereby authorize NBCC to bill my credit card as listed below for professional fees for myself or _____.

I agree that NBCC may bill my credit card at the full fees assessed for professional services including the following:

(Please initial)

- _____ Appointments that elect to pay by credit card.
- _____ Missed appointments. (Standard rate)
- _____ Appointments that have been canceled less than 24 hours notice (Standard rate)
- _____ Telephone consultations (billed in 15 minute increments based on \$150.00 per hour)
- _____ Balances of charges not paid by me or my insurance
- _____ Insufficient funds/returned check fees.

Type of Credit Card:

___ Visa ___ Mastercard ___ Discover ___ American Express
___ FSA cards (not for missed or canceled appointments)

Name as it appears on card: _____

Card Number: _____

Expiration: _____

CVV/CID Code: _____

Zip: _____

Signature: _____

Date: _____

Charges will appear on your statement as New Braunfels Counseling Center.

New Braunfels Counseling Center

790 Generations Dr Ste 410, New Braunfels, TX 78130

INFORMED CONSENT CHECKLIST FOR TELE PSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- * There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- * Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- * We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist/ therapist will explain how to use it.
- * You need to use a webcam or smartphone during the session.
- * It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- * It is important to use a secure internet connection rather than public/free Wi-Fi.
- * Certain platforms may not be secure and HIPPA compliant, if requested by the patient to use.. (e.g. Zoom, Facetime, FB Messenger)
- * It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- * We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- * We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- * If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- * You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- * As your psychologist/therapist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist / Therapists Name / Signature: _____

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

Date: _____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
 - 0 I do not feel sad.
 - 1 I feel sad
 - 2 I am sad all the time and I can't snap out of it.
 - 3 I am so sad and unhappy that I can't stand it.
2.
 - 0 I am not particularly discouraged about the future.
 - 1 I feel discouraged about the future.
 - 2 I feel I have nothing to look forward to.
 - 3 I feel the future is hopeless and that things cannot improve.
3.
 - 0 I do not feel like a failure.
 - 1 I feel I have failed more than the average person.
 - 2 As I look back on my life, all I can see is a lot of failures.
 - 3 I feel I am a complete failure as a person.
4.
 - 0 I get as much satisfaction out of things as I used to.
 - 1 I don't enjoy things the way I used to.
 - 2 I don't get real satisfaction out of anything anymore.
 - 3 I am dissatisfied or bored with everything.
5.
 - 0 I don't feel particularly guilty
 - 1 I feel guilty a good part of the time.
 - 2 I feel quite guilty most of the time.
 - 3 I feel guilty all of the time.
6.
 - 0 I don't feel I am being punished.
 - 1 I feel I may be punished.
 - 2 I expect to be punished.
 - 3 I feel I am being punished.
7.
 - 0 I don't feel disappointed in myself.
 - 1 I am disappointed in myself.
 - 2 I am disgusted with myself.
 - 3 I hate myself.
8.
 - 0 I don't feel I am any worse than anybody else.
 - 1 I am critical of myself for my weaknesses or mistakes.
 - 2 I blame myself all the time for my faults.
 - 3 I blame myself for everything bad that happens.
9.
 - 0 I don't have any thoughts of killing myself.
 - 1 I have thoughts of killing myself, but I would not carry them out.
 - 2 I would like to kill myself.
 - 3 I would kill myself if I had the chance.
10.
 - 0 I don't cry any more than usual.
 - 1 I cry more now than I used to.
 - 2 I cry all the time now.
 - 3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.
12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.
14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.
15.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.
16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.
18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.
19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

- 0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

- 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score _____ Levels of Depression

1-10	_____	These ups and downs are considered normal
11-16	_____	Mild mood disturbance
17-20	_____	Borderline clinical depression
21-30	_____	Moderate depression
31-40	_____	Severe depression
over 40	_____	Extreme depression

THE BURNS ANXIETY INVENTORY

INSTRUCTIONS: The following is a list of symptoms that people sometimes have. Put a check () in the space to the right that best describes how much that symptom or problem has bothered you during this past week. SYMPTOM LIST	0-NOT AT ALL	1-SOMEWHAT	2-MODERATELY	3-A LOT
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CATEGORY I: ANXIOUS FEELINGS

1.	Anxiety, Nervousness, Worry, and Fear	☐	☐	☒	☐
2.	Feeling that things around you are strange, unreal or foggy	☐	☐	☐	☐
3.	Feeling detached from all or part of your body	☐	☐	☐	☐
4.	Sudden unexpected panic spells	☐	☐	☐	☐
5.	Apprehension or a sense of impending doom	☐	☐	☐	☐
6.	Feeling tense, stressed, "uptight," or on edge	☐	☐	☐	☐

CATEGORY II: ANXIOUS THOUGHTS

7.	Difficulty concentrating	☐	☐	☐	☐
8.	Racing thoughts or your mind jumps from one thing to the next.	☐	☐	☐	☐
9.	Frightening fantasies or daydreams	☐	☐	☐	☐
10.	Feeling that you're on the verge of losing control	☐	☐	☐	☐
11.	Fears of cracking up or going crazy	☐	☐	☐	☐
12.	Fears of fainting or passing out	☐	☐	☐	☐
13.	Fears of physical illness or heart attacks or dying	☐	☐	☐	☐
14.	Concerns about looking foolish or inadequate in front of others	☐	☐	☐	☐
15.	Fears of being alone, isolated, or abandoned	☐	☐	☐	☐

16.	Fears of criticism or disapproval	☐	☐	☐	☐
17.	Fears that something terrible is about to happen	☐	☐	☐	☐

CAEGORY III: PHYSICAL SYMPTOMS

18.	Skipping or racing or pounding of the heart (palpitations)	☐	☐	☐	☐
19.	Pain, pressure, or tightness in the chest	☐	☐	☐	☐
20.	Tingling or numbness in the toes or fingers	☐	☐	☐	☐
21.	Butterflies or discomfort in the stomach	☐	☐	☐	☐
22.	Constipation or diarrhea	☐	☐	☐	☐
23.	Restlessness or jumpiness	☐	☐	☐	☐
24.	Tight, tense muscles	☐	☐	☐	☐
25.	Sweating not brought on by heat	☐	☐	☐	☐
26.	A lump in the throat	☐	☐	☐	☐
27.	Trembling or shaking	☐	☐	☐	☐
28.	Rubbery or "jelly" legs	☐	☐	☐	☐
29.	Feeling dizzy, lightheaded, or off balance	☐	☐	☐	☐
30.	Choking or smothering sensations or difficulty breathing	☐	☐	☐	☐
31.	Headaches or pains in the neck or back	☐	☐	☐	☐
32.	Hot flashes or cold chills	☐	☐	☐	☐
33.	Feeling tired, weak, or easily exhausted	☐	☐	☐	☐
Add up your total score for the 33 symptoms and record it here.					
DATE:					

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? <i>Please circle one response only.</i>		
No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

Substance Abuse Self Assessment Questionnaire

Questionnaire to determine whether you might have a drug or alcohol problem:

Have you ever felt you ought to cut down on your drinking or drug use?

Have people annoyed you by criticizing your drinking or drug use?

Have you ever felt bad or guilty about your drinking or drug use?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Do you need more alcohol or drugs to get the same feeling?

Do you notice memory loss, shakes, weight loss, mood swings, loss of appetite or other physical symptoms related to drug use?

Do you have a hard time getting through the day without alcohol or other drugs?

Do you make "getting high" a priority in your day, more important than family, friends, social life, or other commitments?

Do you spend money on alcohol or other drugs that should be used for housing, food, or other necessities?