Delta Behavioral Health

Client Information:

Have you ever been a client of Delta Behavioral Health in the past (circle one)? No Yes If so, when? _____

Legal Name* _____ SS# _____ DOB* _____ Age ____ Gender ID _____ Gender @ birth _____

Address* _____ City* _____ State* _____ ZIP* _____

County _____ Phone:* _____ Marital Status _____ Preferred Name: _____

May we leave a message at this number? Yes No

Place of birth _____ Email _____ Religious preference _____

Employer _____ Occupation _____ Length of Employment ____ County _____

How many people are in your household? _____ What is your approximate annual income? _____

Who referred you to Delta? _____

Who is your Primary Care Physician/Psychiatrist? _____ Phone _____

Emergency Contact* _____ **Relationship*** _____ **Phone*** _____

Address _____ City _____ State _____ ZIP _____

Name of spouse/ Responsible person/parent or Guardian (if minor) _____ SS# _____

Address _____ City _____ State _____ ZIP _____

Home Phone: _____ Other Phone: _____ County _____

May we leave a message? Yes No **Yes No**

Notice of Privacy Practice: Acknowledgement of Receipt

The form, when completed by you acknowledges that you have received a copy of the Notice of Privacy Practices for Delta Behavioral Health.

I, _____, acknowledge that I _____ have received a copy of
(Client name)* (Client name)*

the Notice of Privacy Practices for Delta Behavioral Health on _____.
(Date)*

_____ _____
Signature of client or personal representative* (Date)*

If the acknowledgement is signed by a personal representative, the name of the client and a description of such representative's authority to act for the client must be provided.

_____
(Client's name)

Authority to act for client (example: parent or legal guardian)

* Required Fields

your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- *"Health Care Operations"* are activities that relate to the performance and operation of the practice. Examples of disclosure for health care operations are for quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.

II. Use and Disclosure Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when asked for information for purposes outside treatmen, payment and health care operations, we will obtain an authorization from you before releasing your psychotherapy notes. "Psychotherapy notes" are notes we have made about our conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medial record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psycho-therapy notes) at any time, provided each revocation is in writing. You man not revoke an authorization to the extent that (1) we have relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

An authorization is obtained for using or disclosing (1) PHI in a way that is not described in this Notice, (2) psychotherapy notes, (3) PHI for marketing purposes, and (4) PHI in a way that is considered a sale of PHI.

III. Uses and Disclosures with Neither Consent Nor Authorization

PHI may be used or disclosed without your consent or authorization in the following circumstances:

- **Child Abuse**: if you provide information which leads to suspicion of child abuse, neglect, or death due to maltreatment, it is required that this be reported to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to child protective services investigation, we must do so.
- **Adult and Domestic Violence**: If information you provide gives reasonable cause to believe that a disabled adult is in need of protective services, we must report this to the Director of Social Services.
- **Health Oversight**: The North Carolina Psychology Board has the power, when necessary to subpoena relevant records should a Delta provider be the focus on inquiry.
- **Judicial or Administrative Proceeding**: If you are involved in a court proceeding and a request is made for information about the professional services that have been provided to you and/or the records thereof, such information is privileged under state law, and we must not release this information without your written authorization or a court order. This privilege does not apply when you are being evaluated for a for a third partry, e.g. for evaluation for disability or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious threat to Health or Safety**: ou confidential information my be disclosed to protect you or others from a serious threat of harm by you
- **Workers' Compensation**: If you file a workers' compensation claim, we are required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.
- **When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law**. This includes certain narrowly defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA regulated products, or for specialized government functions such as fitness or military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Provider Duties

Patient Rights:

- *Right to Request Restrictions*: You have a right to request restriction on certain uses and disclosure of PHI about you. However, we are not required to agree to a restriction you request
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing a provider at Delta. Upon your request, we will send your bills to another address.
- *Right to Inspect and Copy* – you have a right to inspect or obtain a copy (or both) of PHI in you mental health and billing records for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have the decision reviewed. At your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – you have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny you request. At your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this notice). On your request, we will discuss with you the details of the accounting process.
- *Right to Restrict Disclosures When You Have Paid for Your Care Out-o- Pocket*. You have the right to

DELTA
BEHAVIORAL HEALTH

Clients at Delta Behavioral Health have a right to:

- Humane treatment that is free of mental and physical abuse, neglect or exploitation.
- Treatment free of restrictive or restraining devices and restrictive clinical guidelines.
- Engage in consultation with your provider and know your treatment choices, regardless of costs, and be notified in advance of all potential risks and benefits of treatment, and to refuse any treatment, as well as a right to access medical care for treatment of physical ailments.
- Share in the formation of your treatment plan, and receive a copy by asking a therapist
- Provide input on policies and services, and to complaints or grievances.
- Choose a provider and have access to information about that provider.
- Have access to information in language you can understand and to have your conditions and treatment explained in understandable language.
- Fair treatment regardless of race, religion, gender, age, ethnicity, disability, sexual orientation or source of payment.
- Have treatment and other information kept private with release of information only according to procedures established by law.
- Know the state and federal laws pertaining to rights and responsibilities in the treatment process, including the right to appeal to the contracted MCO any denial, reduction, suspension, or termination of services beyond the ordinary discharge process.
- Prepare an advance psychiatric directive for mental health treatment in the event you are unable to temporarily decide for yourself.
- All rights and responsibilities of any citizen.

Clients at Delta Behavioral Health have a responsibility to:

- Provide information needed to develop and continue effective treatment.
- Follow medication plans and provide information about medication changes, including changes by other providers.
- Follow the plans and instructions of your treatment plan.
- Ask questions about your care to gain a better understanding of treatment.
- Treat care givers with dignity and respect.
- Keep appointments or give 24 hour notice if unable to attend as scheduled.
- Let providers know of problems paying fees.

Report complaints to Jane St. John, Member/Manager for resolution. If needed, contact the Governor's Advocacy Council for Persons with Disability at 1-800-821-6922, the NC Careline at 1-800-662-7030, or the Office of Advocacy and Customer Service at 1-919-715-3197.

Delta Behavioral Health
1606 Physicians- Drive, Ste 104 - Wilmington, NC 28401- (910) 343-6890

INFORMED CONSENT, OFFICE POLICIES, GENERAL INFORMATION & AGREEMENT FOR SERVICES

This form provides you (client) with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA pre-emptive analysis.

Psychological Services

Welcome to our practice. Participation in therapy can result in a number of benefits to you, or your children, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Our staff will ask for your feedback and views on therapy, its progress and other aspects of the therapy, and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. Our staff may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes, another family member views a decision that is positive for one family member, quite negatively. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, our staff is likely to draw on various psychological approaches according, in part, to the problem that is being treated and our assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive- behavioral, cognitive, psychodynamic, existential, system/family, humanistic or psycho- educational. All persons have permission to seek emergency medical care while at Delta Behavioral Health, PLLC.

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission. **We at Delta, work as a team and may share your specific case information with other staff while maintaining your confidentiality**. The information shared is only to assist you (client) in receiving better services and for purposes of helping Delta with quality improvement activities. Health insurance companies may also require certain medical information in order to justify services. Only the minimum necessary information will be communicated to the carrier. Our staff will not release records to any outside party unless we are authorized to do so by you, the client, and all adult family members who were part of the treatment. At Delta minors may seek and receive periodic services from a physician without parental consent in accordance with G.S. 90-21.5

By law, the staff at Delta are mandated reporters when there is a reasonable suspicion of child, dependent or elder abuse or neglect. In addition, if our staff becomes concerned about your personal safety or the possibility of you injuring someone else we will do whatever we can, within the limits of the law, to prevent you from harming yourself or others and to ensure that you receive the proper medical care.

Custody Evaluations

Delta does not do custody evaluations and will not make recommendations regarding custody. With your written consent, however, we will speak to custody evaluators.

Therapeutic Relationship

Therapy never involves sexual or any other dual relationship that impairs our staffs' objectivity, clinical judgment or therapeutic effectiveness. In order to respect your confidentiality our staff will not acknowledge working with anyone without his/her written permission. This includes bumping into our clients out in the community. Despite the sometimes-intimate nature of the therapeutic process the relationship between the client and his/her therapist is a professional one. Consequently, our staff will always uphold the standards of care and ethical codes dictated to us by our respective boards and state laws.

Cancellation

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, and if regulations allow the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

Complaint and Appeals

Delta reviews and processes all complaints and provides feedback to the person filing the complaint within 72 hours if desired. Regarding appeals, it is our goal to assist persons served at Delta with reaching satisfaction regarding their concern within the constraints of our operations and to that end, will continue to work to resolve all issues within the organization. Complaint forms are available in the lobby or can be requested at 910-343-6890. In addition, both Trillium and DHHS maintain complaint lines. Trillium can be reached at 1-866-998-2597. The consumer care line in Raleigh is 1-800- 662-7030. Client has the right to refuse treatment without threat of termination of services and that consent can be withdrawn at any time.

I have carefully read the above Agreement and Office Policies and General Information, including Delta's team and confidentiality, carefully. I understand them and agree to comply with them:

Client Name (Print)	Date	Signature

Client Name (Print)	Date	Responsible Adult Signature if Applicable

Psychotherapist (Print)	Date	Signature

1606 Physicians Dr., Ste. 104
Wilmington, NC 28401
Telephone: 910.343.6890
Fax: 910.332.1233

Notice of Client Rights at Delta Behavioral Health: Acknowledgement of Receipt

The form, when completed by you acknowledges that you have received a copy of the your Rights at Delta Behavioral Health.

I, _____, acknowledge that I have received a copy of my rights at Delta Behavioral Health on
(Client name)
_____ (Date). I reviewed my rights with _____ (admission counselor/therapist).

_____ _____
Signature of client or personal representative (Date)

If the acknowledgement is signed by a personal representative, the name of the client and a description of such representative's authority to act for the client must be provided.

_____
(Client's name)

_____
Authority to act for client (example: parent or legal guardian)

Assignment of Benefits

Patient name: _____ DOB: _____ Chart #: _____

Social Security Number: _____ Insurance #: _____

I hereby authorize payment directly to Delta Behavioral Health, PLLC. I understand that I am financially responsible for any charges, including fees not paid by the insurance company.

_____

Signature Date

I authorize Delta Behavioral Health, PLLC, and the clinical or clerical staff of Delta Behavioral Health, PLLC, to release information about me to my medical insurance company. This authorization will end if I give written instructions to Delta Behavioral Health, PLLC, or the clinical staff of Delta Behavioral Health, PLLC, which I may do at any time.

_____

Signature Date

Medicare Authorizations

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services (formerly Health Care Finance Administration) or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature _____ Date: _____

Medigap Authorization Statement

I authorize any holder of medical or other information about me to release to Delta Behavioral Health or its clinical or authorized clerical staff any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature _____ Date: _____

DELTA BEHAVIORAL HEALTH

1606 Physicians Drive, Unit 104
Wilmington, NC 28401

Authorization to Disclose Health Information

I _____ Social Security Number: _____ Date of Birth: _____
hereby authorize Delta Behavioral Health, located at 1606 Physicians Drive, Unit 104, Wilmington, NC 28401 to communicate with and disclose to one another (Only one facility/person may be entered)
Facility/person name: **MY PHARMACY**
Address _____ City _____ State _____ Zip _____
Phone _____ Fax Number _____
the below information; and to release the above named organization and affiliated individual from all legal liabilities that may arise from this action.

Information to be released. Only specified information as indicated by my **initials and check-mark** including

_____ ☐ Diagnosis and medication specific information

for the specific purpose(s)

☐ Discharge Planning/Continuing Care
☐ General/Verbal Coordination of Care
☐ Continuity of Care
☐ Prescription Accuracy

I understand that my information may not be protected from re-disclosure (45 C.F.R. Part 164) by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (42 C.F.R. Part 2), the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g. insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I understand that this authorization will expire on the following date, event or condition: _____
_____
I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I further understand that I may request a copy of this signed authorization.

_____ _____ _____
Signature of client Date Witness

_____ _____ _____
Signature of representative Date Relationship/Authority

STAFF USE ONLY
This release revoked on:
_____
Date

Staff Signature:

Delta Behavioral Health

Crisis Information

If a suicidal act or gesture has occurred, we will not take a phone call from you for 24 hours unless it is an emergency.

It will be considered an emergency if your behavior has resulted in the need for medical intervention; if medical intervention is needed, the call will focus on getting the necessary medical intervention to you, and only a medical intervention. We will process problems you were experiencing at your next therapy session, and will work to schedule a session as quickly as possible. If you call us for help, you will need to tell us where you are and what you have done. If you are not prepared to tell us these things, do not call in an emergency.

If you have made a suicide plan and think you might not be able to stop yourself from going through with your plan, we want you to call us instead – and call before you act on the plan. If you call, you must accept the help that is given. Remember, your judgment is clouded at those times of distress, and calling us is what you have managed to do to help yourself. Since you are not able to think clearly enough to solve your problems at that time, you must be willing to accept the help given. If you are unwilling to accept the help, do not call.

Our first choice is <u>not</u> to refer you to inpatient hospital. We will work with you to identify a safety plan such as having a friend or relative stay with you until you can come to a therapy session. However, you need to know that we will utilize hospitalization if it becomes necessary to help you get through a distressing time.

If you call us for help, you will be calling knowing these guidelines and limitations.

Client Name: _____

Record Number : _____

Insurance ID: _____

Δ Delta Behavioral Health

Patient Psychiatric Intake

Do you have any allergies? _____

Chief Complaint & Brief Description of CURRENT PROBLEM (*Circle any that apply*):

Not sleeping	Over active	Fear of _____
Sleeping too much	Euphoric	Constant worries about _____
Not eating	Grandiosity	Panic
Eating too much	Thought racing	Afraid to leave home
Low fluid intake		Constant worries about _____
No interest in things		Restlessness _____
No energy		Tense
Withdrawn	Tearful	Flashbacks _____
Confused	Pessimistic	Nervousness
Irritable	Crying spells	Certain thought get stuck _____
Guilty	Temper outbursts	_____
Hopeless	Memory problems	Behaviors I have to do over and over
Helpless	Poor concentration	_____
Worthless	Poor work habits	_____
Suicidal	Decisions difficult	

Circle Yes of No and provide explanations for the following

Are you having relationship/marital problems? YES NO
Are you dealing with grief issues? YES NO
Are you having legal difficulties? YES NO If yes, is there a scheduled court date? YES NO
Have you ever been told or do you feel you have an anger problem? YES NO
Have you destroyed property recently or in the past? YES NO
Have you attempted suicide in the past? YES NO How long ago? _____
Has a family member committed suicide? YES NO Relationship _____
Do you hear voices? YES NO If yes, do they say specific things? YES NO If yes, what do they say?
_____
Have you been told you are Paranoid? YES NO If yes, what kinds of paranoid thoughts do you have?
_____
Have you been told you have delusions? YES NO If yes, what are they about?
_____
Do you see things others do not see? YES NO If yes, what kinds of things do you see?
_____
Have you been sexual abused? YES NO
Is there anything else you feel we should know about? _____
_____

Substance Use

Tobacco: Do you use any tobacco products? YES NO

Alcohol: Do you drink alcohol? YES NO If yes, last drink was: _____ Are you in recovery? YES NO

Street Drugs: Do you use street drugs including marijuana? YES NO Have you in the past? YES NO
If Yes, last use was _____. Are you in recovery? YES NO

Caffeine: Do you drink beverages with caffeine in them? YES NO

Prescription Medicines: Do you run out of prescription medications before it is time to re-fill? YES NO
If yes, for which medicines _____

See other side for more information

Altman Self-Rating Mania Scale (ASRM)

Name _____ Date _____

Instructions:

1. There are 5 statements groups on this questionnaire: read each group of statements carefully.
2. Choose the one statement in each group that best describes the way you have been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word "occasionally" when used here means once or twice; "often" means several times or more and "frequently" means most of the time.

Question 1

- ☐ 0 I do not feel happier or more cheerful than usual.
- ☐ 1 I occasionally feel happier or more cheerful than usual.
- ☐ 2 I often feel happier or more cheerful than usual.
- ☐ 3 I feel happier or more cheerful than usual most of the time.
- ☐ 4 I feel happier or more cheerful than usual all of the time.

Question 2

- ☐ 0 I do not feel more self-confident than usual.
- ☐ 1 I occasionally feel more self-confident than usual.
- ☐ 2 I often feel more self-confident than usual.
- ☐ 3 I feel more self-confident than usual.
- ☐ 4 I feel extremely self-confident all of the time.

Question 3

- ☐ 0 I do not need less sleep than usual.
- ☐ 1 I occasionally need less sleep than usual.
- ☐ 2 I often need less sleep than usual.
- ☐ 3 I frequently need less sleep than usual.
- ☐ 4 I can go all day and night without any sleep and still not feel tired.

Question 4

- ☐ 0 I do not talk more than usual
- ☐ 1 I occasionally talk more than usual.
- ☐ 2 I often talk more than usual.
- ☐ 3 I frequently talk more than usual.
- ☐ 4 I talk constantly and cannot be interrupted

Question 5

- ☐ 0 I have not been more active (either socially, sexually, at work, home or school) than usual.
- ☐ 1 I have occasionally been more active than usual.
- ☐ 2 I have often been more active than usual
- ☐ 3 I have frequently been more active than usual.
- ☐ 4 I am constantly active or on the go all the time

Permission for use granted by EG Altman, MD

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ☐ Group ☐ CPT-C ☐ CPT ☐

PCL-5: WEEKLY

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

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

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr – National Center for PTSD

DASS23

Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3
22	I thought about death or suicide	0	1	2	3
23	I wanted to kill myself	0	1	2	3

Past Psychiatric Treatment

Have you been hospitalized for psychiatric problems? YES NO
If Yes, when was you last hospitalization: _____ What was the reason you were hospitalized? _____ Where? _____ If more than one hospitalization, how many times have you been hospitalized for psychiatric problems? _____

Outpatient treatment: Have you been in outpatient treatment? YES NO
If yes, where was your last treatment? _____
When was the last date you saw a psychiatrist/MD prescribing medications for your mental health problems? _____ When did you last see a therapist? _____

Medication History (psychiatric and other)

Current Medications

Name	Dose	f	Date Started	Reason	Effective?	What side effects did/do you have?

Please circle all that apply:

- High blood pressure Heart disease History of stroke
- Thyroid problems Seizure history
- Diabetes; if yes, do you take insulin? ___
- Respiratory / breathing problems
- Hepatitis; if yes, which type? ____ Type A _ Type B ____Type C
- Sexually transmitted disease. If Yes, explain _____
- HIV / AIDS
- Alcohol use; if yes, when was your last drink? _____
- History of seizures when stopping alcohol use
- Distory of Delirium Tremors (DT's) when stopping alcohol use. Explain symptoms _____ _____
- Chronic pain. Please explain _____
- Could be pregnant (Circle one): YES NO Not Applicable
- Change in mental state such as confusion, disorientation, or unconsciousness
- Use of tobacco products; if yes, what type? _____ use per day _____
- Drug use; if yes, what types do you use and when was the last use of each? _____
- Other _____

Who is your doctor? _____ **Last/current psychiatrist** _____
Phone Numbers: _____ _____
Therapist _____ **Pharmacy** _____
Phone Numbers: _____ _____
Do you take any herbal remedies? YES NO Reason, if yes _____
Are you taking any over the counter medications at this time? YES NO Reason, if yes _____
Are you taking vitamins & mineral supplements: YES NO If yes, list types: _____
_____
_____

Your Name: _____ Date: _____