AUSTIN FAMILY MENTAL HEALTH, P.A.

PATIENT INFORMATION FORM

Patient's Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ - _____ - _____ Sex: ☐Male ☐Female

Best Contact Phone Number: _____ Okay to leave message? ☐Yes ☐No

Email address: _____ Employer/School: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Partner

Name of spouse/partner: _____

Medical Doctor's Name: _____ Phone Number: _____

Have you consulted a Psychiatrist before?

If so, name and address: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Allergies: _____ List of Current Medications: _____

Medications Continued: _____

Pharmacy name: _____ Pharmacy Address: _____
Phone Number: _____

IF PATIENT IS A MINOR, please provide the following information if different from above:

Parent's / Guardian's Name (s) _____
Parent's/Guardian's Email: _____
Parent's/Guardian's Cell Number: _____Okay to leave message? ☐Yes ☐No

Address: _____ City: _____ Zip: _____

Relationship to Patient: ☐Parent ☐Legal Guardian

CORRESPONDENCE INFORMATION:

Please initial below if you would like to provide authorization to our office to correspond with you via email.

INITIAL _____

INSURANCE INFORMATION:

Insurance Carrier: _____ ID Number: _____ Group Number: _____

Subscriber Information:
Subscribers Name: _____ Phone Number: ( ) _____-_____ Email: _____
Address: _____Social Security: _____ - _____ - _____ DOB: _____

I, _____, authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to Austin Family Mental Health, PA.

INITIAL _____

If you are over the age of 18 and a parent/guardian is responsible for payment, and you authorize us with permission to speak to them about your account, please provide their information below:

Name: _____ Relationship: _____ Phone Number: _____
Address:_____Email:_____

PAYMENT FOR SERVICES: I, _____, understand payment is required at the time care is provided. Payment with cash, checks and credit cards is accepted at the office at the time of your appointment. Your signature on this form notes your agreement to pay **and authorize our office to charge your credit/debit card on file** for all services provided by this office, including but not limited to copays/deductibles, missed appointments, late cancellation fees, telephone consults, prescription fees and non-urgent after hours phone calls. If you wish to use a different card than the one that is on file at the time of service, please provide us with the new card information when you arrive for your appointment. Should you have difficulty paying for services, we are more than happy to discuss payment arrangements.

INITIAL _____

I would like to sign an authorization form so that the following person (s) may speak with you about my care:

Name: _____ Phone: _____ Email: _____

Relationship: _____

HIPAA PRIVACY POLICIES:

Signing below confirms I have read the office's HIPAA & Texas Privacy Policies and have been offered a copy of them. It also notes my agreement that my Private Health Information may be transmitted by phone, fax and email.

Signature: _____ Patient/Guardian Date: _____

Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)
April 14, 2003

Austin Family Mental Health has the responsibility to protect the privacy of your personal and health information as described in this notice. Personal health information includes medical (or psychological) information and individually identifiable information, such as your name, address, telephone or social number. Austin Family Mental Health is required by applicable federal and state laws to maintain the privacy of your personal and health information or "PHI."

Austin Family Mental Health will protect your privacy by, limiting how we may use or disclose your PHI; limiting who may see your PHI; inform you of our legal duties with respect to your PHI; and explain and strictly adhere to our privacy policies. These policies are in effect as of April 14, 2003, and will remain in effect until updated and until you receive notice of any changes. Austin Family Mental Health reserves the right to change these policies and the terms of this notice as allowed by state and federal laws, rules or regulations.

Uses and Disclosures of Clients Personal and Health Information:

Austin Family Mental Health may disclose your PHI to insurance carries in order to receive payment for claims for the services provided to you by Austin Family Mental Health within the limits established by the Texas Medical Board.

Austin Family Mental Health may use your PHI to contact you with information about services provided, appointment reminders, or for collection of co-pays or your account balance (if any).

Austin Family Mental Health may use your PHI to the extent necessary to avert a serious and imminent threat to your health or safety of others. Austin Family Mental Health may disclose this information to the proper authorities, if we reasonably believe that you are a possible victim of child abuse, child neglect.

Austin Family Mental Health must disclose your PHI when we are required to do so by the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws.

Austin Family Mental Health may disclose your PHI in response to a court order or subpoena, although every effort will be made to obtain your consent for the releases of any personal or health information, as required by confidentiality regulations as set by the Texas Medical Board.

Austin Family Mental Health may disclose your PHI to law enforcement officials or personnel of a correctional institution if you are in lawful custody while receiving treatment.

Your Rights:

You have the right to review or obtain copies of your personal and health information, subject to the limitations of the TMB. Your request must be in writing and you may be charged a fee for copying of the record.

You have the right to request and receive a list of instances in which Austin Family Mental Health disclosed your PHI for purposes other than treatment and claims processing.

You have the right to request that Austin Family Mental Health place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by the agreement. You also have the right to terminate or amend previously requested restrictions. Requests for additional restrictions or requests for termination of requested restrictions must be in writing.

You have the right to request that Austin Family Mental Health communicate with you in confidence about your PHI by alternative means. You must specify how we may contact you in writing, if you do not wish to be telephoned at your primary or secondary listed telephone numbers.

You have the right to request and amendment of your PHI. The request must be in writing and include the information to be amended. If Austin Family Mental Health agrees to the amendment, we will make a reasonable effort to include the changes in any future disclosures of information.

You have the right to receive a copy of this notice in written form.

You have the right to file a complaint if you believe Austin Family Mental Health has violated your privacy rights or you disagree with a decision we made about access to your PHI. A complaint may be made to Austin Family Mental Health or you may also submit a written complaint to The U.S. Department of Health & Human Services Office of Civil Rights. Austin Family Mental Health supports your right to file a complaint and will assist you by providing address information for the HHS, and will not retaliate in any way if you choose to file a complaint with us or HHS.

Written Authorization to Use or Disclose Your PHI:

Austin Family Mental Health will request written authorization from you to use your PHI or to disclose it to anyone for any purpose or situation not included in this document. You may revoke this authorization in writing at any time. Your revocations will not affect any use or disclosure permitted by your authorization while it was in effect. We will not disclose your PHI for any reason except those described in this notice without your written consent.

Acknowledgement of This Notice of Privacy Regarding Your PHI:

Acknowledgement of this notice of privacy will be made part of your medical record with Austin Family Mental Health. Please sign and date below. You may request a copy of this notice at any time.

_____
Patient/Client Name

_____
Relationship to Patient:

_____
Signature of Patient/Client or Legal Guardian (if minor)

_____
Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Office Policies and Procedures

Welcome to our office. We appreciate the opportunity to serve you. Please read the following information carefully. If you have any questions or concerns, please do not hesitate to ask a member of our staff or your provider. The following policies are subject to change without notice.

Appointments:

New Patients: The $60.00 deposit that you paid to secure your new patient appointment will be forfeited if one of the following occurs:

- If you no show to your scheduled appointment
- If you fail to provide us with 24-business hours' notice of cancellation
- If you are more than 10-minutes late to your appointment which results in us having to reschedule you to another day

1. In consideration of all patients, individuals who arrive 10-minutes late may need to reschedule
2. Appointments must be cancelled 24-business hours in advance to avoid a missed appointment fee. The fees are as follows: Nurse practitioners: 20-30 min. = $125, 45-60 min. = $175; Psychiatrist: 20-30 min. = $150, 45-60 min. = $180
3. Missed appointment fees must be paid *prior to* the next appointment. Patients who have missed more than one appointment may be required to put a credit card on file in the event another appointment is missed
4. 3 missed or late cancellations will result in the discontinuation of our professional relationship
5. Our EMR system will send *courtesy* appointment reminders 1-2 days prior to your scheduled appointment; however, it is ultimately the client's responsibility to attend scheduled follow-ups
6. We encourage clients to make or move up an appointment when a complaint or a problem occurs regarding their mental health and/or medication changes. Phone calls and emails to your provider may be assessed a fee

Initial _____

Billing and Payment:

We believe in the importance of providing access to care to the greater Austin area and choose to accept insurance. We have put policies in place to ensure we can maintain an insurance-based practice and serve the community.

- Payment (i.e. co-payment, co-insurance, deductibles, fee-for-service, and any balance) is due at the time of service. If you are unable to make payment at the time of service, you may be asked to reschedule your appointment.

- The information provided to us by your insurance company is not always accurate and we encourage you to be informed as to what benefits *your insurance covers* and what your patient responsibility is.

- Our office only submits claims to insurance companies for which we are "in-network." If you wish to file out-of-network with your insurance company, please inform our staff so they can provide you with an itemized statement.

- It is important to communicate with our office if you have a change of insurance as most insurance companies have a *90-day filing deadline*. Failure to provide us with accurate insurance information may result in *your* responsibility of payment in *full* for services provided.

- While payment is due at the time of service, often unpaid balances accrue. It is our policy that as soon as an unpaid balance reaches $200.00 no further services will be provided until the balance has either been cleared or brought below $200.00. *Please note that patients are welcome to set-up a payment plan by authorizing a monthly debit to a credit card to pay their balance. If a patient's payment agreement is declined more than once, the contract is considered null and void and services are discontinued. Patients will be provided a one-month refill of non-controlled medications to allow time to find a new provider. It will be the decision of the provider if they wish to begin the working relationship again once the balance is paid.

- Patients with existing payment plans are not allowed to accrue additional balances and are unable to add to an existing payment plan.

- Accounts with no payment activity for 90 days will be turned over to a collection agency. It is our policy that once an account is turned over, services are discontinued.

Initial _____

Medication Refills:

Prior to calling our clinic, we ask all patients to either have their pharmacy fax us a refill request and/or email their request to: Refills@AustinFamilyMentalHealth.com. Upon request, we will authorize refills when appropriate. Please allow 2 business days to process your request. Patients are to submit requests when they have at least 2-3 days of medications at hand. If you have not heard from our staff in 2 business days after submitting your request, please call us. We utilize an electronic prescribing system and do not provide paper prescriptions.

- Medications taken more than prescribed will be denied an early refill. If you would like to discuss a change in medication, please call the office to setup an appointment.
- Texas law requires patients to be under medical supervision when taking controlled medication. Patients on controlled medications will be required to follow-up with their provider every 90 days.
- Prescriptions requested to be filled the same day will be assessed a $20.00 fee.
- Our office will not refill medications outside of normal business hours.
- There is a $12.00 fee to write controlled medications between appointments. Alternatively, you may come in monthly to obtain your medication.
- All schedule II medications (Vyvanse, Adderall, etc.) must be filled within 21 days or they will expire.
- Stolen/lost controlled medications will not be refilled early and patients will have to wait until they are eligible for another refill.

It is important to note that stimulants are not lifesaving medications and running out does not constitute a medical emergency. Early refills are not permitted.

Initial _____

Prior-Authorizations:

If *your benefit company denies your medication* and requires your provider to provide clinical documentation to approve a medication, you will be assessed a $25.00 fee. This is a very time-consuming task for the provider and staff. We highly suggest you speak with your benefit company if they continue to deny your medication. Please allow 72 business hours to process such requests. If the medication is generic, and affordable, you may want to pay out-of-pocket.

Initial _____

Confidentiality:

Our office understands the need to keep your information confidential, and we will act in good faith to maintain your matters private. Please use caution in leaving us home/work/cell numbers and/or an email address to contact you. Please ensure you provided us with updated information to ensure your confidentiality is not jeopardized.

Our office requires a signed Release of Information to speak with family member, providers, disability companies, or anyone to whom you would like to have access to your information.

We appreciate your cooperation with our Office Policies outlined above.

I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Printed Name: _____

Signature: _____ 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? *Please circle one response only.*

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?	○	○

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

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

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

Severity Measure for Social Anxiety Disorder (Social Phobia)—Adult

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: The following questions ask about thoughts, feelings, and behaviors that you may have had about *social situations*. Usual social situations include: public speaking, speaking in meetings, attending social events or parties, introducing yourself to others, having conversations, giving and receiving compliments, making requests of others, and eating and writing in public. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During **the PAST 7 DAYS, I** have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright in social situations	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	felt anxious, worried, or nervous about social situations	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	had thoughts of being rejected, humiliated, embarrassed, ridiculed, or offending others	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky in social situations	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing in social situations	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	avoided, or did not approach or enter, social situations	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	left social situations early or participated only minimally (e.g., said little, avoided eye contact)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
8.	spent a lot of time preparing what to say or how to act in social situations	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
9.	distracted myself to avoid thinking about social situations	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
10.	needed help to cope with social situations (e.g., alcohol or medications, superstitious objects)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

Patient Name _____ Today's Date _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

PART A	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

PCL-5 with LEC-5 and Criterion A

Part 1

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
2. Fire or explosion	☐	☐	☐	☐	☐	☐
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	☐	☐	☐	☐	☐	☐
4. Serious accident at work, home, or during recreational activity	☐	☐	☐	☐	☐	☐
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	☐	☐	☐	☐	☐	☐
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐	☐	☐
9. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
10. Combat or exposure to a war-zone (in the military or as a civilian)	☐	☐	☐	☐	☐	☐
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
12. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
13. Severe human suffering	☐	☐	☐	☐	☐	☐
14. Sudden violent death (for example, homicide, suicide)	☐	☐	☐	☐	☐	☐
15. Sudden accidental death	☐	☐	☐	☐	☐	☐
16. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
17. Any other very stressful event or experience	☐	☐	☐	☐	☐	☐

Part 2

A. If you checked anything for #17 in PART 1, briefly identify the event you were thinking of:

B. If you have experienced more than one of the events in PART 1, think about the event you consider the worst event, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event (check all options that apply):

Briefly describe the worst event (for example, what happened, who was involved, etc.).

How long ago did it happen? _____ (please estimate if you are not sure)

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe

Was someone's life in danger?

_____ Yes, my life

_____ Yes, someone else's life

_____ No

Was someone seriously injured or killed?

_____ Yes, I was seriously injured

_____ Yes, someone else was seriously injured or killed

_____ No

Did it involve sexual violence? _____ Yes _____ No

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____ Accident or violence

_____ Natural causes

_____ Not applicable (The event did not involve the death of a close family member or close friend)

How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?

_____ Just once

_____ More than once (please specify or estimate the total number of times you have had this experience _____)

Part 3

Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, 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 <u>in the past month.</u>

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