REDEMPTION COUNSELING

NEW CLIENT INTAKE/INSURANCE FORM

How were you referred?: _____ **Requested Therapist:** Tim Deb Either

Reason for Counseling: _____

How long have you been struggling with your current condition? _____

Which of the following describe or relate to your present concerns (Please check):

o Anger issues	o Religious doubts	o Relationship with:	o Loss of:
o Appetite changes	o Legal issues	o Partner	o Self-respect
o Anxiety	o Finances	o Parents	o Faith
o Frequent crying	o Vocational/career issues	o Children	o Meaning
o Binging/Purging	o Physical health	o Others	o Love
o Alcohol/Drugs	o Self esteem		o Abuse Issues:
o Loneliness	o Poor appetite		o Physical
o Self-doubt	o Sleep disturbance		o Sexual
o Guilt	o Hopelessness		o Emotional
o Sexual concerns	o Weight loss/gain		
o Fear	o Mid-life issues		
o Grief	o Other Issues		
o Suicidal feelings			

KEY CLIENT INFORMATION

NAME: _____ DOB_____AGE_____
(Last) (First) (MI) GENDER: M F

MARITAL STATUS: Married Remarried Single Divorced

ADDRESS: _____
(Street) (Apt #) (City) (State) (Zip Code)

PHONE: (CELL) _____ (HM) _____ (WK)_____

MAY CONTACT: YES or NO YES or NO YES or NO

LEAVE MESSAGE: YES or NO YES or NO YES or NO

eMail where you would like to receive appointment reminders: _____

INSURANCE OR SELF PAY:

1ST INSURANCE CARRIER: _____PRIMARY INSURED PARTY: _____ DOB: _____

INS. # with 3 letters included #: _____ GROUP #: _____

PRIMARY INSURED PHONE # _____ EMPLOYER: _____

INSURANCE PHONE #: _____ SECONDARY INSURANCE? IF SO, WHOM? _____

OFFICE USE: ALLOWED VISITS YEARLY: _____ DEDUCTIBLE: _____ COPAY: _____ PRE-AUTH NEEDED: _____

NEXT STEPS

Please SAVE this form with a unique name and email to Deb@RedemptionCounseling.net and we will review your insurance and contact you to schedule an intake appointment. For your first appointment please bring your insurance card, driver's license and the completed CLIENT WELCOME PACK which can be found at RedemptionCounseling.net. If you don't have access to a computer, we have welcome packets available in our office lobby in the top of the magazine rack. Please come 30 minutes early to complete these prior to your first session. **DESIRED TIMES FOR COUNSELING**: (AM, AFTERNOON, PM) _____DAY: _____

REDEMPTION COUNSELING

CLIENT INFORMATION – *to be completed prior to your first appointment*

TODAY'S DATE:	THERAPIST :	REFERRED BY:

GENERAL INFORMATION

NAME: _____ DOB_____AGE_____ GENDER M or F
(Last) (First) (MI)

ADDRESS: _____
(Street) (Apt #) (City) (State) (Zip Code)

PHONE: (CELL) _____ (HOME) _____ (WORK_____

MAY CONTACT:	YES	or	NO	YES	or	NO	YES	or	NO
LEAVE MESSAGE:	YES	or	NO	YES	or	NO	YES	or	NO

EMPLOYMENT HISTORY

OCCUPATION: _____ EMPLOYER: _____

LENGTH OF EMPLOYMENT: _____ DOES YOUR CURRENT WORK SATISFY YOU, IF NOT, PLEASE EXPLAIN _____

_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PREVIOUS EMPLOYER: _____

EDUCATION

HIGHEST GRADE COMPLETED: _____ DEGREE or CERTIFICATION: _____

MOST RECENT SCHOOL ATTENDED: _____

RELIGIOUS BACKGROUND

DO YOU REGULARLY ATTEND A FAITH COMMUNITY? Y OR N _____CONGREGATION_____

RELATIONSHIP INFORMATION

	Single / Never married		Separated		Married / Remarried		Date Married
	Living with partner		Widowed		Divorced		Date Divorced

SPOUSE'S NAME: _____ DOB_____AGE_____ GENDER M or F

ADDRESS: _____EMPLOYER:_____
(Street) (Apt #) (City) (State) (Zip Code)

PHONE: (CELL)_____ (HOME) _____ (WORK)_____

MAY CONTACT:	YES	or	NO	YES	or	NO	YES	or	NO
LEAVE MESSAGE:	YES	or	NO	YES	or	NO	YES	or	NO

MEDICAL INFORMATION

Please check the box if you currently have or have ever had a history of:

	Yes	No		Yes	No
Hyperactivity			Hearing Loss or Ringing		
Impulsivity			Digestive/Bowel Problems		
Frequent headaches/Migraines			Breathing Problems, including Asthma or Emphysema		
Binging/Purging			Neck, Back Pain or Problems		
Cancer			High Blood Pressure		
Chills or hot flashes			Allergies		
Menstrual Irregularities			Stroke		
Sexual Trauma or abuse			Arthritis, Bursitis or Tendonitis		
STD			Diabetes		
Cancer/Tumor/Leukemia			Anemia/Blood disease		
Heart Disease/Murmur			Fainting Spells/Dizziness		
Loss of Consciousness			Seizures/Epilepsy		
Eye Disease			Kidney Disease/Stones		
Thyroid problems			Stomach Ulcers		

Are you currently pregnant or is there a chance that you could be pregnant? Yes No

Do you currently or have you ever smoked? Yes No If yes, when? _____

Do you currently drink alcohol? Yes No How much do you drink per week? _____

How would you rate your level of fitness? (Please circle) Below Average Average Advanced

What do you currently do for physical fitness?

_____

MEDICATIONS / DOCTOR CONTACT INFORMATION / MEDICAL CONDITIONS

Are you currently taking any medications? If yes, please list name, dosage, and frequency:

_____

_____

Do you have any drug sensitivities?

_____

Primary Care
Physician_____Phone:_____

Please tell us about any medical conditions you may have or any physical or mental handicaps present:

_____

_____

Have you been hospitalized for any accidents or conditions? Please list when and your age at time of incident:

_____

_____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?

NAME: _____RELATIONSHIP: _____

PHONE (CELL) _____ (HOME) _____ (WORK) _____

STATE IN YOUR OWN WORDS THE CONCERNS THAT BRING YOU TO COUNSELING

_____

_____

What do you hope to achieve in therapy (your goals/expectations)_____

_____

Have you previously seen a counselor or been engaged in any other type of mental health services? _____ If yes, please list counselors and dates and diagnosis_____

_____

Is there any other information you would like to provide to assist the clinician?

_____

FAMILY INFORMATION

BIRTH FAMILY RELATIONSHIP	NAME	LEVEL OF CONNECTION (GOOD, FAIR, POOR)	ALIVE (Y OR N)	AGE	LIVING WHERE?
FATHER					
MOTHER					
STEPFATHER					
STEPMOTHER					
SIBLING					
SIBLING					
SIBLING					

IMMEDIATE FAMILY RELATIONSHIP	NAME	LEVEL OF CONNECTION (GOOD, FAIR, POOR)	ALIVE (Y OR N)	AGE	OCCUPATION/STUDENT GRADE
SPOUSE					
CHILD					
CHILD					
CHILD					

Signature of Person Completing Form: _____ Date: _____

Signature of Client: _____ Date: _____

REDEMPTION COUNSELING

DISCLOSURES FOR INFORMED CONSENT, FINANCIAL CONSENT, & COMMUNICATION METHOD CONSENT

This document outlines Tim and Debra's training, the confines of the therapeutic relationship, and explains our financial policies. It also discusses ways that we can contact you in the future and establishes your consent for treatment at Redemption Counseling ("RC").

We like to remind our clients that they are the consumer in the therapeutic relationship. What that means is that it is important that you determine if we are the right provider to meet your needs based on our therapeutic style, training, and treatment modalities. We want to ensure that our relationship with you meets your needs. Please see the information below and ask any questions you have in your initial intake session to make an informed decision.

COUNSELOR BACKGROUND AND TRAINING

Tim Bartlett, M.S. is a licensed Mental Health Counselor in the state of Washington. – (#LH60287144). He received his B.A. in English Literature from Western Washington University in 1994. In 1998, Tim graduated with a Master's of Science in Marital and Family Therapy (MSMFT) from Fuller Theological Seminary. He earned a Child Mental Health Specialist Designation (CMHS) through additional postgraduate training and supervision focused on child and adolescent therapy techniques. Tim's primary areas of focus include marital counseling, infidelity recovery, family counseling, parenting issues, adolescent and child counseling, depression and anxiety, workplace stress, and trauma recovery for children and adults. Tim particularly enjoys working with his clients to enhance their ability to clearly communicate their feelings and needs in their primary relationships. Tim's primary treatment modality is cognitive behavioral therapy. His counseling approach is to assist clients with the transformation of inaccurate thoughts, beliefs and self-perceptions that contribute to negative emotions, actions, and reactions. He employs a strengths-based model grounded in encouragement, goal setting, accountability, and practical feedback. Working together with his clients, he identifies their core skills, talents and unrealized spiritual potential to bring about positive change and emotional healing.

Debra Bartlett M.A. is a Washington State Mental Health Counselor (#LH60516273). She earned her B.A. in Business Administration with a minor in Psychology in 1990 and her M. A. in Professional Psychology in 1997 from Azusa Pacific University. In 2003, Debra obtained her School Counseling Credential, E.S.A., at City University. Debra's areas of focus include child and adolescent counseling, parenting concerns, anxiety and depression, communication skills, boundary and assertiveness training, grief and loss, and marital counseling including co-therapy with her husband Tim Bartlett. She enjoys helping clients grow to their full potential by offering personality assessment which allows deeper insight to their God-given temperaments. Debra's primary treatment modality is cognitive behavioral therapy. Her approach to counseling is focused on helping her client's identify their core beliefs and values, so that their actions are aligned with their goals. Another area of focus is to assist her clients to identify root causes of pain from childhood that lead to destructive patterns in their current life experiences. Her goal is to assist clients with the transformation of inaccurate thoughts, beliefs and self-perceptions that lead to self-doubt, a diminished sense of personal value, and poor decisions.

ABOUT INSURANCE BILLING

If you have come to therapy with a plan to use your health insurance, there are a few things that you need to know. Insurance companies require that we provide a medically necessary diagnosis in order to bill for services. Most insurance companies do not pay the therapy costs for general personal or family problems that do not produce medically viable symptomology. Your therapist will be able to determine if there are symptoms present which qualify for a medically necessary diagnosis. If those symptoms are not present, you will be billed for the session costs out of pocket.

Be advised, that a few insurance carriers require us to coordinate care with your primary care physician and/or a behavioral care manager in order to approve visits. This prior authorization process must be approved prior to the first session in order to receive insurance payments. While we seek to do our best to research the coverage in your plan, each medical insurance plan is different and we encourage you to contact your provider to identify the specific mental health benefits of your insurance plan.

We are able to bill most insurance providers, but are not preferred by all network providers (we do not accept Medicare Medicaid or Molina healthcare). Please present a valid insurance card and driver's license at your first appointment. You are responsible for a copayment at each visit and we will bill your insurance directly for the allowable balance. Any outstanding balances, co-payments and deductibles are due prior to your appointment or immediately following. You are responsible for the payment if your health insurance does not cover services provided.

FINANCIAL POLICY

Payment: Our fees are as follows: The initial evaluation is $175 and will take approximately 75 to 90 minutes. Subsequent sessions are for 55 minutes and are billed at $140. If you are currently experiencing financial hardship, discuss this with your therapist so we may attempt to accommodate your need.

Payment Options: We accept check, cash payments, and debit/credit cards are also accepted. If we cannot contact you regarding an unpaid balance, please be aware that we may use an outside collection agency.

THERAPIST INFORMATION

Therapist Availability: While we seek to be available to our clients by telephone for emergencies, there are times we will not be available. In the event your therapist cannot be reached, crisis assistance can be obtained by calling Chelan-Douglas RSN @ 1-800-852-2923 or by dialing 911. Your therapist will try to give prior notice of times they will be out of the office for any extended period of time.

Appearing in Court: Therapists at Redemption Counseling do not qualify as expert witnesses and are not in the practice of appearing in court on behalf of patients for any reason. If you are seeking a therapist to assist with a court case, we will try to help by referring you to a therapist who provides this expertise.

LIMITS OF CONFIDENTIALITY

I understand that all information regarding this work will remain confidential and will not be shared with others outside Redemption Counseling without my consent. I understand that my counselor may receive consultation for my case with other counselors at RC on an occasional basis. I also understand that there are conditions under which this confidentiality must be broken and information be shared with appropriate individuals outside of RC. These conditions are as follows:

- If there is suspicion that a child is being abused.
- If there is evidence of physical abuse of an elder or dependent adult.
- If I am making serious physical threats against others or myself.
- If your therapist is called to court via subpoena (you have a limited privilege to determine what can be kept confidential in such cases.)
- If a complaint is filed against your therapist with the Washington Department of Health or a board.
- If you file a Worker's Compensation Claim.

CONSENT OR DECLINATION OF ELECTRONIC COMMUNICATIONS

I am cautioned that e-mail and texting are not a reliably confidential means of communication. In addition, I understand that my counselor cannot ensure that e-mail and text messages will be received or responded to immediately. I understand that e-mail and text are not the appropriate way to communicate confidential, urgent, or emergency information.

ACTION: Please indicate via initialing which communication methods you authorize:

_____ Emailed appointment reminders and counselor response to client communications via email.
My email address is:_____

_____ Phone communications including leaving voice mail messages.
The phone number(s) I authorize are: _____

_____ Text - I understand the risks of texting, but choose this form of communication at no risk to RC.
The text number I authorize is: _____

Printed Name: _____ Client Signature: _____

OR

☐ I decline all electronic communication methods. Client Signature**:** _____

STATEMENT OF UNDERSTANDING

- I understand I am responsible for all charges for counseling services delivered through this office and that payment is expected at the time of service.
- I understand checks returned for insufficient funds will incur a charge of $35.
- I understand I am responsible to appear for scheduled appointments. I understand if I miss an appointment without providing 24 hours notice, I will be charged for that time.
- If I fail to show for two consecutive appointments without notice, I may be referred elsewhere for services. This is dependent on the circumstance of both the client and the mental health provider.
- I understand there is a possibility of risks and benefits which may occur in counseling. I am giving consent to my voluntary participation in these outlined procedures in which I and/or family will participate in therapy at Redemption Counseling, including confidentiality and exceptions of confidentiality.
- I understand that my therapist will attempt to not approach me or address me by name in a public setting unless I choose to approach or address him/her first.
- I understand I have the right to seek a second opinion at any time, or seek additional or alternative referrals.
- I understand that, if in the course of receiving counseling services, if I should feel unsafe, self-destructive, suicidal, homicidal, etc., I will notify my therapist and take appropriate action, including hospitalization, to protect my health and safety.

I acknowledge I have read and received a copy of this INFORMED CONSENT and agree to the guidelines above.

Signature of Client _____ Date: _____

Signature of Parent or Guardian _____ Date: _____

Signature of Therapist _____ Date: _____

REDEMPTION COUNSELING

NOTICE OF PRIVACY PRACTICES

Note: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. Effective Date: January 1, 2016.

Redemption Counseling only releases information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes our policies related to the use and disclosure of the client's healthcare information. Use and disclosure of protected health information (PHI) is for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for the following purposes.

TREATMENT

Use and disclose health information to:

· Provide, manage or coordinate care - this relates to how your therapist manages your health care data to care for you.

· Consultants - this applies to the sharing of data with other professionals as needed for your care.

· Referral sources - this relates to conversing with outside businesses to release information or transfer it to them in order to provide optimum care for you in therapy and for the benefit of treatment.

PAYMENT

Use and disclose health information to:

· Verify insurance and coverage - this applies to disclosing your basic health information to obtain information regarding your insurance benefits.

· Process claims and collect fees - this applies to disclosing your basic health diagnosis, DOB, etc., to obtain your insurance benefits and coverage for mental health services.

HEALTHCARE OPERATIONS

Use and disclose health information for:

· Review of treatment procedures - this would apply to the review of the treatment plan as needed to maintain HIPAA compliance standards.

· Review of business activities - this applies to needs from agencies to show appropriate HIPAA business compliance.

· Certification - this applies to information needed to maintain insurance credentials with the state of WA.

· Staff training - this applies to the sharing of data, but not names to coordinate with other therapists in the office.

· Compliance and licensing activities - this applies to giving any information the state needs to show counseling law compliance and to maintain license validation.

OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT

· Mandated reporting - If the therapist believes a person is at risk to hurt themselves or harm anyone else, they are required as a mandated reporter in the state of Washington to break confidentiality. This may mean revealing information to an appropriate family member, law enforcement officer, child protective services staff member or other appropriate authorities.

· Emergencies - if the therapist believes there is an eminent need to release your information due to possible harm that may be inflicted to another person (such as domestic abuse,) abuse of a disabled or elderly person, or abuse of a child, they are mandated to report immediately to the appropriate state entity.

· Criminal damage - when there is a case involving criminal damages, your personal data may be requested by the state.

· Appointment scheduling - in cases of appointment scheduling, some personal health information will be used.

· As required by law - if a complaint is filed against your therapist, the Washington department of health may subpoena confidential medical data that is relevant to the complaint.

CLIENT RIGHTS

You as the client have rights under Washington State and Federal law.

Right to request where we contact you

· You have the right to restrict how we contact you regarding appointments if you don't want family members to know of your mental health services. *See "CONSENT OR DECLINATION OF ELECTRONIC COMMUNICATIONS" and "CLIENT INFORMATION FORM" to elect how you prefer we contact you during the course of therapy.*

Right to release your medical records

· Written authorization to release records to others - You have the right to your private health file and will need to sign a release if you want others to have access to your medical file.
· Right to revoke release in writing - You have the right to revoke this release at any time in writing.
· Revocation is not valid to the extent that you have acted in reliance on such previous authorization.

Right to inspect and copy your medical billing records

· Right to inspect and copy records - You have the right to see and receive a copy of your medical file at any time.
· Charges for copying, mailing, etc. - You may be charged copying and mailing charges to obtain your file.

Right to add information or amend your medical records

· You may request to amend your records. You can ask for changes to PHI as long as your PHI is maintained in your file. Keep in mind your therapist can deny this based on the accounting process. Please ask questions of your therapist if needed.
· Any amendments to this consent form must be in writing by Redemption Counseling and given to you as a patient.

Right to accounting of disclosures

· Redemption Counseling is required to keep your records for seven years and you have a right to know of our process to maintain confidentiality of these records.
· Exceptions: this applies to exceptions outlined herein about our disclosure policies.
· Disclosure for treatment, payment or healthcare operations - this applies to disclosures of our processes needed to receive appropriate care, payment or continued healthcare services. You may obtain this information by request.
· Disclosures pursuant to a signed release - this applies to understanding our policy regarding our signed release of information document.
· Disclosure made to client - this applies to your right to these disclosures outlined and our accounting of them.
· Disclosures for national security or law enforcement - this applies to your understanding about our need to disclose in cases related to national security or any law enforcement investigation or proceedings.

Right to request restrictions on uses and disclosures of your healthcare information

· You have the right to request restrictions on certain uses and disclosures of PHI, but **it must be in writing** and your therapist is not obligated to agree with your request. Please discuss further with your therapist.

Right to complain

· Please contact Redemption Counseling and your therapist first if you have a complaint about how your PHI and privacy rights have been protected.
· If not satisfied, you have the right to complain to the U.S. Dept. of Health and Human Services. If you have any complaints about your therapist and/or their counseling services, you may contact Washington State Department of Health, Health Systems Quality Assurance by calling 360-236-4700 or at P.O. Box 47865, Olympia, WA, 98504-7865.

Right to receive changes in policy

· You May request any future changes to this policy be given in writing and Redemption Counseling will notify you of such revisions, but maintains the right to change them at any time in compliance with laws and restrictions. This notice will go into effect January 1, 2016.
· Request to privacy officer - You have the right to request a privacy officer review of such PHI information.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected counseling information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and clinician certifications. I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my counseling information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Client: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

BRIEF PATIENT HEALTH QUESTIONNAIRE (Brief PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name _____ **Age** _____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date** _____

1. Over the last 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
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.

	NO	YES
a. In the last 4 weeks, have you had an anxiety attack suddenly feeling fear or panic? **If you checked "NO," go to question 3.**	☐	☐
b. Has this ever happened before?	☐	☐
c. Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems on this questionnaire so far, 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**

FOR OFFICE CODING: Maj Dep Syn if answer to #1a or b and five or more of #la-i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #la-i are at least "More than half the days" (count #1i if present at all). Pan Syn if all of #2a-e are "YES."

Continued on the other side ➔

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4. In the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
a. Worrying about your health	☐	☐	☐
b. Your weight or how you look	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐
d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e. The stress of taking care of children, parents, or other family members	☐	☐	☐
f. Stress at work outside of the home or at school	☐	☐	☐
g. Financial problems or worries	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you in the past—like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? ☐ NO ☐ YES

6. What is the most stressful thing in your life right now? _____

7. Are you taking any medication for anxiety, depression, or stress? ☐ NO ☐ YES

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy, and childbirth.

a. Which best describes your menstrual periods?

☐ **Periods are unchanged**

☐ **No periods because pregnant or recently gave birth**

☐ **Periods have become irregular or changed in frequency, duration, or amount**

☐ **No periods for at least a year**

☐ **Having periods because taking hormone replacement (estrogen) therapy or oral contraceptives**

	NO (or does not apply)	YES
b. During the week before your period starts, do you have a serious problem with your mood—like depression, anxiety, irritability, anger or mood swings?	☐	☐
c. If YES, do these problems go away by the end of your period?	☐	☐
d. Have you given birth within the last 6 months?	☐	☐
e. Have you had a miscarriage within the last 6 months?	☐	☐
f. Are you having difficulty getting pregnant?	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**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 irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)