

**NORTHEAST OHIO BEHAVIORAL HEALTH, LTD.  
REGISTRATION FORM**

**CLIENT INFORMATION**

**DATE:** \_\_\_\_\_

Client Name \_\_\_\_\_ Soc Sec. # \_\_\_\_\_

Address: Street \_\_\_\_\_ Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation (even if currently unemployed) \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Major source of income (employment, unemployment, welfare, etc.) \_\_\_\_\_

Race: Asian Black/African Amer. Native Amer./Amer.Indian White Unknown  
Ethnicity: Puerto Rican Mexican Cuban Other Hispanic Not Hispanic or Latino

**GUARANTOR INFORMATION** (Party responsible for charges not covered by insurance)

\_\_\_\_\_ Same as Above

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ D.O.B. \_\_\_\_\_

**INSURANCE INFORMATION**

Primary:

Name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Effective Date \_\_\_\_\_

Address: Street \_\_\_\_\_ Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Secondary:

Name of Insurance Company \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Effective Date \_\_\_\_\_

Other:

Medical Assistance Program \_\_\_\_\_ 12 Digit Medical Assistance Number \_\_\_\_\_

Is this a Workman's Compensation Case? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes: Name of Attorney: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Does insurance require precertification for treatment? \_\_\_\_\_

**(over)**

**AUTHORIZATION FOR RELEASE OF INFORMATION:**

I Hereby authorize Northeast Ohio Behavioral Health, LTD to release such information in connection to my treatment to the above named insurance company(ies) for the purpose of processing the insurance claim.

**GUARANTEE OF ACCOUNT:**

I understand I am financially responsible for charges not covered by this authorization.

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize payment of the benefits otherwise payable to me by the designated insurance companies directly to Northeast Ohio Behavioral Health, LTD. The amount not to exceed regular charges.

**PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED**

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Client (parent, if minor – guardian – legal representative)

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**REMINDER CALLS:**

In order to provide our clients with appointment reminder calls, NEOBH requires written permission from the client/parent or guardian.

I would like an appointment reminder call \_\_\_\_\_  
(Signature)

Phone numbers: (1) \_\_\_\_\_ (2) \_\_\_\_\_

It is permissible / not permissible for NEOBH to leave a message.

Leave message \_\_\_\_\_  
Signature

DO NOT leave message \_\_\_\_\_  
Signature

**NORTHEAST OHIO BEHAVIORAL HEALTH, LTD.  
FEE AGREEMENT FORM**

- Diagnostic Assessment/Initial Intake Interview - \$140 per 45 minutes session.
- Individual Counseling - \$100 per 45 minute session, \$60.00 per 20-30 minute session.
- Group Counseling - \$45 per person per hour.
- Specialized Services/Evaluations/Assessments – fees vary and are explained under a separate document which will be presented if applicable.
- Summary Letters - \$50.00 per letter.
- Reports - \$160.00 per report.
- Fees for reports, testing, letters, telephone consultations and other services will not be billed to Insurance, Medicaid or most third party payers and are therefore your financial responsibility. Payment is due in advance of the service being provided.
- There will be a \$25 charge for checks returned for non-sufficient funds.
- **We reserve the right to charge for your visit if there is not a 24 hour notice of cancellation.** This will not be billed to Insurance, Medicaid or third party payers and is therefore your financial responsibility. Additionally, we reserve the **right to refuse to provide future services** should you demonstrate a history of no shows and/or late cancellations.
- **Deductible and co-pay amounts, in addition to those services not covered by another payer, are due at the time of each visit.**
- Although we may bill your insurance company and/or third party payer, **you are ultimately responsible for payment of services rendered, and for contacting your insurance company and/or third party payer if payment is not received in a timely manner.**
- If your bill for services rendered is not paid promptly, we may find it necessary to turn your account over to a collection agency. We will make every effort to avoid this by working with you to ensure timely payments on your account. However, if it does become necessary to turn your account over to a collection agency, we reserve the right to charge an additional collection fee.
- For your convenience, we accept Visa, MasterCard, Cash, Personal Checks and Money Orders.

**STARK COUNTY RESIDENTS ONLY:**

**You may apply for Public Subsidy Funding through the Mental Health and Recovery Services Board of Stark County for certain services provided by NEOBH. Please select from one of the two options below:**

**Option 1 – I waive my right** to be considered for public subsidy funding offered by my county and therefore agree to pay 100% of charges not covered by Insurance, Medicaid or any other third party payer. \_\_\_\_\_ (initials)

**Option 2 – I wish to be considered** for Public Subsidy Funding. A separate Financial Interview with an NEOBH representative will be scheduled. Proof of Income will be required. \_\_\_\_\_ (initials)

I have read and fully understand the above provisions. I give permission to and request that Northeast Ohio Behavioral Health, Ltd. bill my Insurance, Medicaid or any third party payer for services rendered to me or to a member of my family. I clearly understand that it is still my responsibility to make sure that the bill is paid in a timely manner. If, for any reason, any portion or the entire bill is not paid by Insurance, Medicaid or any third party payer, I agree to make arrangements for prompt payment to Northeast Ohio Behavioral Health, Ltd.

**\*REQUIRED INFORMATION FOR ALL CLIENTS:** Family Income: \$ \_\_\_\_\_ per month Family Size: \_\_\_\_\_ persons

\_\_\_\_\_  
Signature of Client or Parent/Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of NEOBH Representative

\_\_\_\_\_  
Date Signed

## MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.\*

### Adult

<b>Client is an adult?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, complete the following information.</b>	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	Date

### Minor

<b>Client is a Minor?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, indicate if child is in legal custody of the following (this is not the foster parent).</b> <input type="checkbox"/> Parent <input type="checkbox"/> CSB <input type="checkbox"/> DYS <input type="checkbox"/> Court <input type="checkbox"/> Other (specify): _____
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone No. of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

\*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.



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**NORTHEAST OHIO BEHAVIORAL HEALTH, LTD.**

**Authorization for Disclosure of Confidential Information and/or  
Enrollment into the Multi-Agency Community Services  
Information System (MACSIS)**

To be eligible to receive public funds to help pay for the cost of your services, we must provide information to the Mental Health and Recovery Services Board of Stark County and/or to the Agency/Board in your county of residency.

The information must be provided in order to:

- Enroll you in your residing counties plan
- Determine what public funds can be used to pay for your services
- Pay NEOBH through a system connected with the Ohio Department of Mental Health, Ohio Department of Alcohol & Drug Addiction Services, and the Ohio Department of Job and Family Services

ALL INFORMATION COLLECTED WILL BE KEPT CONFIDENTIAL, consistent with State and Federal law. All uses for the information collected are described in NEOBH's HIPAA Privacy Practices Policy.

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Signature of Client or Parent/Legal Guardian

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Date

**Northeast Ohio Behavioral Health, Ltd.**

**PERMISSION FOR TREATMENT**

I hereby authorize Northeast Ohio Behavioral Health, Ltd. to provide \_\_\_\_\_  
Client's Name

with the following services:

- \_\_\_\_\_ Individual Psychotherapy
- \_\_\_\_\_ Psychological Testing/Evaluation/Assessment
- \_\_\_\_\_ Family Counseling
- \_\_\_\_\_ Custody Evaluation
- \_\_\_\_\_ Parent Consultation
- \_\_\_\_\_ CPST – Community Psychiatric Supportive Treatment
- \_\_\_\_\_ Other \_\_\_\_\_

I understand that mental health services sometimes carry a risk of undesirable side effects and am aware that I am entitled to an explanation of such possible side effects. I further understand that only those services listed above will be provided unless I give signed authorization for additional services.

\_\_\_\_\_  
Signature of Client or Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Client (if under 18)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**Client Rights, Civil Rights and Grievance Procedures:**

I have received a copy of Northeast Ohio Behavioral Health, Ltd.'s Client Rights, Civil Rights and Grievance Procedures. I understand that I can ask any questions that I may have about these policies, at any time.

\_\_\_\_\_  
Signature of Staff Member                      Signature of Client/Parent/Guardian                      Date

**Privacy Practices Policy:**

I have received a copy of Northeast Ohio Behavioral Health, Ltd.'s Notice of Privacy Practices. I understand that I can ask any questions that I may have about these policies, at any time.

\_\_\_\_\_  
Signature of Staff Member                      Signature of Client/Parent/Guardian                      Date

Northeast Ohio Behavioral Health, Ltd.

PRIMARY CARE PHYSICIAN COMMUNICATION FORM

Client: Please fill out the data in the box only and sign at the "X". Thank You!

Client's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Check here if client does not have a Primary Care Physician.

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in regards to it. This release will automatically expire twelve (12) months from the date signed.

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
(Print Client's Name) (Print Treating Clinician's Name)

- To release any applicable information TO my Primary Care Physician (as listed above).
 NOT to release information to my Primary Care Physician (as listed above).
 To receive the following information FROM my Primary Care Physician (as listed above):

X \_\_\_\_\_ / / \_\_\_\_\_
Signature of Client or Guardian Date

Office Use Only

Dear Dr. \_\_\_\_\_:

Your patient, \_\_\_\_\_, was recently seen in our office for outpatient counseling. We hope that the following information will help in coordinating this patient's care. Please call if further information would be helpful.

Date of initial consultation: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Diagnosis and brief description of presenting problem(s): \_\_\_\_\_

Treatment Recommendations: \_\_\_\_\_

Treating Clinician's Name: \_\_\_\_\_

Address/Phone:

Sincerely,

2795 Front Street, Suite A; Cuyahoga Falls, OH 44221; 330-945-7100.

4510 Dressler Rd. NW; Canton, OH 44718; 330-494-5155.

213 Market Avenue N., Suite 200; Canton, OH 44702; 330-451-1701.

CARE Center @ Akron Children's Hospital; 1 Perkins Square; Akron, OH 44308; 330-945-7100.

Clinician's Signature

Northeast Ohio Behavioral Health, Ltd.

SUPERVISION DISCLOSURE STATEMENT

Dear Client:

Your therapist, \_\_\_\_\_, is a (circle appropriate title):

- Psychology Assistant
Pre / Post-Doctoral Psychology Trainee
Professional Counselor
\_\_\_\_\_

who is being supervised by (circle appropriate Supervising Psychologist/Supervisor):

- Robin Tener, Ph.D.
Patricia Seifert, Ph.D., P.C.C.-S.
Penny Griffith, Ph.D.
Aimee Thomas, Ph.D., P.C.C.-S
Gail Mager, P.C.C.-S.
\_\_\_\_\_

Treatment services provided to you may include Intake Evaluation/Diagnostic Assessment, Individual, Group, Family or Conjoint Counseling, and Psychological Testing. Through methods such as the taping of treatment sessions, review of psychological testing data, review of notes of treatment sessions and discussion of the content of treatment sessions, your therapist will receive supervision that will enable him/her to develop important skills. Supervision of your therapist will enable Northeast Ohio Behavioral Health, Ltd. to ensure that you are receiving the best possible treatment services.

Confidentiality is important at NEOBH. Both your therapist and his/her supervisor are bound by specific State and Federal laws, as well as by professional ethics that govern confidentiality. Any information that may be recorded within a counseling session is strictly confidential, is used only for training, and is erased when training is completed. Detailed information about confidentiality can be found in the Client Rights and HIPAA Privacy Rules materials that are provided to each client/guardian during the initial appointment. Please note that all therapists at NEOBH follow relevant laws regarding the duty to report suspected child abuse, or imminent harm to another person.

You have already received information regarding the financial policies of NEOBH. If we are billing insurance, bills will be submitted under the name of our agency and/or under the name of the Supervising Psychologist/Supervisor. In either case, it will be clear who provided the billed service.

The Supervisor is ultimately responsible for the services that are provided by your therapist. You may request a meeting with your therapist's supervisor before, during or following your treatment. If you have concerns about your treatment, please contact the supervisor at the following numbers:

- Dr. Robin Tener: (330) 945-7100 or (330) 494-5155
Dr. Patricia Seifert: (330) 945-7100
Dr. Penny Griffith: (330) 945-7100
Dr. Aimee Thomas: (330) 494-5155
Gail Mager, P.C.C.-S.: (330) 945-7100 or (330) 494-5155
\_\_\_\_\_:

Any additional concerns regarding your treatment at Northeast Ohio Behavioral Health, Ltd. may be reported to Dr. Robin Tener, Executive Director, at (330) 945-7100 or (330) 494-5155.

I have read the above and understand the nature of the supervisory procedures. I recognize that I can ask any questions regarding supervisory issues, and may speak to my therapist's supervisor. I consent to having my counseling sessions taped for the purposes of supervision.

Client's Name: \_\_\_\_\_ Client's/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ NEOBH Representative's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ NEOBH Supervisor's Signature: \_\_\_\_\_



## NORTHEAST OHIO BEHAVIORAL HEALTH ADULT BACKGROUND INFORMATION

Name (First, MI, Last)			
Date	Date of Birth	Age	
<b>LIVING SITUATION</b>			
My Home <input type="checkbox"/> Rent <input type="checkbox"/> Own		**Residential Care/Treatment Facility (if applicable) <input type="checkbox"/> Hospital <input type="checkbox"/> Temporary Housing <input type="checkbox"/> Residential Care <input type="checkbox"/> Nursing Home	
**Other (if applicable) <input type="checkbox"/> Relative's/Guardian's Home <input type="checkbox"/> Friend's Home <input type="checkbox"/> Adult Foster Care Home <input type="checkbox"/> Homeless in Shelter/No Residence <input type="checkbox"/> Respite Care <input type="checkbox"/> Other:			
**Identify Person's Name or Facility in which you live:			
Household Member Names	Relationship to Client	Age	How do you get along with this person?
Significant Family Members/ Others Not Listed Above	Relationship to Client	Age	How do you get along with this person?
<b>SOCIAL INFORMATION</b>			
Which family members or friends provide you with the greatest support?			
What kinds of activities do you enjoy?			
Are you involved in any support or self-help groups?			
Are you involved in a church or do you practice a religion?			

EDUCATION, EMPLOYMENT, AND MILITARY INFORMATION			
<b>Education History</b> (check all that apply) <input type="checkbox"/> GED <input type="checkbox"/> HS Graduate		Highest Grade Completed	Years of Vocational Training Completed
<input type="checkbox"/> College			
Number of Years, Quarters or Semesters	Degree/Major	<input type="checkbox"/> Other Degrees:	
History of Learning Difficulties <input type="checkbox"/> None <input type="checkbox"/> Learning Disability Type(s): _____ <input type="checkbox"/> Mental Retardation			
<b>Employment</b> (check all that apply) <input type="checkbox"/> Full Time (35 hrs. or more per week) <input type="checkbox"/> Part Time (less than 35 hrs. per week) <input type="checkbox"/> Unemployed/Date Last Worked: _____			
Not in Labor Force <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Living in Institution <input type="checkbox"/> Other: _____			
If employed, name of employer: _____			
<b>Job Performance History</b>			
# of Jobs in Last 5 Years	What kinds of jobs have you had?		
Job Attendance <input type="checkbox"/> Above Average <input type="checkbox"/> Normal <input type="checkbox"/> Tardiness <input type="checkbox"/> Absenteeism			
Job Performance <input type="checkbox"/> Exemplary <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Below Average			
Employment Interests/Skills Do you like your job? <input type="checkbox"/> No <input type="checkbox"/> Yes (If not currently employed) Do you make enough money? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you want to work? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you had any special job skills training? If "yes" what kind? _____			
<b>Military History</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe branch of service, duties, and any trauma experienced during service. _____			
Type of Discharge		Date of Discharge	
MENTAL HEALTH TREATMENT HISTORY			
Outpatient Mental Health Treatment <input type="checkbox"/> None			
Agency	Check if Current	Past (Date)	Clinician Name
Previous or Current Diagnoses (if known): _____			

MENTAL HEALTH TREATMENT HISTORY (continued)		
Psychiatric Hospitalizations/Residential Treatment Facilities <input type="checkbox"/> None		
Facility	Date of Service	Reason (suicidal, depressed, etc.)

CURRENT MEDICATION INFORMATION (Prescription/Over-the-Counter/Herbal) <input type="checkbox"/> None					
Medication	Reason for Taking Medication	How Much/How Often?	Is It Helping?		
			Yes	No	Unsure
Primary Care Physician/Family Doctor:				Last physical exam:	
Other Prescribing Physician(s):					

Past Medications for Mental Health Problems <input type="checkbox"/> None	
Medication	Reason for Discontinuation

ALCOHOL/DRUG HISTORY				
Illegal drug use/abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes		Non-prescription drug abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Prescription drug abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes		Alcohol abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Drug/Substance/Alcohol	Age of First Use	Date of Last Use	Frequency of Use	Amount

ALCOHOL/DRUG TREATMENT HISTORY		
Have you had any alcohol or drug treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Current: <input type="checkbox"/> Outpatient <input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Residential <input type="checkbox"/> Other:		
Past: <input type="checkbox"/> Outpatient <input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Residential <input type="checkbox"/> Detox <input type="checkbox"/> Other:		
Name of Provider Agency	Type of Service	Date of Service

<b>LEGAL HISTORY</b>	
Do you have a Legal Guardian/Custodian? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Legal Guardian/Custodian: Address: Phone # :	
Current Legal Status <input type="checkbox"/> None <input type="checkbox"/> On Probation <input type="checkbox"/> Detention <input type="checkbox"/> On Parole <input type="checkbox"/> Awaiting Charge <input type="checkbox"/> Alcohol/Drug Related Legal Problems <input type="checkbox"/> Conditional Release <input type="checkbox"/> Outpatient Commitment <input type="checkbox"/> Court Ordered to Treatment <input type="checkbox"/> Other:	
History of Legal Charges <input type="checkbox"/> None      Juvenile: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: <input type="checkbox"/> Status Offense (e.g., Unruly) <input type="checkbox"/> Delinquency Adult: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: <input type="checkbox"/> Misdemeanor <input type="checkbox"/> Felony	
List and Date Most Recent Legal Charges	
Convictions <input type="checkbox"/> None	
Incarcerations <input type="checkbox"/> None	Name and Phone # of Probation/Parole Officer
Civil Proceedings <input type="checkbox"/> None	Domestic Relations Court Problems (custody, protective services, restraining order)
Juvenile Court Involvement (related to child abuse, neglect, or dependency) Current: <input type="checkbox"/> No <input type="checkbox"/> Yes    Comment: _____ Past: <input type="checkbox"/> No <input type="checkbox"/> Yes    Comment: _____	
Child Support Enforcement Orders <input type="checkbox"/> None	
Children's Protective Services Involvement with Family <input type="checkbox"/> None	
Name of Children's Protective Services Caseworker(s) Assigned to Family <input type="checkbox"/> None	
<b>ABUSE HISTORY</b>	
Please check any types of abuse you have experienced: <input type="checkbox"/> None <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Community Violence <input type="checkbox"/> Physical Neglect <input type="checkbox"/> Emotional Abuse <input type="checkbox"/> Elder Abuse <input type="checkbox"/> Sexual Abuse/Molestation <input type="checkbox"/> Other:	
Comment on abuse history:	

<b>PROBLEM CHECKLIST</b>	
What problems are you having?	
Check	Check All Current Problem Areas, Please Explain:
	<b>Nutritional/Eating Pattern Changes</b>
	<b>Pain Management</b>
	<b>Depressed Mood/Sad</b>
	<b>Grief/Loss Issues</b>
	<b>Anxiety</b>
	<b>Distressing/Disturbing Life Events – Recent or Historic</b>
	<b>Anger/Aggression</b>
	<b>Oppositional Behaviors</b>
	<b>Problems Paying Attention/Concentrating</b>
	<b>Impulsivity</b>
	<b>Sees or Hears Things That Other People Do Not</b>
	<b>Mood Swings/Hyperactivity</b>
	<b>Substance Use/Addiction</b>
	<b>Other Addictive Behaviors (i.e. Food, Internet)</b>
	<b>Sleep Problems</b>
	<b>Difficult Circumstances at Home or at School</b>
	<b>Health Issues/Medical History (include any allergies and food/drug reactions)</b>
	<b>Other:</b>

**CURRENT SOURCES OF STRESS**

PLEASE LIST YOUR MOST SIGNIFICANT SOURCES OF STRESS OR WORRY:

1. \_\_\_\_\_

2. \_\_\_\_\_

WHAT IS THE MAIN GOAL YOU WISH TO ATTAIN IN SEEKING SERVICES?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOW WOULD YOUR LIFE BE DIFFERENT IF YOU COULD MANAGE SOME OF THESE PROBLEMS BETTER?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INFORMATION**

PLEASE ADD ANY INFORMATION YOU FEEL MIGHT BE HELPFUL IN ASSISTING IN YOUR TREATMENT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your signature below indicates you understand the questions, could ask for assistance if needed, and that this information is true to the best of your knowledge.	
Client's Signature:	Date:
Therapist's Signature:	Date:

<b>DASS 21 -- Adult Mental Health Outcome Scale</b>	Name:	Male	Race:	Date of Birth:	Today's Date:
		Female			
<p>Please read each statement and circle a number (0, 1, 2 or 3) that indicates how much the statement applies to you <i>over the past week</i>. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p><b>The rating scale is as follows:</b></p> <p><b>0</b> <i>Did not apply to me at all</i>  <b>1</b> Applied to me to some degree, or <i>some of the time</i>  <b>2</b> Applied to me to a considerable degree, or <i>a good part of the time</i>  <b>3</b> Applied to me very much, or <i>most of the time</i></p>					
1.	I found it hard to "wind down"	0	1	2	3
2.	I tended to over-react to situations	0	1	2	3
3.	I felt that I was using a lot of nervous energy	0	1	2	3
4.	I found myself getting agitated / upset	0	1	2	3
5.	I was intolerant of anything that kept me from doing what I wanted to be doing	0	1	2	3
6.	I felt that I was rather touchy	0	1	2	3
<b>S Total:</b>					
7.	I was aware of dryness in my mouth	0	1	2	3
8.	I experienced difficulty breathing or rapid breathing, even though I was not exercising	0	1	2	3
9.	I experienced trembling (e.g. in my hands)	0	1	2	3
10.	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
11.	I felt I was close to panic	0	1	2	3
12.	I felt scared without any good reason	0	1	2	3
13.	I was aware of my heart beat (heart rate increase, heart missing a beat) even though I was not exercising	0	1	2	3
<b>A Total:</b>					
14.	I couldn't seem to experience any positive feelings at all	0	1	2	3
15.	I found it hard to work up the energy to do things	0	1	2	3
16.	I felt that I had nothing to look forward to	0	1	2	3
17.	I found it hard to relax	0	1	2	3
18.	I felt down-hearted and "blue"	0	1	2	3
19.	I was unable to become enthusiastic about anything	0	1	2	3
20.	I felt I wasn't worth much as a person	0	1	2	3
21.	I felt that life was meaningless	0	1	2	3
<b>D Total:</b>					
<b>S+A+D Combined Total:</b>		<b>Combined Total Multiplied by TWO:</b>			