FOR OFFICE USE ONLY

DATE:_____

CID_____ NEW REOPEN UPDATE THERAPIST:_____

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

NAME:_____
LAST FIRST MIDDLE MAIDEN

ADDRESS:_____
STREET/ROUTE APT./P.O. BOX CITY STATE ZIP CODE

COUNTY:_____ DATE OF BIRTH:_____ SEX: _____

PRIMARY RACE _____ SECONDARY RACE _____ VETERAN: _____ YES _____ NO

ENGLISH PROFICIENCY _____ MOTHER'S FIRST NAME: _____RELIGION:_____

MARITAL STATUS: NEVER MARRIED____ MARRIED____ SEPARATED____ DIVORCED____ WIDOWED____

REFERRAL SOURCE:_____ LEGAL GUARDIAN'S NAME: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL:_____

ADDRESS:_____

FAMILY MEMBERS PRESENTLY LIVING IN YOUR HOUSEHOLD:

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	EMPLOYER

** IF HOMELESS, CHOOSE ONE OF THE FOLLOWING: _____ CONTINUALLY HOMELESS FOR A YEAR OR MORE
_____ 4 OR MORE EPISODES OF HOMELESSNESS IN THE LAST 3 YEARS ____ HOMELESS BUT 1 OR 2 NOT APPLICABLE

EDUCATION (LAST YEAR COMPLETED)_____ SPOUSE'S EDUCATION_____

YOUR OCCUPATION:_____ EMPLOYER:_____

SPOUSE'S OCCUPATION:_____ EMPLOYER:_____

ARE YOU EMPLOYED NOW? YES_____ NO_____ FULL-TIME_____ PART-TIME_____

DURATION OF EMPLOYMENT_____ TOTAL JOINT YEARLY INCOME _____

SOURCE OF INCOME _____

SOCIAL SECURITY #:_____ MEDICARE #: _____

MEDICAID #: _____ INSURANCE COMPANY NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

E-MAIL ADRESS: _____ May we contact you at this address? YES NO

PHYSICIAN:_____ DATE OF LAST PHYSICAL:_____

ARE YOU CURRENTLY PREGNANT? ___YES ___NO PREVIOUS PSYCHIATRIC HOSPITALIZATION: ____ YES ____ NO

WHERE: _____ ADMISSION DATE:_____ DISCHARGE DATE:_____

PREVIOUS COUNSELING: ___ YES ___ NO WHERE:_____ DATES:_____

CURRENT MEDICATIONS:_____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?_____

OFFICE USE ONLY

Private Pay	County	Medicare	FeeMod/	CID_____	APPLE_____
Insurance	City	TXIX	Means	EAP	MAC_____

DAKOTA COUNSELING INSTITUTE

CLIENT INSURANCE INFORMATION

Medicare Number:_____

Medicaid Number:_____

Health Insurance Company Name: _____

Insurance Company address: _____

_____

_____

Policy Number:_____ Group Number:_____

Insured's Name (Policyholder):_____

Insured's Date of Birth:_____

Insured's Address: _____

_____

I authorize my health care provider to release information requested on my insurance form. I authorize payment of any benefits directly to Dakota Counseling Institute. I understand that I am fully responsible for any charges that are not covered by my insurance policy. This authorization will remain in effect until revoked by me in writing.

Patient / Parent / Guardian Signature:_____

Updated 2017

Financial Agreement

The typical fees for service are as follows:

Outpatient Intake	$173
Outpatient Therapy	$169 - $384
Psychiatric Evaluation	$280 - $352
Medication Management	$184 - $246

These rates are subject to adjustment due to the variance in the length of sessions, intensity of service provided, and/or June 1 of each year due to contractual inflation. The typical therapeutic hour and follow-up appointments are 55 minutes. The typical psychiatric evaluation is 45-90 minutes with follow-up appointments 15-30 minutes.

Any insurance coverage or changes in coverage should be reported to the front desk. Pre-authorization of services is the responsibility of the insured. Dakota Counseling Institute is unable to guarantee payment by the insurance company due to the individuality of each plan. Denials may be due to non-covered diagnosis or other non-covered events. The agency will assist with the filing of insurance, but all charges are the responsibility of the client from the date the service is rendered. As a reminder, your insurance contract is between you, your employer when applicable, and the insurance company.

Dakota Counseling Institute will work with clients on their outstanding balances as long as the payments are reasonable and regular. We accept cash, checks, Visa and MasterCard. Returned checks are subject to an additional collection fee. Balances older than 30 days are subject to interest charges of 1 ½% per month.

I have read and understand the above information.

_____ _____

Signature of Client/Parent/Guardian Date

_____ _____

Witness Date

Updated July 2019

Dakota Counseling Institute, Inc.
About Our Notice of Privacy Practices

In compliance with the law, we are committed to protecting your personal health information.

The attached Notice of Privacy Practices state:

- Our obligation under law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this Notice and to obtain your written acknowledgment that you have received a copy of this Notice.

Patient Acknowledgment of Receipt

I, _____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices at Dakota Counseling Institute.

_____

Client Date

_____

Parent/Guardian Date

Documentation of Good Faith

___ Attempted to distribute the Notice of Privacy Practices to the client/parent/legal guardian, but they declined to acknowledge receipt.
___ The Notice of Privacy Practices was mailed to the client/parent/legal guardian.
___ Other _____

_____

Staff Member Date

Updated 2017

DAKOTA COUNSELING INSTITUTE
TREATMENT CONTRACT

The following is a contract between Dakota Counseling Institute professional staff and you, the consumer, to provide treatment to you. By signing this contract, both parties acknowledge that they have read, understand and agree with the terms set forth in this document.

Informed Consent: By signing this contract, you give consent to receive treatment by DC Institute professional staff. You have a right to be informed of your diagnosis. You have the right to receive information about the nature, purpose, and risks of any tests, treatment, or procedures suggested to you. You are encouraged to ask the clinician working with you any questions you may have regarding your treatment and its potential outcome. If your treatment involves individual, group, couple, or family therapy sessions, you must understand that the issues, which brought you to seek therapy, may become worse before they get better. For example, you may feel more anxious or depressed in the beginning phases of treatment. In rare cases, you may experience loss of contact with reality, or you may experience strong suicidal intent, both of which could necessitate a period of hospitalization in a psychiatric facility. During the course of therapy, interpersonal relationships may change. If you have experienced significant trauma at some time in the past, you may experience flashbacks or a reliving of past experiences and feelings associated with these.

Confidentiality: Confidentiality means that the information you share with DC Institute and its employees will not be released to other individuals or outside agencies, with the following exceptions:

1. If you sign a release specifying to whom the information is released, what information you want released, and for what time period the release of information is valid.

2. Some insurance companies and EAP's request information about your treatment. When you sign on with an insurance company and/or EAP, you sign a waiver or a release of authorization for such information. Therefore, we will release the requested information to your insurance company and/or EAP unless you inform us in writing that you do not want us to do this. Once we receive your request in writing, all information gathered about you after the request is received will not be released to your insurance company and/or EAP. However, if you make such a request, you become solely responsible for the cost of your treatment.

3. Upon a proper court order, your records and/or the testimony of your primary mental health professional may be released.

4. All mental health professionals are mandated reporters. This means that the clinician working with you has to report child abuse or abuse of other dependent persons. **This process will follow all guidelines set forth by State Law.**

5. If your primary mental health professional judges you to be a danger to yourself or others and you refuse voluntary hospitalization, necessary information will be released to outside agencies to insure your and others' safety and to insure continuity of treatment. **This process will follow all guidelines set forth by State Law.**

6. Your financial obligation, name and address may be referred to outside collection agencies, including small claims court, if your account is delinquent.

7. Contact with your HMO for coordination of care.

8. If you are under the age of 18, or have a legal guardian, your parents/legal guardians have the right to obtain information about your treatment, and the right to sign releases of information to other agencies about your treatment on your behalf.

9. If you are a parent bringing your minor child for treatment, please be advised that all information requested by or shared with one parent will also be made available to the other parent, unless such parent's rights have been terminated by a court of law and such termination order has been placed in the child's client file.

10. If you are the partner in couple's therapy, any release of records must be approved and signed by both parties, and the information will be made available to both parties participating in these counseling sessions.

11. If services are funded, wholly or in part, through State Contract or Medicaid monies, the State of South Dakota, Division of Behavioral Health, will receive certain demographic information about you and may, periodically, review records to assure our compliance with contract

requirements. At no time will we release your name or your address. If you have further questions about this, please ask staff.

12. If you receive services from more than one professional staff member of Dakota Counseling Institute, members of your treatment team will likely exchange information in order to coordinate services and provide you with the best treatment available.

Grievance Procedure: Dakota Counseling Institute is committed to providing high quality mental health services through its various programs. Our goal is to provide the most effective services possible, and we want you to be satisfied with the services you receive. As is the case with any service provider, however, occasionally there will be times when a person receiving services is dissatisfied with the services provided by the agency. If you believe that you have a legitimate complaint regarding services provided to you, please try to discuss the situation or the nature of your dissatisfaction with the staff member providing services to you. Most problems are likely to be resolved at this level.

If the problem is not resolved by talking directly to the staff person providing services to you, you may submit a written explanation of your complaint to the Clinical Director of Dakota Counseling Institute. The Clinical Director will respond to your complaint verbally and in writing within 15 days of receiving it. If the problem is not resolved at this level, you may forward your complaint in writing to the Executive Director of Dakota Counseling Institute. The Executive Director will respond to your complaint verbally and in writing within 15 days of receiving it.

If you and the Executive Director do not resolve the problem to your satisfaction, you may contact the Division of Mental Health at the following address and phone number:

Department of Social Services
Division of Behavioral Health
700 Governor's Drive
Pierre, SD 57501-5070

Phone: (605) 773-3123
Fax: (605) 773-7076

I have read this treatment contract and agree with the terms set forth in this document.

_____ _____
Client Date

_____ _____
Parent/Guardian Date

_____ _____
Witness/Therapist Date

Parental Consent: I, _____ parent/legal guardian of _____, hereby consent to have this child treated by Dakota Counseling Institute professional staff.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness/Therapist Date

(Please initial)

_____ I have been provided with a copy of the Consumer's Rights.

[Updated 2017]

Dakota Counseling Institute
Client Rights

As a client of Dakota Counseling Institute, your rights include, but are not limited to the following:

- The right to confidentiality and privacy of all medical records and information given in treatment.
- The right to be treated with respect and dignity.
- The right to receive treatment that is sensitive to you as an individual in a non-discriminatory manner.
- The right to actively participate in your treatment plans as well as any modification of that plan to insure your understanding and agreement with this plan.
- The right to know the reasons why a particular treatment is considered appropriate.
- The right to refuse any proposed treatment or medication unless in an emergency.
- The right to receive an explanation of diagnosis and prescribed medications and any side effects.
- The right to be fully informed of the fees for therapy.
- The right to locate alternative sources of assistance.
- The right to be informed of the volunteer or student status of a therapist.
- The right to review your case records unless conditions arise as specified by South Dakota Codified Law.
- The right to assert grievances if your rights are violated.
- The right to have a copy of all paperwork and notices signed and/or initialed and to receive a copy of the clients' rights and responsibilities in writing, or in an accessible format, during the intake process and be able to discuss the rights and responsibilities with DCI staff.
- The right to have access to advocacy services at any time.

To maximize beneficial consumer outcome, clients should be aware of their responsibilities.
The client is responsible for:

- Following recommended and agreed upon treatment plan
- Financial obligations of mental health services
- Punctuality of appointments and notification to center if unable to attend a session
- Consideration of the rights of the staff and other clients
- Being respectful of the property of others
- Maintaining cleanliness and order
- Providing accurate medical and personal information

Signature of Client/Parent or Guardian _____ Date _____

Dakota Counseling Institute, Inc.
Client Rights

Clients' rights (67:62:07:01). Dakota Counseling Institute will ensure that client's rights are fully protected. DCI will give each client, the client's parent if the client is under 18 year of age, or the client's guardian, if any, a copy of the clients' rights and responsibilities in writing, or in an accessible format, during the intake process and will discuss the rights and responsibilities with the client or the client's parent, guardian or advocate.

The clients' rights and responsibilities statement will be posted in a place accessible to clients. Copies are also available in locations where clients can access them without making a request to center staff. In addition, DCI makes the clients' rights and responsibilities statements available to the division. DCI will provide services to each client in a manner that is responsive to the client's need in the areas of age, gender, social support, cultural orientation, psychological characteristics, sexual orientation, physical situation, and spiritual beliefs.

Guaranteed rights (67:62:07:02). Dakota Counseling Institute will ensure that a client's rights guaranteed under the constitution and laws of the United States and the State of South Dakota including:

- The right to refuse extraordinary treatment as provided in SDCL 27A-12-3.22;
- The right to be free of any exploitation or abuse;
- The right to seek and have access to legal counsel;
- To have access to an advocate as defined in subdivision 67:62:01(2) or an employee of the state's designated protection and advocacy system;
- The right to confidentiality of all records, correspondence, and information relating to assessment, diagnosis, and treatment pursuant to SDCL 27A-12-26 and the security and privacy of HIPAA, 45 C.F.R., Parts 160 and 164 (September 26, 2016); and
- The right to participate in decision making, related to treatment, to the greatest extent possible.

Updated February 2017

Dakota Counseling Institute, Inc.
Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Dakota Counseling Institute, we are committed to treating and using protected health information (PHI) about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Dakota Counseling Institute, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Dakota Counseling Institute, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,

- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Dakota Counseling Institute is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. You may request a copy of the current notice from any of our locations.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Roswitha Konz, Clinical Director, at (605) 996-9686 or at r.konz@dakotacounseling.net.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Updated February 2017

Dakota Counseling Institute

Grievance Process for Persons Receiving Services Reimbursed by the South Dakota Division of Community Behavioral Health

Dakota Counseling Institute is committed to providing high quality mental health and chemical dependency services through its various programs. As is the case with any service provider, however, occasionally there will be times when a person receiving services is dissatisfied, for some reason, with the services provided by the agency. If you believe that you have a legitimate complaint regarding services provided to you, the following procedure should be followed.

For all types of services provided by Dakota Counseling Institute, first try discussing the situation or the nature of your dissatisfaction with the staff member providing services to you. Our goal is to provide the most effective services possible and we want you to be satisfied with the services you receive. Most problems are likely to be resolved at this level.

If the problem is not resolved by talking directly to the staff person providing services to you, you may submit a written explanation of your complaint to the Clinical Director or Clinical Supervisor of Dakota Counseling Institute within 15 days of making your dissatisfaction known to the person providing services to you. The Clinical Director or Clinical Supervisor will respond to your complaint verbally and in writing within 15 days of receiving it.

Throughout the grievance process, if you feel a need for additional personal support, you may find it helpful to contact the National Alliance for the Mentally Ill—South Dakota at

PO Box 88808
Sioux Falls, SD 57109
605.271.1871
800.551.2531
namisd@midconetwork.com

or South Dakota Advocacy Services at sdadvocacy.com, 800.658.4782.

If you and the Clinical Director/Clinical Supervisor do not resolve the problem to your satisfaction, you may contact the Division of Mental Health at the following address and phone number:

Division of Behavioral Health
Department of Social Services
811 East 10th, Department 9
Sioux Falls, SD 57103
Phone: 605.367.5236
Fax: 605.367.5239

Updated February 2017

MICHELLE L. CARPENTER
Executive Director

ROSWITHA KONZ, M.A.
Clinical Director

JANAE OETKEN, CCDCIII
Clinical Supervisor

DCI
DAKOTA COUNSELING INSTITUTE

March 4, 2013

In our continuous effort to improve the process of requesting refills for previously prescribed medications, we have updated our policy. **All refill requests need to be made Monday thru Thursday. Refill requests are still to be called into your pharmacy, without exception.** Your pharmacist in turn will take care of receiving authorization for renewal of the medication from us.

As stated in previous communication, we recommend that you plan your refill needs carefully. You will need to plan at least 24 hours for your refill request to be processed, or the following Monday if your request was received on a Thursday. Please keep in mind that any prescriptions for controlled substances will not be renewed until 2-3 days before your refill is due.

Sincerely,

Roswitha Konz, M.A.
Clinical Director

PARENTAL INFORMATION SHEET

CHILD: _____ TODAY'S DATE: _____

CHILD LIVES WITH: _____
(NAME)

_____
(STREET ADDRESS)

_____
(STATE/ZIP)

_____
(TELEPHONE)

_____
(RELATIONSHIP TO CHILD)

BIOLOGICAL FATHER: _____
(NAME)

_____
(STREET ADDRESS)

_____
(STATE/ZIP)

_____
(TELEPHONE)

BIOLOGICAL MOTHER: _____
(NAME)

_____
(STREET ADDRESS)

_____
(STATE/ZIP)

_____
(TELEPHONE)

PARENTS ARE
(Please check one) [ ] married and living together [ ] married and separated

[ ] legally divorced [ ] not married and living together

[ ] not married and living separately

(if divorced or living separately, please check one) [ ] both parents have legal custody

[ ] mother's parental rights have been terminated

[ ] father's parental rights have been terminated

DAKOTA COUNSELING INSTITUTE
CHILD/ADOLESCENT PARENT QUESTIONNAIRE

IDENTIFYING INFORMATION

Child's Name:_____ Today's Date:_____

Child's Date of Birth:_____ Child's Age:_____ Sex: Male___ Female___

PRESENTING PROBLEM

Reason for today's visit? _____

_____

When did these problems begin? _____

PARENTS, SIBLINGS, AND OTHERS IN HOME

Mother's Name: _____ Mother's Age: _____

Occupation: _____ (Full-time/part-time?)

Education/highest grade completed: _____

Father's Name: _____ Father's Age: _____

Occupation: _____ (Full-time/part-time?)

Education/highest grade completed: _____

Does your child have stepparents? No ___ Yes ___
If yes, please complete the following information:

Name(s): _____

Relationship(s) to child: _____

Address(es)/phone(s): _____

_____

Is the child adopted or being raised by persons other than his/her biological parents? No ____ Yes ____

If yes, explain: _____

_____

Names of siblings	Age	Gender	Lives at child's home?	Nature of relationship with child?
1.				
2.				
3.				

Please list any others living in the household:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

FAMILY CIRCUMSTANCES

Who cares for the child when parents or caregivers are at work or gone? _____

With whom does the child currently live? _____

Are the parents divorced or separated? No ____ Yes ____

If yes, who has custody? _____

How often does the noncustodial parent see the child? _____

How frequently does this child see her/his grandparents? _____

Has the family recently experienced any unusual or stressful events? No ____ Yes ____

If yes, explain: _____

PREGNANCY

Did the mother receive prenatal care? No ____ Yes ____

If yes, what kind? _____

Length of pregnancy: _____

Did the mother experience any emotional or medical difficulties during the pregnancy? No ____ Yes _____

If yes, explain: _____

Length of labor: _____hours Apgar scores: _____

Birth weight: ____lbs. _____oz. Length: _____inches

DEVELOPMENT

Was this child breast-fed or bottle-fed? _____ Age weaned: _____

Did the child experience any of the following problems during infancy or toddlerhood? If yes, please explain.

Colic	No ___ Yes ___
Excessive crying	No ___ Yes ___
Delayed language development	No ___ Yes ___
Unclear speech	No ___ Yes ___
Eating problems	No ___ Yes ___
Delayed fine motor skills	No ___ Yes ___
Delayed gross motor skills	No ___ Yes ___

At what approximate age did your child begin exhibiting the following behaviors?

Crawled: _____ Sat alone: _____

Walked independently: _____ Spoke first words: _____

Spoke in sentences: _____ Was toilet trained: _____

For an adolescent, please indicate the following:
Age at onset of puberty: _____ Age at first menstruation (for a girl): _____

Which hand does your child use for writing? _____ Eating? _____

Throwing? _____ Other? _____

Has your child been the victim of abuse? No __ Yes __

If yes, please explain: _____

MEDICAL AND PSYCHIATRIC HISTORY

Name of child's primary care physician: _____

Address: _____

Phone: _____

Date of most recent physical exam: _____ Results: _____

Date of most recent dental exam: _____ Results: _____

Date of most recent vision exam: _____ Results: _____

Date of most recent hearing exam: _____ Results: _____

Has the child experienced any of the following medical problems? If yes, please explain.

Frequent colds	No __ Yes __	Vision problems	No __ Yes __
Frequent ear infections	No __ Yes __	Does your child wear glasses?	No __ Yes __
Asthma	No __ Yes __	Hearing problems	No __ Yes __
Gastrointestinal problems	No __ Yes __	Cerebral palsy	No __ Yes __
Muscle pain	No __ Yes __	Lead poisoning	No __ Yes __
Skin problems	No __ Yes __	Seizures	No __ Yes __
Repetitive behaviors (head banging, rocking, etc.)	No __ Yes __	Congenital problems	No __ Yes __
Allergies	No __ Yes __		

Please list any other health concerns: _____

Medication

Is your child currently taking any kind of medication? No __ Yes __

If yes, indicate name, dose, and reason for medication: _____

Is your child experiencing any side effects from the medication(s)? _____

Alcohol or Drug Use

Does your child use alcohol or drugs? No ___ Yes ___

If yes, explain: _____

Does anyone in your family have a history of drug or alcohol abuse? No ___ Yes ___

If yes, is there current drug or alcohol abuse in the home? No ___ Yes ___ By whom? _____

Previous Evaluations

Has your child ever had any of the following evaluations? If yes, please indicate name of examiner, date of examination, and reason for exam.

Psychological evaluation: No ___ Yes ___

If yes, name of evaluator: _____ Date of evaluation: _____

Reason for evaluation: _____

Psychiatric evaluation: No ___ Yes ___

If yes, name of evaluator: _____ Date of evaluation: _____

Reason for evaluation: _____

Neurological/Neuropsychological evaluation: No ___ Yes ___

If yes, name of evaluator: _____ Date of evaluation: _____

Reason for evaluation: _____

Treatment History

Has your child ever received counseling or psychiatric treatment? No ___ Yes ___

If yes, indicate dates, name of treating professional, reason for treatment, and effectiveness of treatment:

_____

_____

Family's Health

Mother's present health: _____

Father's present health: _____

Has anyone in your family experienced a mental, psychological, or academic problem, such as mental retardation, learning disabilities, schizophrenia, depression, epilepsy, or a bipolar disorder? No ___ Yes ___

If yes, explain: _____

SOCIAL HISTORY

How does your child relate to other children? _____

Does your child prefer to play with younger or older children? No ___ Yes ___

If yes, indicate which (younger or older) and explain: _____

Does your child have a best friend? No ___ Yes ___

How many friends does your child have? _____

RECREATIONAL INTERESTS

Does your child participate in sports or recreational activities outside of school? No ___ Yes ___

If yes, describe: _____

What does your child like to do in his/her free time? _____

_____

Have the child's interests in these activities changed recently? No ___ Yes ___

If yes, please explain: _____

What are your family's favorite activities? _____

BEHAVIORAL SYMPTOMS

Does your child have difficulty with any of the following problems? If yes, please explain.

Has trouble meeting new people; is shy or withdrawn	No ___ Yes ___
Is overly anxious	No ___ Yes ___
Seems sad or depressed	No ___ Yes ___
Has thought of suicide	No ___ Yes ___
Refuses to comply with adults' requests or violates parental rules	No ___ Yes ___
Has conduct problems	No ___ Yes ___
Is physically cruel to other people or animals	No ___ Yes ___
Is inattentive	No ___ Yes ___
Problems concentrating	No ___ Yes ___
Is restless	No ___ Yes ___
Makes careless mistakes	No ___ Yes ___
Has trouble playing quietly	No ___ Yes ___
Has frequent mood shifts	No ___ Yes ___
Frustrates easily	No ___ Yes ___
Has difficulty managing anger	No ___ Yes ___
Has eating problems	No ___ Yes ___
Has fears/phobias	No ___ Yes ___
Has hallucinations	No ___ Yes ___
Has experienced trauma	No ___ Yes ___

Has your child ever experienced difficulty with the law? No ___ Yes ___

If yes, explain: _____

EDUCATIONAL STATUS AND HISTORY

Current Status

Name of current school: _____ Grade: _____

Type of school: Private ___ Public ___ Home-schooled ___ Other _____
Teacher(s): _____

School Address: _____

School phone number: _____

Does your child currently receive any special education services? No ___ Yes ___

If yes, please specify: _____

What grades does the child currently receive? _____

Is this a change from previous years? No ___ Yes ___

If yes, explain: _____

School History

Preschool: At what age? _____ For how many days/hours? _____

Any Problems? No ___ Yes ___ If yes, describe: _____

Did the child have difficulty or receive any special education services in any of the following grades? If so, explain.

Kindergarten	No ___ Yes ___
Grades 1-3	No ___ Yes ___
Grades 4-6	No ___ Yes ___
Grades 7-8	No ___ Yes ___
High School	No ___ Yes ___

Does your child dislike going to school? No ___ Yes ___

If yes, why? _____

What are your child's current favorite subjects? _____

What are your child's least favorite subjects? _____

What is your child's approach to his/her schoolwork (disorganized/organized, irresponsible/responsible, etc)?

_____

WORK HISTORY

Does your child have a job, or is your child involved in a vocational program? No ___ Yes ___

If yes, who is the child's current employer? _____

Child's position: _____ Hours worked per week: _____

INTAKE QUESTIONAIRE – CHILD VERSION – AGES 8- 11

NAME:_____ TODAY'S DATE:_____

GRADE IN SCHOOL_____

ADDRESS:_____

Who brought you to today's appointment?_____

Why does this person want you to be seen?_____

What kinds of things would you like to change about yourself or about your family?_____

_____

_____

What kinds of things do others say you need to change or improve upon?_____

_____

Please answer the following questions by circling either YES or NO:

It is easy for me to make friends at school.	YES / NO
I like my teacher.	YES / NO
I get along with my parents most of the time.	YES / NO
I sometimes wake up at night and have a hard time going back to sleep.	YES / NO
I have one best friend with whom I play even outside of school.	YES / NO
School work is hard for me.	YES / NO
I keep thinking about bad stuff in my head.	YES / NO
I worry almost all of the time.	YES / NO
I think others like me.	YES / NO
I think I am too fat.	YES / NO
I feel safe at school.	YES / NO
My brothers/sisters and I fight a lot.	YES / NO
Sometimes I wish I were dead.	YES / NO

Please tell us what kinds of things you like to do: _____

_____

_____

CIRCLE ALL THE FOLLOWING THAT DESCRIBE HOW YOU USUALLY INTERACT WITH OTHER PEOPLE:

I'M A FOLLOWER	SELF-SACRIFICING	ISOLATE MYSELF	MANIPULATIVE	CONFIDENT
COOPERATIVE	INDEPENDENT	QUIET	JOKER	ARGUMENTATIVE
EASILY HURT	I'M A LEADER	BRAGGING	SOCIABLE	RESPECTFUL

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD:

NAME	RELATIONSHIP TO YOU	AGE	DESCRIBE HOW YOU GET ALONG WITH HIM/HER

PLEASE DESCRIBE YOUR RELATIONSHIP WITH YOUR PARENTS BY CIRCLING THOSE THAT APPLY:

WE ARGUE A LOT THEY ARE TOO STRICT WE JOKE AROUND TOGETHER THEY SAY HURTFUL THINGS TO ME

I SNEAK AROUND THEM WE EAT MEALS TOGETHER WE ALL GO OUR OWN WAY THEIR RULES ARE REASONABLE

THEY RESPECT ME I RESPECT THEM THEY YELL A LOT THEY FIGHT ARGUE WITH EACH OTHER

I GET PHYSICALLY HURT BY THEM SOMETIMES

SCHOOL EXPERIENCE

NAME OF SCHOOL:_____CURRENT GRADE LEVEL:_____

CURRENT GRADES (Please circle all that apply): A's B's C's D's F's

FAVORITE SUBJECT_____LEAST FAVORITE SUBJECT_____

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING STATEMENTS

I generally like my teachers.	YES / NO
Others tease me at school.	YES / NO
I enjoy socializing with other students at lunch.	YES / NO
I skip class or a whole day of school a couple of times a month.	YES / NO
I like most of my classes.	YES / NO
I am tardy many days.	YES / NO
I felt mad enough to hurt people at school.	YES / NO
I feel respected at school.	YES / NO
I have been suspended/expelled from school in the past.	YES / NO
I enjoy extra-curricular activities.	YES / NO
School is very stressful for me.	YES / NO

INTAKE QUESTIONAIRE – ADOLESCENT VERSION – AGES 12-17

NAME:_____ SEX: M F AGE:____ DATE:_____

What are your reasons for coming in today?_____

_____

_____

What are your parents'/legal guardians' reasons for bringing you in today?_____

_____

_____

Please check any of the following experiences you have had during the past month:

___SAD, BLUE OR DEPRESSED	___ANXIETY/WORRYING	___SUDDEN PANIC OR FEAR
___UNABLE TO HAVE FUN	___LESS NEED FOR SLEEP	___GETTING INTO FIGHTS
___FEELING WORTHLESS/HOPELESS	___CANNOT STAY FOCUSED	___INTRUSIVE THOUGHTS
___FEELINGS OF GUILT	___FEEL BETTER THAN USUAL	___CONFUSED THINKING
___I FEEL FAT/OVERWEIGHT	___RESTLESSNESS	___NIGHTMARES
___DIFFUCULTY FALLING ASLEEP	___WORRY ALL THE TIME	___IRRITABLE WITH PARENTS
___DIFFUCULTY STAYING ASLEEP	___MY THOUGHTS ARE RACING	___HEARING VOICES IN MY HEAD
___I WISH I WERE DEAD	___I CAN'T SIT STILL	___SEEING THOUGHTS
___USE OF ALCOHOL	___USE OF CIGARETTES	___USE OF OTHER DRUGS
___FEEL ANGRY A LOT	___I DON'T LIKE MYSELF	___I THINK I AM DUMB/STUPID
___GETTING TEASED AT SCHOOL	___GETTING BULLIED AT SCHOOL	___NO FRIENDS AT SCHOOL
___THROW UP AFTER I EAT	___FELT LIKE HURTING SOMEONE	___LOST/GAINED WEIGHT

ARE YOU A VICTIM OF ABUSE? (CIRLCE YES OR NO)

Has anyone ever touched you in your private parts? YES / NO

If yes, have you told anyone about it? YES / NO

Has an adult ever hit, kicked or otherwise hurt you? YES / NO

If yes, have you told anyone about it? YES / NO

Does someone say things to you everday that make you fell bad inside? YES / NO

Have you seen adults hit or fight in your home? YES / NO

CIRCLE ALL THE FOLLOWING THAT APPLY TO YOUR SOCIAL EXPERIENCE:

ONE BEST FRIEND	DRUG USE WITH FRIENDS	SLUFFING SCHOOL
WITHDRAWN FROM SOCIAL SCENE	PHYSICAL VIOLENCE WITH FRIENDS	SEXUAL RELATIONSHIPS
PARTYING	GANG RELATED ACTIVITY	SPORTS RELATED ACTIVITY
SCHOOL DANCES	GOING TO MOVIES WITH FRIENDS	FEW FRIENDS
GOING TO THE GYM	DATING	BREAKING RULES
GETTING HURT	SHOWING OFF FOR PEOPLE	
WORRIED OR ANXIOUS AROUND PEOPLE	DESTRUCTION OF PROPERTY WITH FRIENDS	

CIRCLE ALL THE FOLLOWING THAT DESCRIBE HOW YOU USUALLY INTERACT WITH OTHER PEOPLE:

I'M A FOLLOWER	SELF-SACRIFICING	ISOLATE MYSELF	MANIPULATIVE	CONFIDENT
COOPERATIVE	INDEPENDENT	QUIET	JOKER	ARGUMENTATIVE
EASILY HURT	I'M A LEADER	BRAGGING	SOCIABLE	RESPECTFUL

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD:

NAME	RELATIONSHIP TO YOU	AGE	DESCRIBE HOW YOU GET ALONG WITH HIM/HER

PLEASE DESCRIBE YOUR RELATIONSHIP WITH YOUR PARENTS BY CIRCLING THOSE THAT APPLY:

WE ARGUE A LOT THEY ARE TOO STRICT WE JOKE AROUND TOGETHER THEY SAY HURTFUL THINGS TO ME

I SNEAK AROUND THEM WE EAT MEALS TOGETHER WE ALL GO OUR OWN WAY THEIR RULES ARE REASONABLE

THEY RESPECT ME I RESPECT THEM THEY YELL A LOT THEY FIGHT ARGUE WITH EACH OTHER

I GET PHYSICALLY HURT BY THEM SOMETIMES

SCHOOL EXPERIENCE

NAME OF SCHOOL:_____CURRENT GRADE LEVEL:_____

CURRENT GRADES (Please circle all that apply): A's B's C's D's F's

FAVORITE SUBJECT_____LEAST FAVORITE SUBJECT_____

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING STATEMENTS

I generally like my teachers.	YES / NO
Others tease me at school.	YES / NO
I enjoy socializing with other students at lunch.	YES / NO
I skip class or a whole day of school a couple of times a month.	YES / NO
I like most of my classes.	YES / NO
I am tardy many days.	YES / NO
I felt mad enough to hurt people at school.	YES / NO
I feel respected at school.	YES / NO
I have been suspended/expelled from school in the past.	YES / NO
I enjoy extra-curricular activities.	YES / NO
School is very stressful for me.	YES / NO

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	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 or 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 are 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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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
☐	☐	☐	☐

Division of Behavioral Health
Mental Health Outcome Tool
Family
INITIAL

Todays' Date: _____/_____/_____

Client STARS ID:|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Program ☐ CYF Services (SED) ☐ ART
☐ MRT ☐ FFT

---

1. Would you say that in general your child's health is:

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

a. Now thinking about your child's physical health, which includes physical illness and injury, how many days during the past 30 days was your child physical health not good? ____

b. Now thinking about your child's mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your child's mental health not good? ____

c. During the past 30 days, approximately how many days did your child's poor physical or mental health keep you from doing your child's usual activities, such as self-care, school, work, or recreation? ____

2. Please answer the following question	Number of Nights/Times	Don't know
In the past 30 days, how many times has your child been arrested? *Federally Required Element	____	☐

3. Please answer the following questions based on the <u>past 6 months</u>...	Number of Nights/Times	Don't know
a. How many times has your child gone to an emergency room for a psychiatric or emotional problem?	____	☐
b. How many nights has your child spent in a facility for:		
i. Detoxification?	____	☐
ii. Inpatient/Residential Substance Use Disorder Treatment?	____	☐
iii. Mental Health Care?	____	☐
iv. Illness, Injury, Surgery?	____	☐
c. How many times has your child been arrested?	____	☐
d. How many nights has your child spent in a correctional facility including JDC or Jail (as a result of an arrest, parole or probation violation)?	____	☐
e. How many times has your child tried to commit suicide? *Federally Required Element	____	☐

Family MH Form –Initial Interview

4. Please indicate your level of agreement or disagreement with the statements by checking the choice that best represents your feelings or opinion over the past 6 months. (Please answer for relationships with persons other than your behavioral health provider(s).) *Federally Required	Response Options						
	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Not applicable	Refused
Domain: Social Connectedness Questions 1-4							
1. My child knows people who will listen and understand them when they need to talk.	☐	☐	☐	☐	☐	☐	☐
2. In a crisis, my child would have the support they need from family and friends.	☐	☐	☐	☐	☐	☐	☐
3. My child has people that he/she are comfortable talking with about their problems.	☐	☐	☐	☐	☐	☐	☐
4. My child has people with whom they can do enjoyable things.	☐	☐	☐	☐	☐	☐	☐
Domain: Improved Functioning Domain: Questions 5-11							
5. My child is able to do things he or she wants to do.	☐	☐	☐	☐	☐	☐	☐
6. My child gets along with family members.	☐	☐	☐	☐	☐	☐	☐
7. My child gets along with friends and other people.	☐	☐	☐	☐	☐	☐	☐
8. My child does well in school and/or work.	☐	☐	☐	☐	☐	☐	☐
9. My child is able to cope when things go wrong.	☐	☐	☐	☐	☐	☐	☐
10. My child is able to handle daily life.	☐	☐	☐	☐	☐	☐	☐
11. I am satisfied with our family life right now.	☐	☐	☐	☐	☐	☐	☐

Chestnut Health Systems

GAIN
GLOBAL APPRAISAL OF INDIVIDUAL NEEDS
Coordinating Center

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|__| / |__|__| / 20 |__|__|

The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0
IDScr 1. **When was the last time** that you had **significant** problems with…					
a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
e. thinking about ending your life or committing suicide?	4	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0
EDScr 2. **When was the last time** that you did the following things **two or more times**?					
a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
d. Had a hard time waiting for your turn.	4	3	2	1	0
e. Were a bully or threatened other people	4	3	2	1	0
f. Started physical fights with other people	4	3	2	1	0
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0
SDScr 3. **When was the last time** that…					
a. you used alcohol or other drugs weekly or more often?	4	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0

(Continued)

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.

	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone? 4 3 2 1 0
b. took something from a store without paying for it? 4 3 2 1 0
c. sold, distributed, or helped to make illegal drugs? 4 3 2 1 0
d. drove a vehicle while under the influence of alcohol or illegal drugs? 4 3 2 1 0
e. purposely damaged or destroyed property that did not belong to you? 4 3 2 1 0

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) ..... Yes 1 No 0

v1. _____

_____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

v1. _____

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Staff Use Only

8. Site ID: _____ Site name v. _____
9. Staff ID: _____ Staff name v. _____
10. Client ID: _____ Comment v. _____
11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered
13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: _____
15. Referral comments: v1. _____

Scoring

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				

Division of Behavioral Health
Mental Health Outcome Tool
Youth
INITIAL

Todays' Date: ____/____/____

Client STARS ID: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Program ☐ CYF Services (SED) ☐ ART ☐ MRT ☐ FFT

1. Would you say that in general your health is:

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

a. Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good? ___

b. Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good? ___

c. During the past 30 days, approximately how many days did your poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? ___

2. Please answer the following question	Number of Nights/Times	Don't know
In the past 30 days, how many times have you been arrested? *Federally Required Element	____	☐

3. Please answer the following questions based on the <u>past 6 months</u>...	Number of Nights/Times	Don't know
a. How many times have you gone to an emergency room for a psychiatric or emotional problem?	____	☐
b. How many nights have you spent in a facility for:		
i. Detoxification?	____	☐
ii. Inpatient/Residential Substance Use Disorder Treatment?	____	☐
iii. Mental Health Care?	____	☐
iv. Illness, Injury, Surgery?	____	☐
c. How many times have you been arrested?	____	☐
d. How many nights have you spent in a correctional facility including JDC or Jail (as a result of an arrest, parole or probation violation)?	____	☐
e. How many times have you tried to commit suicide? *Federally Required Element	____	☐

Youth MH Form –Initial Interview

4. Please indicate your level of agreement or disagreement with the statements by checking the choice that best represents your feelings or opinion over the past 6 months. (Please answer for relationships with persons other than your behavioral health provider(s).) *Federally Required	Response Options						
	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Not applicable	Refused
Domain: Social Connectedness Questions 1-4							
1. I know people who will listen and understand me when I need to talk.	☐	☐	☐	☐	☐	☐	☐
2. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐	☐
3. I have people that I am comfortable talking with about my problems.	☐	☐	☐	☐	☐	☐	☐
4. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐	☐
Domain: Improved Functioning Domain: Questions 5-11							
5. I am able to do things I want to do.	☐	☐	☐	☐	☐	☐	☐
6. I get along with family members.	☐	☐	☐	☐	☐	☐	☐
7. I get along with friends and other people.	☐	☐	☐	☐	☐	☐	☐
8. I do well in school and/or work.	☐	☐	☐	☐	☐	☐	☐
9. I am able to cope when things go wrong.	☐	☐	☐	☐	☐	☐	☐
10. I am able to handle my daily life.	☐	☐	☐	☐	☐	☐	☐
11. I am satisfied with my family life right now.	☐	☐	☐	☐	☐	☐	☐

Question to be answered by Clinician

GAIN Short Screener (GAIN-SS) Scoring					
Screener	Items	Past Month (4)	Past 90 Days (4, 3)	Past Year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDSer	1a – 4e				