STEPPING STONES REHABILITATION SERVICES

FOR OFFICE USE ONLY

DATE:_____

CID_____

STARS ID_____

PHONE:_____(HOME)

_____(CELL)

_____(WORK)

NAME:_____

LAST FIRST MIDDLE MAIDEN

ADDRESS:_____

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

EMAIL ADDRESS:_____ May we contact you at this address? ☐ YES ☐ NO

COUNTY:_____ DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

SEX: ☐ MALE ☐ FEMALE PREGNANT: ☐ YES ☐ NO DUE DATE:

PRIMARY RACE_____ SECONDARY RACE _____ VETERAN: ☐ YES ☐ NO

ENGLISH PROFICIENCY MOTHER'S NAME RELIGION

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED

REFERRAL SOURCE:_____ LEGAL GUARDIAN'S NAME: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL:_____

ADDRESS:_____

MEDICARE #:_____ MEDICAID (TITLE XIX) #:_____

INSURANCE COMPANY:_____

POLICY/ID NUMBER: _____ GROUP NUMBER: _____

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? ☐ FULL-TIME ☐ PART-TIME ☐ UNEMPLOYED ☐ RETIRED

DURATION OF EMPLOYMENT/UNEMPLOYMENT:_____

SOURCE OF INCOME _____TOTAL YEARLY HOUSEHOLD INCOME _____

PHYSICIAN: DATE OF LAST PHYSICAL:_____

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

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?_____

NUMBER OF DUI CHARGES IN THE LAST 10 YEARS _____

NUMBER OF CONVICTIONS *OTHER* THAN DUI _____

CONSENT FOR INFORMATION DISCLOSURE

I,_____, hereby authorize the exchange of information between **Stepping Stones/DCI** and the SD DEPARTMENT OF SOCIAL SERVICES, DIVISION OF BEHAVIORAL HEALTH and the **re-disclosure** of that information by **Stepping Stones/DCI** and the SD Division of Behavioral Health to:

__X__ DSS Division of Medical Services for Medicaid information
__X__ South Dakota Foundation for Medical Care
____ South Dakota Department of Health
____ DSS Division of Correctional Behavioral Health
____ South Dakota Department of Corrections or Juvenile Corrections Agent _____
____ Unified Judicial System or Court Services Officer, _____
____ My parents and/or legal guardian and/or prospective foster parents _____
__X__ Mountain Plains Research for purpose of reporting required demographic information
____ Law Enforcement Officials (City and/or County)
____ My current and/or former educational institution for purpose of obtaining academic information
__X__ The designated accredited alcohol and drug treatment provider and/or funding source necessary to facilitate my entry into chemical dependency treatment or services.
____ Physician, IHS, and/or Medical Clinic/Facility _____
____ Other _____
____ Other _____

Purpose of and need for the disclosure is to inform the person(s) or agency(ies) listed above of my:

__X__ Treatment Needs Assessment and DSS Approval Form
__X__ Diagnosis and Treatment Recommendations
__X__ Eligibility for treatment services
__X__ Financial Information and Funding Sources
__X__ Medical, dental, and/or eye care information and/or eligibility
__X__ Treatment Plan and/or Continued Care Reviews
__X__ Attendance, cooperation, and progress in treatment
__X__ Discharge Summary and/or Aftercare Plans
__X__ Group data for reports to evaluate outcome of treatment
__X__ Education Information
__X__ Legal Information
____ Other (be specific): _____

The above information will be used for the following: To provide the above noted individuals with information requested as noted above, about the individual named above, to coordinate all available information to ensure placement in the appropriate level of care, to ensure adequate funding, determine the diagnosis, course of treatment, follow-up, or need for other services, to ensure a full continuum of care and to ensure quality services.

I understand that *some or all of this information may at times be communicated via electronic transmission.*

I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it, by signing the revocation section of my copy of this form and returning it to ___Staff___ at ___Stepping Stones/DCI___. In any event, this consent will expire automatically as follows:

One year after this consent form is signed OR

_____.

(Specification of the date, event or condition upon which this consent expires)

I also understand that my alcohol and/or treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F. R. Pts. 160 & 164, and 42 U.S.C. §§ 290 dd-2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may redisclose it only in connection with their official duties.

Dated:_____ **Client Signature:** _____

Witness Signature: _____

REVOCATION SECTION I hereby revoke this consent

_____ _____

(Signature) (Date)

Revised 02/21

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTE: Please fill out a separate release for each person, facility, etc.

I, _____, authorize Stepping Stones/
CLIENT NAME Dakota Counseling Institute
901 South Miller
☐ Release/Obtain Information: Mitchell, SD 57301

(include Name, Address, Phone, and/or Fax when applicable) _____

_____

_____

This information is regarding _____
CLIENT NAME

_____ - _____ - _____ _____
SOCIAL SECURITY NUMBER DATE OF BIRTH

The following information is being released/requested: (be specific, "entire file" requests cannot be honored.)

☐ treatment needs assessment
☐ treatment plan and/or continued care reviews
☐ diagnosis & treatment recommendations
☐ progress notes/group notes
☐ financial information and funding sources
☐ legal information
☐ discharge summary and/or aftercare plans
☐ medical, dental, and/or eye care information/eligibility
☐ other (be specific) _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that I have the right to refuse to sign this authorization and am not required to sign this form to receive treatment or be eligible for services. I also understand that my alcohol and/or treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may re-disclose it only in connection with their official duties. I understand that any revocation does not cover materials released prior to receipt of the written revocation by Dakota Counseling Institute. I understand that records may be faxed to the requesting recipient. Unless revoked earlier, this authorization will be effective for one year from the date signed.

Expiration Date: _____ / _____ / _____

_____ _____
WITNESS CLIENT

_____ _____
DATE PARENT/GUARDIAN

_____ _____
Phone:(605) DATE

(NOTE: A COPY SHALL BE AS VALID AS THE ORIGINAL DOCUMENT)

Revised 6/17/21

FINANCIAL ELIGIBILITY (Calendar Year 2026)

Instructions
Please read and complete all questions on this form. This information will be used to determine your eligibility for services funded by the Division of Behavioral Health.

Behavioral Health Provider Use Only	
☐ **Eligible** – Annual Review Date:	
☐ **Ineligible**	BH Provider:
CID #:	Signature:

Personal Information *(Please Print)*

Client Name: _____
(First) *(MI)* *(Last)*

Parent/Guardian or Representative (if applicable): _____

☐ Yes ☐ No I (SED or SUD client) have applied for and been denied Medicaid and CHIP-NM.
☐ Yes ☐ No I (SMI client) have applied for and been denied SSI.

Description of Household

Total Number of Persons Living in Household (dependent on household income): _____

Financial Information

Annual Gross Income: All sources of earned and unearned income for the household members included above. Do not include any income earned from a child under the age of 18 or any dependent attending school.

1) Earned Income *(i.e. wages)* $_____

2) Unearned Income *(i.e. child support, TANF, SSDI)* $_____

Minus Annual Deductions/Expenses:

3) $_____ Earned Income Deduction *(Deduct 20% of Earned Income. Do not deduct 20% from unearned income.)*

4) $_____ Childcare Expenses *(up to $6.000/year)*

5) $_____ Child Support Payments

6) $_____ Annual out of pocket prescription medication costs and lab work.

7) $_____ Annual health insurance premiums.

8) $_____ Assistive devices purchased within the last 12 months.

(describe) _____

Annual Net Income:

9) $_____ *(deduct lines 3 through 8 from line 1 and 2)*

Household Size	Annual Income
1	$29,526
2	$40,034
3	$50,542
4	$61,050
5	$71,558
6	$82,066
7	$92,574
8	$103,082
9	$113,590
10	$124,098

I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report changes in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services. I understand that if I am determined eligible and my situation should change before my annual review date, it is my responsibility to notify the Behavioral Health Provider so that eligibility can be reevaluated. Eligibility could be affected by increases in income, changes in the number of persons in the household, and/or any other significant change in financial circumstance.

_____
Signature (Client or Parent/Guardian Date

STEPPING STONES

Alcohol/Substance Abuse Rehabilitation Services

901 South Miller • Mitchell, SD 57301 • (605) 995-8180 • Fax (605) 995-8183

MICHELLE CARPENTER
Executive Director

JAMAE OETKEN
Clinical Supervisor

Date of Screening: _____

Client Name: _____

TB Screening

1. **A Productive Cough for a 2-3 week Duration? Yes_____ No_____**
   If answer Yes: Explain:_____
   _____
   _____.

2. **Any Unexplained Night Sweats? Yes_____ No _____**

3. **Any Unexplained Fevers? Yes _____ No _____**

4. **Any Unexplained Weight Loss? Yes _____ No _____**

CLIENT RIGHTS

Clients of Dakota Counseling Institute, Inc. dba as Stepping Stones are guaranteed all basic human rights of citizenship unless these rights have been previously withdrawn due to a client's legal status. The following are client rights that have been established:

1. The right to seek and have access to legal counsel.
2. The right to refuse extraordinary treatment.
3. The right to refuse to be a subject in a human research project.
4. The right to confidentiality in all records, correspondence, and conversations relating to treatment except with written consent.
5. The right to reasonable visitation with family and friends.
6. The right to conduct private telephone conversations.
7. The right to communicate with a physician.
8. The right to send and receive uncensored and unopened mail.
9. The right to practice a religion and attend religious services.
10. The right to a grievance procedure if the above rights have been violated.
11. The right to be free from sexual exploitation and financial exploitation from staff or others associated with Dakota Counseling Institute, Inc.

Clients who feel their rights have been violated may file a grievance as outlined in the Grievance Policy and Procedures.

GRIEVANCE POLICY

1. If you feel that any of your rights as a client at the treatment program have been violated, please discuss the matter immediately with your counselor. The counselor will attempt to resolve your concern(s) in a prompt and efficient manner.
2. If you are not satisfied with the response that the counselor has given you, you have the right to bring questions and concerns regarding your rights to the Clinical Supervisor. The Clinical Supervisor will fully investigate the situation and will respond with options within two business days.
3. If the Clinical Supervisor does not resolve the concern, you have the right to appeal to the Executive Director. The appeal must be in writing, signed, and dated within two business days. The Executive Director will either resolve the issue or refer you to a hearing committee within two business days.
4. The hearing committee will hear the concern(s) and respond to you in writing within 24 hours. This decision of the hearing committee is final.

I HAVE READ AND FULLY UNDERSTAND THE PROGRAM DESCRIPTION, CLIENT RIGHTS, AND GRIEVANCE PROCEDURE.

Client Signature	**Date**
Witness Signature	**Date**

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

Revised 4-22-19

FINANCIAL AGREEMENT

The typical fees for ADULT services are as follows:

Treatment Needs Assessment	$ 250.00
Intensive Outpatient Treatment	$ 3500.00
Detox	$ 100.00 per day
Aftercare	$ 75.00 private pay
MRT	$ 125.00 book and $75.00 class
Individual	$ 25.00 per session
DUI	$ 325.00
UA's	$ 30.00
Anger Management	$ 75.00

These fees apply if they don't have Title XIX or other Insurance.

The typical fees for ADOLESCENT services are as follows:

Treatment Needs Assessment	$ 250.00
Individual	$ 125.00
Diversion	$ 125.00

These fees apply if the adolescent doesn't have Title XIX except for the diversion fee; that doesn't change.

These rates are subject to adjustment due to program qualifications and assistance.

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. Some reasons for denial may be pre-existing conditions, non-covered diagnosis, or no mental health benefits. 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, and, when applicable, the insurance company.

Dakota Counseling Institute will work with patients 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 1.5% per month.

I have read and understand the above information.

_____ _____

Signature of Client Date

_____ _____

Witness Date

Updated 06/01/2024

NOTICE TO CLIENTS OF FEDERAL CONFIDENTIALITY LAW

The confidentiality of alcohol and other drug abuse patient records maintained by this program are protected by federal law and regulations. The program may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as an alcohol or other drug abuser unless:

1) The patient consents in writing.

2) The disclosure is allowed by a court order.

3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal laws and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal laws and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse and neglect from being reported under state law to appropriate state and local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal law and 42 CFR Part 2 for federal regulations).

I have read the above information and understand its provisions. I have received a true copy of the same.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

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 a written acknowledgment that you have received a copy of this Notice.

Patient Acknowledgment or 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.

☐ The Notice of Privacy Practices was mailed to the client/parent/legal guardian.

☐ Other _____

_____

Witness Date

Informed Consent for TeleBehavioral Health Services

The following information is provided to clients who are seeking TeleBehavorial Health therapy. This document covers your rights, risks and benefits associated with receiving TeleBehavorial Health services, our policies, and your authorization. Please read this document carefully, note any questions you would like to discuss, and sign.

TeleBehavioral Health Defined:
TeleBehavioral Health means the remote delivery of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secure by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting (via Zoom) is our preferred method of service delivery.

Limitations of TeleBehavioral Health Therapy Services
While TeleBehavioral Health offers serval advantages such as convenience and flexibility, it is an alternative form of therapy or adjust to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service on your or our side (e.g. phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. In addition, there is a risk of misunderstanding the intended message without face-to-face visual or auditory cues. For example, it may be difficult to pick up on facial expressions or auditory nuances in what is being said.
Additionally, the therapy office decreases the likelihood of interruptions. Interruptions can be minimized and privacy maximized by finding a private and quiet location on your end where sessions can be conducted. We will use therapist's offices with the door closed for maximum privacy. Visual sessions must be conducted on a WI-FI connection for the best connection and to minimize disruption.

In Case of Technology Failure
We understand that during a TeleBehavioral Health session we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party (e.g. internet provider) may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call the office at 605-995-8180. Please make sure you have a phone available to you, and that we have the correct phone number for you. We may also reschedule if there are problems with connectivity.

Structure and Cost of Sessions
Our preferred method of service delivery for psychotherapy services is face-to-face. However, based on your ability to make in-person sessions and our availability, we may provide virtual psychotherapy if your treatment needs determine that TeleBehavioral Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, or a combination of TeleBehavioral Health and face-to-face sessions. We will discuss what is best and what works best for you.
Although most third payors do pay for TeleBeahvioral Health services, you remain responsible for

any and all cost of treatment, whether provided in person or via TeleBehavioral Health. Please contact your insurance provider to verify coverage for TeleBehavioral Health services.

The structure and cost of TeleBehavioral Health sessions are exactly the same as for face-to-face sessions described in other documents provided to you.

Email
Email is not a secure means of communication and may compromise your confidentiality. If you are in a crisis please do NOT communicate this via email as we will not receive your message in a timely manner.

Social Media – Facebook, Twitter, LinkedIn, Instagram, Pinterest, etc.
Please refrain from making contact with therapists via any social media site or any social media messaging systems. Adding clients as friends or contacts on any of these sites or messaging systems can compromise your confidentiality and the privacy of both clients and therapists. It may also blur the boundaries of the therapeutic relationship. If you have any questions about this, please bring these up with your provider.

Cancellation Policy
In the event that you are unable to keep either a face-to-face appointment or a TeleBehavioral Health appointment, you must notify the office at 605-995-8180 at least 24-hours in advance. If such advance notice is not received, your appointment will be considered a no show. If you no show, any future appointments that were scheduled to "reserve" a particular time and day for you will be cancelled. After three no shows we may discuss discontinuation of services.

Emergency Management Plan
In the event of crisis, please call our office and you will be scheduled with another provider in our office if your regular therapist is not available. For a crisis occurring after business hours, please contact our on-call service at 605-995-8180. You will need to give a phone number where you can be reached and you can give your name if you want. The operator will call the on-call clinician with this information, and the on-call clinician will give you a call back, usually within 5 minutes. If your phone settings are on blocking calls from unknown, private or blocked numbers, please be sure to unblock this feature so the on-call clinician can get back to you. In addition, for those receiving tele-mental health services we need the name and number of your local law-enforcement entity, the name and number of the closest emergency room, and you will need to provide the name and number of an emergency contact person. These all must be completed to participate in TeleBehavioral Health Services.

Law-enforcement _____ telephone # _____
(local Sheriff or Police Department)

Hospital Name and Location _____

_____ telephone # _____

Emergency Contact Person Name _____

Relationship _____ telephone # _____

You may also call the Helpline at 800-273-8255. In case of any emergency, you may call 9-1-1.

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand that I am solely responsible for maintaining the strict confidentiality of any user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where the disclosure is required by law.

Consent to Treatment

I, voluntarily agree to receive online therapy services for continued care, treatment, or other services and authorize Dakota Counseling Institute to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Dakota Counseling Institute at any time. By signing this informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein, and have been given opportunity to ask questions and seek clarification of anything unclear to me.

I consent to the use of the following forms of communication via technology:

☐ Phone reminders of appointments (call or texting)
☐ Fax
☐ TeleBehavioral Health sessions via VSee and/or Zoom.

Printed Name	Signature	Date
Parent/Guardian printed name	Signature	Date

The clinician's signature below indicates that he or she has discussed this form with you and has answered any questions you have regarding this information.

Printed Name	Signature	Date

ADMISSIONS SURVEY

NAME_____ **SSN#**_____ **DATE**___/___/___

SURVEY COMPLETED: BEGINNING OF TREATMENT_____ NAME OF PROGRAM_____
END OF TREATMENT _____ REFERRAL SOURCE_____
ASSESSMENT/EVALUATION _____

INSTRUCTIONS: Below is a list of problems and areas of life functioning in which some people are experiencing difficulty. Using the scale below, write in the spaces next to each item the number that best describes the degree of difficulty you have been experiencing in each area during the past week. **NOTE**: If you are just beginning treatment or have been incarcerated for some time, please evaluate the items based on your life before entering Detox or treatment.

PLEASE RESPOND TO EACH ITEM. DO NOT LEAVE ANY BLANK SPACES. IF THERE IS AN AREA THAT YOU CONSIDER TO BE INAPPLICABLE, PUT THE NUMBER "0".

SCALE OF DIFFICULTY

0	**NO DIFFICULTY OR NOT APPLICABLE**
1	**A LITTLE**
2	**MODERATE**
3	**QUITE A BIT**
4	**EXTREME**

TO WHAT EXTENT ARE YOU HAVING DIFFICULTY IN THE AREA OF:

_____ 1. Managing day to day life (getting to places on time, handling money, etc.)
_____ 2. Household responsibilities (shopping, cooking, laundry, other chores)
_____ 3. Work (completing tasks, performance level, finding and keeping jobs)
_____ 4. School (performance, attendance, etc.)
_____ 5. Leisure time, recreational activities
_____ 6. Adjusting to major life stress (moving, separation, divorce, new job, etc.)
_____ 7. Relationships with family members
_____ 8. Getting along with other than family
_____ 9. Isolation or feelings of loneliness
____ 10. Being able to be close to others
____ 11. Being realistic about yourself
____ 12. Recognizing, expressing feelings
____ 13. Developing independence, autonomy
____ 14. Goals or direction in life
____ 15. Lack of self confidence, feeling bad about self
____ 16. Apathy, lack of interest in things
____ 17. Depression, loneliness
____ 18. Suicidal feelings or behaviors
____ 19. Physical symptoms(head and stomach aches, aches/pains, sleep problems, dizziness)
____ 20. Fear, anxiety, panic
____ 21. Confusion, concentration, memory
____ 22. Disturbing or unreal thoughts or beliefs
____ 23. Hearing voices, seeing things
____ 24. Manic, bizarre behaviors
____ 25. Mood swings, unstable moods
____ 26. Uncontrollable, impulsive behavior (eating disorder, hand washing, hurting yourself)
____ 27. Sexual activity or preoccupation
____ 28. Drinking alcohol, taking illegal drugs
____ 29. Controlling temper, anger, violent outbursts

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

	YES	NO
0. Do you enjoy a drink now and then?	NO	
1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	NO	
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	NO	
3. Does your wife, husband, a parent, or other near relative every worry or complain about your drinking.	NO	
4. Can you stop drinking without a struggle after one or two drinks?	NO	
5. Do you ever feel guilty about your drinking?	NO	
6. Do friends or relatives think you are a normal drinker?	NO	
7. Are you able to stop drinking when you want to?	NO	
8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	NO	
9. Have you gotten into physical fights when drinking?	NO	
10. Has your drinking ever created problems between you and your wife, husband, a parents or other relative?	NO	
11. Has you wife, husband (or other family members) ever gone to anyone for help about your drinking?	NO	
12. Have you ever lost friends because of your drinking?	NO	
13. Have you ever gotten into trouble at work or school because of drinking?	NO	
14. Have you ever lost a job because of drinking?	NO	
15. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	NO	
16. Do you drink before noon fairly often?	NO	

17. Have you ever been told you have liver trouble? Cirrhosis? NO

18. After heavy drinking have you ever had Delirium Tremens (D.T.'s) or severe shaking, or heard voices or seen things that weren't there? NO

19. Have you ever gone to anyone for help about your drinking? NO

20. Have you ever been in a hospital because of drinking? NO

21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization? NO

22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem? NO

23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic behavior? NO

    (IF YES, HOW MANY TIMES? _____)

24. Have you ever been arrested, or taking into custody, even for a few hours, because of other drunk behavior? NO

    (IF YES, HOW MANY TIMES? _____)

NATIONAL DEPRESSION SCREENING DAY© – ADULT SCREENING FORM

1) Age: ________

2) Sex: ________ (M/F)

3) Current Marital Status:
☐ Divorced / Separated ☐ Never Married
☐ Living with Partner ☐ Widowed
☐ Married

4) Ethnic / Racial Group:
☐ African American ☐ Caucasian
☐ American Indian ☐ Hispanic
☐ Asian American ☐ Other

5) Have you ever been treated for:
(Check all that apply) Yes No
Depression .... ☐ .. ☐
Bipolar Disorder .... ☐ .. ☐
Generalized Anxiety Disorder .... ☐ .. ☐
Post-Traumatic Stress Disorder ...... ☐ .. ☐

If yes:
Did treatment include medication ..... ☐ .. ☐

6) Have you ever been treated for:
(Check all that apply)
☐ Alcohol Abuse ☐ HIV
☐ Cancer ☐ Seizure Disorder
☐ Chronic Pain ☐ Thyroid Problem
☐ Diabetes ☐ None of the above
☐ Drug Abuse
☐ Heart Disease / Stroke

Participant No. ________

7) Have you ever attempted suicide: . . . Yes No NO

THE HANDS© DEPRESSION SCREENING TOOL (The Harvard Department of Psychiatry / National Depression Screening Day Scale)

Pick one option for each question from dropdown box

■ Over the past two weeks, how often have you:

1.	been feeling low in energy, slowed down?	all of the time
2.	been blaming yourself for things?	all of the time
3.	had poor appetite?	all of the time
4.	had difficulty falling asleep, staying asleep?	All of the time
5.	been feeling hopeless about the future?	All of the time
6.	been feeling blue?	All of the time
7.	been feeling no interest in things?	All of the time
8.	had feelings of worthlessness?	all of the time
9.	thought about or wanted to commit suicide?	all of the time
10.	had difficulty concentrating or making decisions?	All of the time

Total Score:

THE MOOD DISORDER QUESTIONNAIRE

Pick one option for each question from drop down box

■ Please answer each question as best you can.

1. Has there ever been a period of time when you were not your usual self and...

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	NO
...you were so irritable that you shouted at people or started fights or arguments?	NO
...felt much more self-confident than usual?	NO
...you got much less sleep than usual and found you didn't really miss it?	NO
...you were much more talkative or spoke much faster than usual?	NO
...thoughts raced through your head or you couldn't slow your mind down?	NO
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	NO
...you had much more energy than usual?	NO
...you were much more active or did many more things than usual?	NO
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	NO
...you were much more interested in sex than usual?	NO
...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	NO
...spending money got you or your family into trouble?	NO

Total Score:

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?
Please check (✓) one response only. ☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

See reverse for additional screening tools

CLINICIAN: FILL OUT SCREENING RECOMMENDATION SECTION (See box on reverse side)

CARROLL-DAVIDSON GENERALIZED ANXIETY DISORDER SCREEN©

■ These questions are to ask about things you may have felt most days in the Past 6 Months

pick yes or no from drop down box

1. Most days I feel very nervous.	NO
2. Most days I worry about lots of things.	NO
3. Most days I cannot stop worrying.	NO
4. Most days my worry is hard to control.	NO
5. I feel restless, keyed up or on edge.	NO
6. I get tired easily.	NO
7. I have trouble concentrating.	NO
8. I am easily annoyed or irritated.	NO
9. My muscles are tense and tight.	NO
10. I have trouble sleeping.	NO
11. Did the things you noted above affect your daily life (home life, or work, or leisure) or cause you a lot of distress?	NO
12. Were the things you noted above bad enough that you thought about getting help for them?	NO

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Total Score:

MODIFIED SPRINT (SPRINT-4©) PTSD SCREEN

If at any time you have experienced or witnessed a traumatic event, which involves loss of life, serious injury or threat of either:

■ Please respond to these questions about how you have felt most days in the past week.

Choose yes or no

1. Have you been bothered by unwanted memories, nightmares, or reminders of this event?	NO
2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened?	NO
3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?	NO
4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?	NO

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Total Score:

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

PLEASE RETURN THIS FORM TO STAFF FOR SCORING.

SCREENING RECOMMENDATION (TO BE FILLED OUT BY CLINICIAN ONLY)

■ I spoke with the participant and recommended: (Check all that apply)

Follow-up for:
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ No follow-up needed
- ☐ Generalized Anxiety Disorder
- ☐ Post-Traumatic Stress Disorder

■ If a Community-Based Site:
- ☐ Outpatient Referral
- ☐ Inpatient Referral
  - ☐ Voluntary
  - ☐ Emergency

■ If a Primary Care Facility:
- ☐ Treated in office
- ☐ Referred Elsewhere
- ☐ Emergency

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