

FOR OFFICE USE ONLY

CID: _____

NEW

REOPEN

UPDATE

DATE: _____

THERAPIST: _____

NAME: _____

LAST

FIRST

MIDDLE

MAIDEN

PHONE: _____

HOME

CELL

WORK

ADDRESS: _____

STREET

APT/ P.O. BOX

ADDRESS: _____

CITY

STATE

ZIP CODE

COUNTY

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

ENGLISH PROFICIENCY: _____ PRIMARY RACE: _____ SECONDARY RACE: _____ RELIGION: _____

MOTHERS FIRST NAME: _____ LEGAL GUARDIAN'S NAME: _____

MARITAL STATUS: NEVER MARRIED ___ MARRIED ___ SEPERATED ___ DIVORCED ___ WIDOWED ___ VETAN: YES / NO

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

BILLING 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 PAST 3 YEARS _____ HOMELESS BUT 1 OR 2 ARE NOT APPLICABLE

EDUCATION (LAST YEAR COMPLETED) _____ SPOUSE'S EDUCATION: _____ SPOUSE'S OCCUPATION _____

YOUR OCCUPATION: _____ EMPLOYER: _____ DURATION OF EMPLOYMENT: _____

EMAIL ADDRESS _____

☐ By selecting this box, you are consenting to receiving your statement and invoices electronically instead of in paper form. Please be sure to have email address and cell phone number on this form. Thank you.

TOTAL JOINT INCOME: _____ SOURCE OF INCOME: _____ EMPLOYED: FULL-TIME _____ PART-TIME _____

REFERRAL SOURCE: _____ PRIMARY PHYSICIAN/CLINIC: _____

INSURANCE/COVERAGE: _____ POLICY NUMBER: _____

PREVIOUS COUNSELING YES / NO WHERE? _____ ADMIN/DISCHARGE DATES _____

PREVIOUS PSYCHIATRIC HOSPITALIZATION? YES / NO WHERE? _____ ADMIN/DISCHARGE DATES _____

CURRENT MEDICATIONS: _____

WHOM MAY WE CONTACT IN CASE OF EMEGENCY _____

NAME

CONTACT NUMBER

Dakota Counseling Institute

Client Insurance Information

Medicare Number: _____

Medicaid Number: _____

Health Insurance Company: _____

Insurance Company Address: _____

Policy Number: _____ Group Number: _____

Insured Name: (Policy Holder): _____

Insured's Date of birth: _____ Insured's Phone Number: _____

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: _____

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 _____

Financial Agreement

The typical fees for services are as follows:

Outpatient Intake	\$236.20
Outpatient Therapy	\$107.30 - \$208.80
Psychiatric Evaluation	\$265.90 - \$346.60
Medication Management	\$142.90 - \$283.80

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

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 acknowledgement that you have received a copy of this notice.

Patient Acknowledgement 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

Dakota Counseling Institute

Treatment Contract

The following is a contract between Dakota Counseling Institute (DCI) and its professional staff, and you, the client. This contract must be agreed to and signed in order 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 DCI professional staff, or a student or intern who is under the supervision of a licensed professional staff member. 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 involved 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. The same is true for medications if you are seeking medication management of your symptoms. All medications have the potential for side effects, and not every medication works the same for everyone. 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 DCI 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 EAPs request information about your treatment. When you sign on with an insurance company and/or EAP, you sign a waiver or a release of information authorizing 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 made 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 the 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 the 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 any 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. Similarly, if your therapist is under supervision of a licensed provider, the supervisor will

periodically review records, and you therapist may discuss your case in supervision meetings. All participants in supervision are bound by the same confidentiality standards as your therapist.

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 have a 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 Behavioral Health at the following address and phone number:

South Dakota Department of Social Services
Division of Behavioral Health
700 Governors Drive
Pierre, SD 57501

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

I have read this treatment contract and understand its terms. My signature below indicates that I 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/protected adult treated by Dakota Counseling Institute professional staff.

Parent/Legal Guardian Date

Witness/Therapist Date

(Please initial)

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

[Revised 5/2024]

REGARDING SUBPOENAS AND PROFESSIONAL STAFF TESTIMONY

Occasionally, professional staff members of Dakota Counseling institute are ordered to provide testimony in court regarding their professional contact (e.g. Psychotherapy, medication management, case management, psychological testing, mental health evaluation, emergency assessment) with clients. For any professional staff member to appear in court, he or she must have been served an official subpoena to appear in court on a stated date and time.

When a member of the professional staff is subpoenaed to testify regarding treatment of a current client, the staff member will discuss any possible testimony with the client at their next session. A rough outline of content of the testimony will be discussed with the client and, when possible, with the client's attorney,

Professional staff members giving testimony in court are considered expert witnesses, meaning they will be asked to give opinions and discuss hypothetical questions rather than simply asked to repeat factual data. Clients will need to be aware that their attorneys will be billed for the time professional staff are out of the office and thus unable to see other clients, **whether or not they are called to testify in the end.** Therefore, if, for example, a professional staff member is ordered to be in court at 9:00 am, does not testify until 11 am and then is on the stand for an hour, the attorney will be billed for three hours. Hours are billed in 30-minute increments at the psychotherapy rate valid at the time of testimony. Insurance companies, Medicaid/Medicare, and any other third-party payers will not be billed for court testimony. You need to be aware of this as in the vast majority of cases attorneys will recover these costs from you, the client. Attorneys will also be billed for the time it takes to travel to and from the office to the court house where testimony is to be given.

By signing below, you indicate that you have read and understand the above information regarding professional staff testimony, and agree to the terms and conditions outlined above.

Client Signature

Date

Witness Signature

Date

Dakota Counseling Institute
Background and Information Questionnaire
Therapy Part Adult

Please answer all of the questions to the best of your ability. If you do not know an answer, put "unknown". If you need help, please ask the Receptionist for assistance. Feel free to use the back for more room to write.

Today's Date: _____ Your Name: _____

Maiden name and/or other names you are known by: _____

Preferred Name: _____ Pronouns: _____

Current Difficulties:

What are your reasons for seeking treatment now? Please list major concerns or anything you would like the therapist to know. _____

When did the problems first start? _____

Symptoms present during the past month

(circle all that apply)

Sad, Blue or Depressed	Anxiety/ Worrying	Sudden Panic or Fear
Loss of Interest in Activities	Decreased need for Sleep	Doing things Over and Over
Feeling of Worthlessness	Cannot Stay Focused	Constant Intrusive Thoughts
Feeling of Hopelessness	Feel Better than Usual	Re-Experiencing Frightening Events
Feeling of Guilt	Increased Activity Level	Nightmares

Symptoms present during the past month (continued)

Recent Weight Loss	Talking Too Much	Seeing things that others Cannot See
Sleeping too Much	Thoughts Racing	Hearing things that Others Can't Hear
Poor Concentration	Irritability	Disorganized Thoughts
Low Energy	Tense Muscles	Decrease in Memory
Low Self-Esteem	Confused Thinking	Intense Fear of Weight Gain
Thoughts of Death	Situational Fears	Vomiting for Weight Control

Please list any other symptoms you have experienced which are not listed here? _____

Please list any previous mental health care provider you have previously consulted: _____

Please list all Medications, Psychiatric and other, which you are currently taking. Please include dose and frequency if known. _____

Medical History

Date of last physical? _____

Please list any physical problems you are currently being treated for? _____

Please circle any of the following which you have experienced at some point in your life:

High Fever Head injury/ Concussion Loss of consciousness Seizures

Have you ever been hospitalized for medical reasons? YES NO If yes, please list name(s)

Hospital(s), Date(s) and reason for hospitalization(s). _____

Family History

Marital Status (please circle)

Single Married Partnered Separated Divorced Widowed It's Complicated

If you are in a relationship, please indicate your level of satisfaction with the relationship by circling one of the following.

Very Satisfied Satisfied Neutral Unsatisfied Very Satisfied

Does anyone in your family have a history of mental illness? YES NO

Has anyone in your family attempted or committed suicide? YES NO

Have you had any recent traumatic or Stressful events in your life? YES NO

If yes, please explain. _____

If in a relationship, please briefly describe your relationship with your partner: _____

Where were you born/raised? _____

Who raised you? _____

Do you have any religious or spiritual preferences? _____

Additional Information: _____

Family History Continued

Please briefly describe your relationship with your parents: _____

If you have children, please describe your relationship with your children: include ages of children and if they live with you. _____

If you have siblings, please briefly describe your relationship with you brothers and sisters: _____

History of Abuse

Were you ever abused as a child? YES NO

If yes please specify by circling those that apply: Physical Sexual Emotional Neglect

If you would like to explain more on this please feel free to write on the back of the sheet of paper.

Is there domestic violence in your home at this time? YES NO

Have you ever been in a relationship that you were the victim of domestic violence? YES NO

Have you ever been convicted of charges related to domestic violence? YES NO

Have you ever been investigated for abusing or neglecting children in your care? YES NO

Have you ever been convicted of a felony? YES NO If yes, explain _____

Are you currently facing legal charges? YES NO If yes briefly explain: _____

Have you ever been a victim of a crime? YES NO If yes, explain: _____

Are you currently on probation? YES NO If yes, who is your PO: _____

Substance Abuse

(Reminder if you run out of space feel free to use the back of the paper)

Please circle any that apply and explain if this is current or past and last time you used this substance.

Tobacco: _____

Alcohol: _____

Marijuana: _____

Other street drugs: _____

Over the counter: _____

Prescriptions (abuse): _____

Did any of your family members abuse drugs or alcohol while you were growing up? YES NO

Have you ever received treatment for drugs or alcohol? YES NO If yes, please give

dates and name of treatment facility. _____

Vocational/Financial Concerns

Are you currently employed? YES NO

If you are employed, how long have you been with your current employer? _____

employer and who is your employer? _____

Rate your job satisfaction by circling below

Very Satisfied Satisfied Neutral Unsatisfied Very Unsatisfied

Do you have financial difficulties or concerns? 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

☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Division of Behavioral Health
Adult and Youth Mental Health Disorder Outcome Tool

Client STARS ID: |

Date: _____

Tool Type:

- ☐ Initial
☐ Update
☐ Discharge

- ☐ Adult
☐ Youth

1. Would you say that in general your mental health is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. What is your employment status?
☐ Employed full time (35+ hours per week) ☐ Employed part time ☐ Homemaker
☐ Student ☐ Retired ☐ Other (specify)
☐ Disabled ☐ Unemployed

3. Which of the following best describes your current residential status?
☐ Independent, living in a private residence ☐ Homeless ☐ Dependent, living in a private residence
☐ Residential Care (group home, rehabilitation center, agency-operated care) ☐ Foster Home/ Foster Care ☐ Institutional setting (24/7 care by skilled/specialized staff/doctors)
☐ Other (specify) ☐ Crisis Residence ☐ Jail/Correctional Facility

4. What is your highest education level completed?
(12= GED and High School diploma or self-contained special ed classes) _____

- a. If enrolled in school, have you attended school at any time in the past 3 months? ☐ Yes ☐ No ☐ Refused

5. Please answer the following questions based on the past 30 days:

- a. Have you been arrested? ☐ Yes ☐ No ☐ Refused

- b. Did you have enough money to meet your needs? ☐ Yes ☐ No ☐ Refused

- c. Have you been satisfied with the conditions of your living space? ☐ Yes ☐ No ☐ Refused

- d. In the past 30 days, have you felt...

- | | |
|---|---|
| i. Nervous? | ☐ Yes ☐ No ☐ Refused |
| ii. Hopeless? | ☐ Yes ☐ No ☐ Refused |
| iii. Restless or fidgety? | ☐ Yes ☐ No ☐ Refused |
| iv. So depressed that nothing could cheer you up? | ☐ Yes ☐ No ☐ Refused |
| v. That everything is an effort? | ☐ Yes ☐ No ☐ Refused |
| vi. Worthless? | ☐ Yes ☐ No ☐ Refused |
| vii. Bothered by psychological or emotional problems? | ☐ Yes ☐ No ☐ Refused |

Division of Behavioral Health
Adult and Youth Mental Health Disorder Outcome Tool

6. Please answer the following questions based on the past 6 months:

a. Have you spent time in a facility for:

- i. Detoxification/Inpatient or Residential Substance Use Disorder Treatment?
- ii. Mental Health Care?
- iii. Any illness, injury, or surgery to the human body?

☐ Yes ☐ No ☐ Refused

☐ Yes ☐ No ☐ Refused

☐ Yes ☐ No ☐ Refused

b. Have you spent time in a correctional facility including jail/prison/JDC (because of an arrest, parole, or probation violation)?

☐ Yes ☐ No ☐ Refused

c. Have you had suicidal thoughts?

☐ Yes ☐ No ☐ Refused

7. 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.

Response Options

Strongly disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable	Refused
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Domain: Social Connectedness Questions a-g

a. I am happy with the friendships I have, who will listen and understand me when talking.

☐ ☐ ☐ ☐ ☐ ☐ ☐

b. I have people with whom I can do enjoyable things.

☐ ☐ ☐ ☐ ☐ ☐ ☐

c. I feel I belong in the community.

☐ ☐ ☐ ☐ ☐ ☐ ☐

d. In a crisis, I would have the support I need from family or friends.

☐ ☐ ☐ ☐ ☐ ☐ ☐

e. I have people that I am comfortable talking with about my problems.

☐ ☐ ☐ ☐ ☐ ☐ ☐

f. I have family or friends that are supportive of my recovery.

☐ ☐ ☐ ☐ ☐ ☐ ☐

g. I generally accomplish what I set out to do.

☐ ☐ ☐ ☐ ☐ ☐ ☐

Domain: Functioning Questions h-q

h. I do things that are more meaningful to me.

☐ ☐ ☐ ☐ ☐ ☐ ☐

i. I can take care of my needs.

☐ ☐ ☐ ☐ ☐ ☐ ☐

j. I can handle things when they go wrong.

☐ ☐ ☐ ☐ ☐ ☐ ☐

k. I can do things that I want to do.

☐ ☐ ☐ ☐ ☐ ☐ ☐

l. I get along with family, friends, and other people.

☐ ☐ ☐ ☐ ☐ ☐ ☐

m. I can deal with crisis.

☐ ☐ ☐ ☐ ☐ ☐ ☐

n. I do well in social situations.

☐ ☐ ☐ ☐ ☐ ☐ ☐

o. I do well in school and/or work.

☐ ☐ ☐ ☐ ☐ ☐ ☐

p. My symptoms are not bothering me as much.

☐ ☐ ☐ ☐ ☐ ☐ ☐

q. My housing situation is a safe place to live.

☐ ☐ ☐ ☐ ☐ ☐ ☐