

Treatment Participation and Payment Policy

Our mission is to support your health and well-being by providing high-quality mental health care in a respectful and compassionate environment. This document is designed to help you understand participation in services at Center for Life Management (CLM). Please read it carefully, and let us know if you have any questions before signing.

Informed Consent to Treat

By signing this agreement, you consent to receive mental health treatment and related support services provided by CLM staff. You will receive ongoing assessment and evaluation of your mental health needs and services will be recommended to you based your assessed medical necessity. You understand that:

- Services may include assessments, individual and group therapy, case management, community support, medication management, crisis support, and other clinically appropriate interventions.
- Treatment is voluntary, and you may withdraw from services at any time unless court ordered to care.
- The risks and benefits of treatment will be explained to you by your provider, and you are encouraged to ask questions to support informed decision-making.
- You have the right to participate actively in developing your treatment plan.

Shared Parenting or Guardianship Responsibilities

CLM recognizes that children and dependent adults may have more than one parent or guardian who shares responsibility for their care. By signing this agreement, the consenting parent or guardian acknowledges and agrees that:

- Consent to treatment provided by one legal parent or guardian is considered valid and sufficient for CLM to initiate and continue services.
- The parent or guardian providing consent has the responsibility to inform and communicate with all other legal parents/guardians that fact that they have consented to the treatment of their child/ward at CLM and also regarding treatment decisions and progress.
- It is the responsibility of the consenting parent/guardian to inform CLM of an objection to treatment by another parent/guardian who has legal authority to consent for treatment.
- Legal paperwork indicating court orders may be requested to initiate or continue care.
- CLM will not mediate disagreements between parents or guardians regarding treatment decisions. If disputes arise, CLM may request documentation (e.g., custody agreements or court orders) to guide clinical and administrative actions.
- It remains the responsibility of all legal parents/guardians to coordinate with one another regarding the care of the client.

Telehealth Services

CLM offers telehealth as an option for service delivery. By signing, you consent to receive care through secure video or telephone platforms when appropriate. You understand that:

- Telehealth may not be appropriate for all situations, and in-person appointments may sometimes be required.
- Confidentiality protections apply in telehealth just as they do in-person for both the client and provider.
- You are responsible for ensuring you have access to a private space and reliable technology during telehealth sessions.
- Services rendered over telephone may be billable.

Attendance and Cancellation

- **24-Hour Notice:** We require at least 24 hours' notice for appointment cancellations.
- **Excused Cancellations:** Last-minute rescheduling may be permitted in cases of unforeseen illness, psychiatric crisis, or family emergency.
- **No-Show Appointments:** Repeated missed appointments without notice may result in fees being charged to your account and/or impact your ability to remain in services.
- **Appointment Confirmations:** By providing your preferred contact information, you consent to receive appointment confirmations and reminders via text, phone call, and/or email. You may update or withdraw this consent at any time by notifying our office.

Financial Responsibility and Payment

CLM is committed to helping you access care and maintain financial transparency. Please review the following:

- **Insurance Coverage:** We will bill your insurance directly. However, insurance may not cover the full cost of services. You are responsible for any remaining balance, including co-pays, deductibles, or services not covered. Individuals who may otherwise qualify for NH Medicaid and refuse to apply will be responsible for the full cost of services.
- **Updated Insurance Information:** You are responsible for providing current and accurate insurance information. Failure to update this information may result in denied claims for which you will be billed directly.
- **Outstanding Balances:** Per New Hampshire He-M regulations, failure to pay for services or apply for insurance which could cover your services may result in case closure.
- **Payment Arrangements:** If you are unable to pay in full, you may work with CLM's Finance Department to establish a payment plan.
- **Additional Fees:** You may incur fees for missed appointments (no-shows), crisis care, or other services not covered by insurance.
- **Acute Care Fees:** Additional charges may apply if services are rendered by CLM's Acute Care Services during a psychiatric crisis.
- Should you or your child/ward stop receiving services from CLM, payment is expected for sessions that have already been provided prior to the end of treatment.

Authorization to Release Information for Payment Purposes

By signing this agreement, you authorize CLM to release necessary medical and billing information to your insurance company, third-party payer, or other authorized agencies for the purpose of processing claims related to your treatment and payment.

Acknowledgment and Agreement

By signing below, you acknowledge that you have read and understood this Participation, Service Agreement, and Payment Policy. You agree to comply with these terms, ask questions when clarification is needed, and work collaboratively with CLM to support your treatment and financial responsibilities.

Client Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

Client Rights Statement

At Center for Life Management (CLM), we are committed to providing care in an atmosphere of dignity, respect, and partnership. As a client, you have important rights related to your personal well-being, your treatment, and the confidentiality of your information.

Personal Rights

As a client of CLM, you have the right to:

- Be treated with dignity, respect, and compassion at all times.
- Receive services in an environment free from discrimination based on age, race, ethnicity, culture, national origin, religion, sex, sexual orientation, gender identity or expression, disability, or socioeconomic status.
- Be safe from abuse, neglect, exploitation, or mistreatment.
- Request reasonable accommodations if you have a disability or specific needs.
- File a complaint or grievance without fear of retaliation, and to have your concerns heard and addressed fairly.

Treatment Rights

As part of your care at CLM, you have the right to:

- Participate actively in developing your treatment plan and making decisions about your care.
- Be informed of the potential risks, benefits, and alternatives to treatment.
- Decline or withdraw from services at any time, within the limits of the law and professional standards.
- Receive services in the least restrictive setting that is clinically appropriate.
- Request a second opinion or referral to another provider if desired.
- Be informed in clear language about your diagnosis, treatment, and progress during periodic review of your services.

Confidentiality and Exceptions

CLM respects your right to privacy. Information shared in treatment is kept confidential except in the following circumstances, as required or permitted by law. In these situations, only the necessary information will be shared, and whenever possible, you will be informed.:

- If there is suspected abuse or neglect of a child, elder, or vulnerable adult.
- If you present a serious risk of harm to yourself or others.
- If your records are requested by court order or as otherwise required by law.
- In cases of involuntary emergency admission or guardianship proceedings.
- To family members or other persons who reside in the same home if a psychiatric crisis occurs.
- For purposes of billing, payment, and health care operations.

Confidentiality in Practice and Recording of Sessions

To protect the privacy of both clients and staff:

- CLM does *not* permit recording of sessions (audio, video, or other methods) by clients or staff unless there is prior, explicit, written consent from all parties involved. This may include recording sessions for AI-assisted clinical documentation.
- This protocol protects your right to confidentiality as well as the confidentiality and privacy of CLM staff.
- Both clients and staff have the right to expect that what is shared in treatment, subject to the exceptions as outlined above, remains private and respectful.

Questions or Concerns

If you have questions about your rights or concerns about your care, you are encouraged to:

- Speak directly with your provider.
- Contact CLM's Compliance Officer.
- File a grievance following CLM's Compliance policy, available upon request.

Acknowledgment of Receipt

I have received and reviewed a copy of the Client Rights Statement from Center for Life Management.

Client Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____



Client ID#: _____

Notice of Confidentiality for Alcohol and Drug Treatment Information

Federal law provides special confidentiality protections for your alcohol and drug treatment records for people aged 12 and older. These protections are stricter than standard health privacy rules. The purpose of this notice is to help you understand your rights and the limits of disclosure of your treatment information.

Special Protections Under 42 CFR Part 2

- Records that identify you as receiving alcohol or drug treatment services are protected by federal law (42 CFR Part 2)
- These records generally cannot be shared with anyone outside of Center for Life Management (CLM) without your written consent
- This protection is stronger than the general health information privacy protections under HIPAA

When Information May Be Shared With Your Consent

- To coordinate your care among members of your treatment team
- With your insurance company, if you authorize it
- Any other person or agency you specifically authorize in writing

When Information May Be Shared Without Your Consent

Federal law allows disclosure of alcohol and drug treatment information without your consent in limited circumstances, including:

- Medical emergencies (to protect your health or safety)
- Mandated reporting of child abuse or neglect
- Crimes committed on CLM premises or against CLM staff
- Court orders that meet strict federal requirements
- Internal program operations (for quality assurance, billing, or compliance purposes as permitted by law)

Additional Consents May Be Required

Because of these special protections, you may be asked to sign extra consent forms if your alcohol and drug treatment information needs to be shared for purposes such as:

- Coordinating with outside medical providers
- Communicating with schools, courts, or community agencies
- Billing and insurance coverage

Acknowledgement of Notice

I have read (or had explained to me) this notice regarding the confidentiality of alcohol and drug treatment information. I understand that these records are specially protected under HIPAA and 42 CFR Part 2, and that my written consent is generally required before information about my treatment may be shared.

Client Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____

Client Code of Conduct

At Center for Life Management (CLM), we are committed to providing a safe, supportive, and respectful environment for all individuals receiving services. To ensure that everyone has the best experience, we ask that all clients adhere to the following Code of Conduct. This document outlines the behavior and responsibilities expected during your time in our care.

1. Respect and Dignity

- Treat all staff, fellow clients, and visitors with courtesy, respect, and dignity at all times.
- Avoid any forms of discrimination, harassment, or aggression, including but not limited to racial, cultural, religious, gender, or sexual harassment.

2. Safety and Well-being

- Refrain from any violent, threatening, or harmful behavior that may jeopardize the safety of others or yourself.
- Comply with the CLM's policies regarding the use of substances, including alcohol, recreational drugs, and any unauthorized medications as outlined in CLM's Treatment Participation and Payment Agreement.
- CLM maintains a NO WEAPONS policy while on CLM property, inside CLM buildings, or when with staff in the community.
- Follow any recommendations or instructions from providers regarding treatment plans, medications, or service sessions.

3. Confidentiality and Privacy

- Respect the confidentiality and privacy of all individuals receiving services, as well as that of staff.
- Do not disclose any personal or sensitive information about other clients without their consent.
- Abide by policies and guidelines, including restrictions on personal electronic devices and recording. Recording of sessions and phone calls is not permitted by staff or client without written consent.

4. Attendance and Punctuality

- Attend scheduled sessions, appointments, or group meetings as required, arriving on time. If you are unable to attend, please notify front office staff at least 24 hours in advance.
- If you are late or miss a session, please contact the front office to reschedule.

5. Property and Facilities

- Respect the property and resources provided by the facility. This includes personal property as well as facility-owned items and spaces.
- Do not damage, deface, or remove any property from the premises.
- Maintain a clean and orderly environment, disposing of trash properly and informing CLM staff when there is a cleanliness or safety issue that requires attention.

6. Substance Use and Medication Adherence

- Adhere to CLM's policy regarding medication use, including taking prescribed medications as directed by your healthcare provider as outlined in CLM's Participation Agreement.
- Bringing illegal substances or alcohol onto the premises is prohibited.

- Smoking, vaping or using any illegal substances during sessions, including telehealth, is prohibited.
- If you are prescribed medication outside of CLM, please notify staff of any changes in your medication regimen. Please notify staff of any concerns you have about side effects or interactions.
- To promote safe and coordinated care, you are encouraged to share information about medications prescribed through Center for Life Management with their other healthcare providers, as appropriate.

7. Collaboration with Staff

- Engage actively and openly in your treatment process, and communicate openly with your healthcare providers, therapists, and support staff.
- Follow the agreed-upon treatment plan, and ask questions or raise concerns if you do not understand any part of your treatment.
- Inform staff of any changes in your personal, physical, or mental health that may impact your treatment.

8. Disruptive Behavior

- Refrain from disruptive or inappropriate behavior during sessions or within the facility, including loud outbursts, offensive language, or any form of verbal or physical aggression.
- If you experience any emotional distress, please inform a staff member immediately so that they can provide appropriate support.
- Behavior that disrupts the therapeutic process or threatens the comfort and safety of others may result in a review of your services and possible discharge.

9. Rights and Responsibilities

- You have the right to be informed of your treatment plan, to provide consent for treatment, and to refuse any treatment within the limits of the law.
- You have the responsibility to participate in your treatment to the best of your ability, to inform staff of any difficulties you experience, and to respect the rights of others receiving care.

10. Violations and Consequences

- Clients who fail to adhere to the Code of Conduct may face consequences, including verbal or written warnings, suspension of services, or termination of care.
- Any behavior that is deemed illegal, harmful, or violent may result in immediate removal from the facility and possible legal action.

By signing below, you acknowledge that you have read, understood, and agree to abide by the Client Code of Conduct during your time at the Center for Life Management.

Client Signature: _____

Printed Name: _____

Date: _____

We believe that by maintaining this Code of Conduct, we can ensure a positive and safe experience for all clients. Your cooperation is greatly appreciated, and we look forward to supporting you on your journey toward better mental health.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

*** All sections on authorization form must be completed in order to be valid***

Client Name: _____ **DOB:** _____ **Case #:** _____

I hereby authorize Center for Life Management (CLM) to **Obtain from** **Disclose to** **or Exchange**
my protected health information including psychiatric/mental health information with:

Primary Care Physician

Name: _____	<input type="checkbox"/> Check if PCP
Address: _____	<input type="checkbox"/> Request Records
Phone: _____ Fax: _____	<input type="checkbox"/> Send Records

Information to be released / obtained / exchanged **(check all that apply):**

**please note information to be disclosed is limited to the minimum necessary for the purpose stated below.*

- Intake / Assessment Psychiatric Evaluation / MD Consults Treatment / Service Plan Labs
- Progress Notes Complete Record Other (specify) _____

Dates of treatment: _____ to _____ **or** Check here for all dates of treatment

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that I may revoke this authorization at any time by notifying CLM in writing. However, revocation does not cover information that was received or disclosed prior to CLM receiving revocation.
- I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that Center for Life Management (CLM) shall not condition treatment on my providing authorization for the requested use or disclosure **AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.**
- For cases where parents share joint custody; at the discretion of CLM, records released to one parent with joint custody may be disclosed to the other parent without specific request.

I AUTHORIZE CLM TO RELEASE / OBTAIN THE FOLLOWING INFORMATION:

PLEASE INITIAL AS APPROPRIATE

_____ **Alcohol and/or Drug Treatment Information** (I understand that all related information is protected under Federal Regulation 42 CFR and that I have the right to refuse release.)

_____ ***PLEASE NOTE:** When client is 12 yrs or older and seeking substance abuse treatment independently, client's initials only are needed.

_____ **HIV Related Information** (I understand that I have the right to refuse release.)

The purpose of the release is(Specify): _____

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

To receiving provider: This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F. R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS CONSENT WILL AUTOMATICALLY EXPIRE ON THE CONCLUSION OF YOUR TREATMENT.

Center for Life Management (CLM) - Medical Records Department
10 Tsienneto Road, Derry, NH 03038 - Phone: (603) 434-1577 - Fax: (603) 965-0227

Date: _____

Name: _____

ID: _____

PHOENIX

Please take this opportunity to answer the following questions.

Phoenix Questions	Check one answer only for each question.
<p>Consumer's Employment Status</p>	<p><input type="checkbox"/> 1. Employed (competitively employed full or part time, includes supportive employment)</p> <p><input type="checkbox"/> 2. Not in labor force (retired, sheltered workshop, volunteer, homemaker, student, disabled)</p> <p><input type="checkbox"/> 3. Unemployed (seeking employment but not currently working)</p> <p><input type="checkbox"/> 4. Not available</p>
<p>Consumer's Living Status</p>	<p><input type="checkbox"/> 1. Private residence (house, apartment, hotel, dorm, barrack or single room occupancy)</p> <p><input type="checkbox"/> 2. Supportive housing (subsidized housing or a financially supported private residence, HUD, Section 8, sheltered care)</p> <p><input type="checkbox"/> 3. Foster Home (licensed home to provide foster care and therapeutic foster care facilities)</p> <p><input type="checkbox"/> 4. Residential Care (group home, therapeutic group home, board and care, residential treatment, rehabilitation center)</p> <p><input type="checkbox"/> 5. Crisis Residence (residential stabilization program, limited for persons until they reach stabilization)</p> <p><input type="checkbox"/> 6. Children's Residential Treatment (organization, not licensed as a psychiatric hospital used to provide provisions of planning programs of mental health treatment with residential care for children)</p> <p><input type="checkbox"/> 7. Institutional Setting (skilled nursing/intermediate care, nursing home, institution for mental disease, inpatient psychiatric hospital, state hospital, veteran's affair hospital)</p> <p><input type="checkbox"/> 8. Jail/Correction Facility (jail, correctional facility, detention center, prison, youth authority facility, juvenile hall, boot camp, or boys ranch)</p> <p><input type="checkbox"/> 9. Homeless (lacks fixed, regular and adequate nighttime residence, homeless shelter, temporary residence for people being institutionalized)</p> <p><input type="checkbox"/> 10. Other (please indicate):</p>

Name: _____ ID Number: _____ Date: _____

Marital Status: _____ Employment Status: _____

Number of Children: _____

HEALTH HISTORY

Please check if you have/had problems related to the areas indicated.

1. GENERAL

Weight Change
Fever
Sweats
Fatigue

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

2. EYES

Glaucoma
Cataracts
Wears Glasses
Blurred or Double Vision

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

3. EARS, NOSE, THROAT

Wears Hearing Aid
Hearing Loss with No Aid
Dizziness
Pain

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

4. RESPIRATORY

Shortness of Breath
Trouble Breathing
Asthma
Bronchitis
Chronic Cough

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

5. CARDIOVASCULAR

Heart Attack
Chest Pain/Angina
Heart Murmur
Rapid Heart Beat
High Blood Pressure
Congenital Heart Condition

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

6. GASTROINTESTINAL

Ulcers
Stomach Pain
Diarrhea
Constipation
Gastro-esophageal Reflux
Nausea

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

7. ENDOCRINE SYSTEM

Diabetes
Hypo/Hyper Thyroid

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

8. URINARY SYSTEMS

Urinary Tract/Bladder Infections
Incontinence
Trouble Urinating
Kidney Problems

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

9. REPRODUCTIVE

PMS
Post or Menopausal

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

10. SKIN

Rashes
Dry Skin
Jaundice
Melanoma

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

11. NEUROLOGIC

Stroke
Seizures
Head Injury
Tingling
Numbness

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

12. MUSCLES/JOINTS

Arthritis
Weakness
Frequent Falls/Unsteady

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

13. BLOOD/LYMPHATIC

Bruising/Bleeding Easily
Anemia
Swollen Lymph Nodes

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

14. PSYCHIATRIC

Sleep Disturbance
Feeling Anxious
Feeling Depressed
Suicidal
Substance Abuse

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

15. SMOKING STATUS

Do You Smoke?
If yes, how much per day _____

16. ALCOHOL USE

Do you consume alcohol?
If so, how much/how often? _____

OTHER MEDICAL CONDITIONS/ADDITIONAL COMMENTS:

ALLERGIES:

CURRENT MEDICATIONS			
NAME	DOSE	FREQUENCY	REASON FOR TAKING

HOSPITALIZATIONS		
DATE(S)	NAME OF FACILITY	REASON

MEDICAL PROVIDERS	NAME	PHONE	DATE LAST SEEN	REASON FOR SEEING
PRIMARY CARE PROVIDER				
SPECIALIST				
SPECIALIST				
SPECIALIST				

FAMILY MEDICAL HISTORY:

	Which Family Member?	Which Family Member?
Cancer/Tumor	_____	Diabetes _____
Heart Disease	_____	Mental Illness _____
Epilepsy	_____	Other Significant Illness _____
Alcoholism	_____	_____

COMMENTS OF REVIEWER:

Reviewed by: _____ Date: _____

PHQ-9 DEPRESSION

Please take this opportunity to answer the following questions.

PHQ-9 (Depression)	Circle one answer only for each question			
Over the last 2 weeks, how often have you been bothered by a little interest or pleasure in doing things?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by trouble falling or staying asleep, or sleeping too much?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by feeling tired or having little energy?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by a poor appetite or overeating?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by feeling bad about yourself - or that you are a failure or have let yourself or your family down?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by trouble concentrating on things, such as reading the newspaper or watching television?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by 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?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?	Not at all	Several days	More than half of the days	Nearly every day
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
I made plans to end my life within the last two weeks.	No		Yes	

Date: _____

Name: _____

ID: _____

GAD-7(ANXIETY)

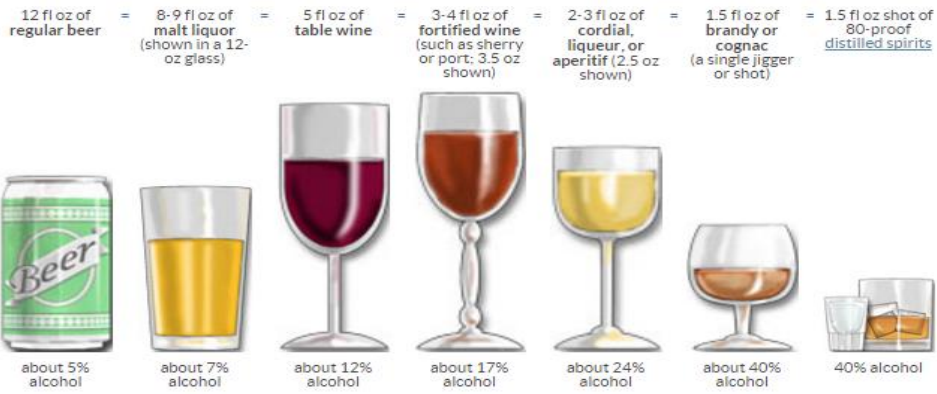
Please take this opportunity to answer the following questions

GAD-7 (Anxiety)	Circle one answer only for each question			
Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by worrying too much about different things?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by trouble relaxing?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by being so restless that it is hard to sit still?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by becoming easily annoyed or irritable?	Not at all	Several days	More than half of the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by feeling afraid as if something awful might happen?	Not at all	Several days	More than half of the days	Nearly every day

DAST

Please take this opportunity to answer the following questions

DAST (Drug Abuse Screening Test):	Circle one answer only for each question	
All questions are regarding the past 12 months and not regarding the following drugs- Alcohol, Tobacco and Caffeine.		
Have you used drugs other than those required for medical reasons?	Yes	No
Do you abuse more than one drug at a time?	Yes	No
Are you unable to stop using drugs when you want to?	Yes	No
Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
Do you ever feel bad about your drug abuse?	Yes	No
Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
Have you ever neglected your family because of your use of drugs?	Yes	No
Have you engaged in illegal activities to obtain drugs?	Yes	No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	Yes	No



Date: _____

Name: _____

ID: _____

The percent of "pure" alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage.

Please use the Standard drink to measure the amount of alcohol consumed.

AUDIT (Alcohol Use Assessment)	Circle one answer only for each question				
In the last 12 months...					
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 time a week	4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last 12 months		Yes within the last 12 months	
Has a relative, or friend, or a doctor or other health worker been concerned about your drinking, or suggested you cut down?	No	Yes, but not in the last 12 months		Yes within the last 12 months	