**CLIENT INFORMATION**

FOR OFFICE USE ONLY: Chart #: _____ Date Opened: ___/___/___ Counselor: _____
Referred by: _____

**PLEASE COMPELTE ALL ITMES:**

Client Name: _____ Age: _____ Date of Birth: ___/___/___

If minor, Parent/Guardian Name: _____

Address:

_____ _____ _____ _____
Street City State Zip

Phone Numbers:

_____ _____ _____
Home Cell Work

Email address (optional): _____

Is it OK to leave a message? Yes_____ No _____ Please circle number above

Person to contact in case of an emergency: _____ _____
Name Phone

Status: Child___ Single___ Dating___ Married___ Living together___ Separated___ Divorced____

Employer: _____ and/or School: _____

Annual household income: $_____

Payment information: (Check one) Insurance--- (provide information below) Sliding fee scale____

_____ _____ _____
Name of Company Policy Number Insured Name

Your relationship to the insured: Self___ Spouse___ Child___ Other:_____

Currently living with:

| Name | Age | Relationship to you | Living together FULL or PART time |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Signature of person completing form: _____ Date:___/___/_____

Signature Page for Acknowledgement of Receipt of

**Notice of Privacy Practices, Informed Consent and Fee and Payment Agreement, Social Media Policy and Notice of Additional Fees**

**By signing this form, you acknowledge that the Community Counseling Center (CCC) has offered you a copy of its Notice of Privacy Practices, its Informed Consent and Fee and Payment Agreement, its Social Media Policy, and its Notice of Additional Fees.**

**The Notice of Privacy Practices explains how your counseling information will be handled and is required by HIPAA, the Federal law concerning medical privacy.**

***Please indicate your responses below and sign and date.***

I have been offered copies of the notice of Privacy Practices, the Informed Consent and Fee and Payment Agreement, the Social Media Policy, and the Notice of Additional Fees. Yes____ No ____

My questions about these forms have been answered. Yes____ No____

_____ _____

Client Signature Date

**Provider Use Only**

If the client is not able to sign due to a disability or emergency, or chooses not to sign, please document that the notices were offered and the reason why the client did not sign.

Client was offered the notices Yes_____ No_____

Reason signature was not obtained:

_____

_____

_____

_____ _____

Staff Signature Date

# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

**Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____**

*If this questionnaire is completed by an informant*, **what is your relationship with the individual? _____**
**In a typical week, approximately how much time do you spend with the individual? _____ hours/week**

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

| | During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|
| I. | 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 | |
| | 2. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 | |
| | 5. Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 6. Feeling nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 | |
| | 7. Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 | |
| | 8. Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 | |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | 0 | 1 | 2 | 3 | 4 | |
| | 10. Feeling that your illnesses are not being taken seriously enough? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 11. Thoughts of actually hurting yourself? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 12. Hearing things other people couldn't hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 | |
| | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 | |
| | 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 | |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 | |
| XII. | 19. Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 | |
| | 20. Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 | |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 | |
| | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 | |
| | 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 | |