

A Better Way Counseling Center  
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Portland, Oregon 97209  
(503) 226-9061

Please use a pen (not pencil) to fill out the following forms. They take about one hour to complete.

The questions you will find on the next few pages are helpful in your treatment. The more we understand about your history and your personal situation, the more we will be able to help you. However, if you find some of them too uncomfortable, feel free not to answer them.

These forms take time and effort on your part. Completing them outside of your appointment time will enable you to talk about your more immediate concerns during your appointment.

# INTAKE FORM

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Personal Information

Name:		Age:	Sex:
Date of Birth: ____ / ____ / ____	Marital Status:		Cell Phone #:
Address:			Work Phone #: ( ) -
City:	State:	Zip:	Message Phone #: ( ) -
# of Children:	Their Ages:		Home Phone #: ( ) -
Nearest Relative Living Separately:			Their Phone #: ( ) -
Partner's Name:			Their Phone #: ( ) -

## Education / Employment Information

Last grade completed in school:	Are you employed now? ____ Yes ____ No
Present Occupation:	Company Name:
Main occupation during past 5 years:	

## Medical Insurance

Insurance Name:	Phone #: ( ) -		
Address:	ID #:		
City:	State:	Zip:	Group #:

## General Information

How did you hear about us? \_\_\_\_\_

Problems you want help with: \_\_\_\_\_

How much have you worked during the past two years? \_\_\_\_\_

Describe your education (# of years of school, special training, etc.): \_\_\_\_\_

Describe any psychological problems you have or have had (e.g. periods of depression, anxiety, fears, phobias, problems with anger, confusion, etc.): \_\_\_\_\_

Describe your living situation: \_\_\_\_\_

Did anyone in your family die before you were 18 years old? \_\_\_\_ Yes \_\_\_\_ No

Who? \_\_\_\_\_ How old were you? \_\_\_\_\_

Other family deaths? \_\_\_\_\_

PLEASE FILL OUT ALL THREE PAGES

When were you last examined by a physician? \_\_\_\_\_ Name \_\_\_\_\_

Present physician's name \_\_\_\_\_ Phone number \_\_\_\_\_

List any major health problems for which you have received treatment:

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**Do you or your family members currently have or have ever had any of the following: (Please check all that apply)**

	SELF	FAMILY
HEART PROBLEMS .....	_____	_____
CANCER .....	_____	_____
NERVOUS BREAKDOWN .....	_____	_____
STROKE .....	_____	_____
CHRONIC ILLNESS _____ ...	_____	_____
ALCOHOL OR DRUG ABUSE .....	_____	_____
LEGAL PROBLEMS .....	_____	_____
LEARNING DISABILITY .....	_____	_____
DEPRESSION .....	_____	_____
OTHER _____ ...	_____	_____

List any medications you are now taking (prescription and non-prescription): \_\_\_\_\_

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Have you been abused or assaulted? (Circle One)      YES    NO    DON'T REMEMBER  
 Did you witness abuse between your parents?      YES    NO    DON'T REMEMBER  
 Did you witness abuse between parent and child?    YES    NO    DON'T REMEMBER

**List everyone currently living in your home, including family and other:**

NAME	AGE	BIRTHDATE	RELATIONSHIP	OCCUPATION

Have you ever received psychiatric or psychological help or counseling of any kind before?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

If you have, please explain: \_\_\_\_\_

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**Please circle any of the following which concern you:**

- |                   |                        |                 |                  |
|-------------------|------------------------|-----------------|------------------|
| NERVOUSNESS       | DEPRESSION             | FEARS           | SHYNESS          |
| SEXUAL PROBLEMS   | SUICIDAL THOUGHT       | SEPARATION      | DIVORCE          |
| FINANCES          | ANGER                  | SELF-CONTROL    | FRIENDS          |
| SLEEP PROBLEMS    | STRESS                 | WORK/SCHOOL     | RELAXATION       |
| HEADACHES         | TIREDNESS              | LEGAL MATTERS   | MEMORY           |
| AMBITION          | ENERGY                 | INSOMNIA        | MAKING DECISIONS |
| LONELINESS        | INFERIORITY FEELINGS   | CONCENTRATION   | EDUCATION        |
| CAREER CHOICES    | MARRIAGE/RELATIONSHIPS | HEALTH PROBLEMS | TEMPER           |
| NIGHTMARES        | CHILDREN               | EATING PROBLEMS | UNHAPPINESS      |
| SEXUAL ABUSE      | PHYSICAL ABUSE         | BOWEL TROUBLES  | BEING A PARENT   |
| MY THOUGHTS       | STOMACH PROBLEMS       | GAMBLING        | BINGE EATING     |
| EATING TOO LITTLE | TOO HEAVY OR THIN      |                 |                  |

**Please circle any of the following strengths you have:**

- |             |             |               |                |               |
|-------------|-------------|---------------|----------------|---------------|
| CONFIDENT   | HARD WORKER | ORGANIZED     | SYMPATHETIC    | GOOD LISTENER |
| DEPENDABLE  | SENSITIVE   | LOGICAL       | LOYAL          |               |
| DECISIVE    | RESPONSIBLE | UNDERSTANDING | SENSE OF HUMOR |               |
| OTHER _____ |             |               |                |               |

**Please use the chart below to describe your use of drugs. Complete the “yes” or “no” lines for each drug listed, and if “yes”, answer the remaining questions on the line.**

	No, I Never Used	Yes, I Used	If yes, age at first use	When using, frequency of use (daily, weekly, etc.)	How long since last used?
Tobacco					
Alcohol					
Marijuana/Hashish					
Cocaine					
Crack					
Crank					
Amphetamine/Speed					
Hallucinogens (LSD, Mushrooms, Mescaline, etc.)					
Coffee					
Other					

**Please add any additional information which you feel may be helpful to us:**

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THANK YOU FOR FILLING OUT THIS FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

**Please answer the following questions. Feel free to use additional paper. If there are some you don't feel comfortable answering, leave them blank and circle them.**

What was the highest grade level you achieved? (For example, you completed high school, or you completed 2 years of college, etc.) \_\_\_\_\_

Have you attended any specialized educational institutions? (For example, a culinary institute, acupuncture college, etc.) \_\_\_\_\_

What companies have you worked for and what type of work did you do at each?

Have you had any medical problems? Did you receive treatment for them, such as medications, hospitalization, etc.? Please list the different problems you've had and what treatment you've had for each, starting from childhood.

Age	Problem	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When was the last time you had a complete physical exam? What was the outcome? When was the last time you saw a physician for any reason? What was the outcome?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is the name of your physician? \_\_\_\_\_

Have you ever had any psychological problems before? Please describe what problems you have had in the past and at what age. Also please describe any treatment, if any, you had for these problems - including counseling, medication, hospitalization etc. and for how long you were treated.

Age	Problem	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had suicidal thoughts in the past 2 months? Yes \_\_\_ No \_\_\_

Have you considered suicide as an option in the past 2 months? Yes \_\_\_ No \_\_\_  
Do you have a suicide plan? \_\_\_ If "yes," what is it? \_\_\_\_\_

Have you ever attempted suicide? Yes \_\_\_ No \_\_\_ How many times? \_\_\_\_\_  
When and how? \_\_\_\_\_

Has anyone in your family ever attempted or succeeded at suicide? Yes \_\_\_ No \_\_\_  
Who? \_\_\_\_\_

Have you ever had any legal issues (criminal or civil)? If so, please explain what the issue was  
and when you had it. (For example, DUII, divorce, identity theft, etc.)

Do you have any friends or family with whom you discuss your deepest problems?  
Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

How many friends or family members do you have with whom you talk on a regular basis:  
Daily (or nearly daily) \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ ?

If you drink alcohol, how often do you drink two drinks in one day (where one drink means one  
oz. of hard liquor, one six oz. glass of wine, or one twelve oz. bottle of beer)? \_\_\_\_\_  
three drinks in one day? \_\_\_\_\_ four drinks in one day? \_\_\_\_\_ more than  
four drinks in one day? \_\_\_\_\_

Please use the space provided to write a short history of your birth family and your present  
family. Include examples of major positive or negative events:

PSYCHOLOGICAL/SOCIAL HISTORY

Instructions: Answer the following questions as they apply to you. On some questions no answers will apply so do not mark anything. Circle the right answers. Some questions will have more than one answer, so circle all that apply. Put a check mark by any answers you want to discuss.

NAME: \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_ SEX \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_

- What is your cultural heritage? (1 answer)
1. Asian
  2. African-American
  3. Caucasian (white)
  5. Hispanic
  6. Native American
  8. Other
1. Who primarily raised you? (1 answer)
    1. Natural Parents
    2. Father Only
    3. Mother Only
    4. Father and Stepmother
    5. Mother and Stepfather
    6. Adoptive Parents
    7. Foster Parents
    8. Institutional Caretakers
    9. Aunt and/or Uncle
    10. Brother and/or Sister
    11. Maternal Grandparent(s)
    12. Paternal Grandparent(s)
    13. Other
  2. How would you characterize your childhood? (Answer all that apply)
 

1. Happy	5. Hard to Remember
2. Frightening	6. Secure
3. Unhappy	7. Painful
4. Dull	8. Regimented
  3. Which descriptor(s) characterize your mother (maternal caretaker)? (answer all that apply)
 

1. Warm	8. Domineering
2. Distant	9. Abusive
3. Uncaring	10. Faultfinding
4. Strict	11. Understanding
5. Unpleasant	12. Perfect
6. Rejecting	13. Affectionate
7. Overprotective	
  4. Which (descriptor(s) characterize your father (paternal caretaker)? (answer all that apply)
 

1. Warm	8. Domineering
2. Distant	9. Abusive
3. Uncaring	10. Faultfinding
4. Strict	11. Understanding
5. Unpleasant	12. Perfect
6. Rejecting	13. Affectionate
7. Overprotective	
  5. How would you describe your parents' (or parent substitutes') relationship? (answer all that apply)
 

1. Warm	8. Domineering
2. Distant	9. Abusive
3. Uncaring	10. Faultfinding
4. Strict	11. Understanding
5. Unpleasant	12. Perfect
6. Rejecting	13. Affectionate
7. Overprotective	
  6. How many brother and sisters did you have? (1 answer)
 

1. One	6. Six
2. Two	7. Seven
3. Three	8. More than seven
4. Four	9. None
5. Five	
  7. Which descriptors characterize you as a child (0 to 12 years of age)? (Answer all that apply)
 

1. Outgoing	8. Emotional
2. Shy	9. Irresponsible
3. Active	10. Nervous
4. Aggressive	11. Rebellious
5. Awkward	12. Serious
6. Happy	13. Stubborn
7. Friendly	
  8. What was your order of birth? (1 answer)
 

1. Oldest	3. Youngest
2. Middle	4. Only Child
  9. What were problems for you as a child (0 to 12 years of age)? (Answer all that apply)
 

1. None	10. Academic
2. Getting along with mother	11. Physical/medical problems
3. Getting along with father	12. Nerves
4. Getting along with sibling(s)	13. Felt I was a burden to my parents
5. Getting along with peers	14. Overweight
6. Getting along with teacher	15. Underweight
7. Bed-wetting	16. Having my feelings hurt
8. Nightmares	17. Fear of failure
9. Excessive fears or worries	
  10. What did your parents (parent caretakers) argue about? (Answer all that apply)
 

1. Money	6. Jealousy
2. Discipline of children	7. Not taking care of the home
3. Relatives interfering	8. Not being a good provider
4. Drinking	9. Never argued
5. Sex	
  11. What was your father's (paternal caretaker's) occupation)? (1 answer)
 

1. Homemaker	9. Unemployed
2. Professional	10. Disabled
3. Owner of Business	11. Government Service
4. Skilled Craftsman	12. Personal Service (e.g. Hair Stylist, Maid)
5. Office Worker	13. Military Service
6. Salesperson	14. Executive
7. Skilled Laborer	15. Does Not Apply
8. Unskilled Laborer	
  12. What was your mother's (maternal caretaker's) occupation)? (1 answer)
 

1. Homemaker	9. Unemployed
2. Professional	10. Disabled
3. Owner of Business	11. Government Service
4. Skilled Craftsman	12. Personal Service (e.g. Hair Stylist, Maid)
5. Office Worker	13. Military Service
6. Salesperson	14. Executive
7. Skilled Laborer	15. Does Not Apply
8. Unskilled Laborer	

13. How would you describe your mother's method of discipline? (1 answer)
1. Strict
  2. Fairly Strict
  3. Fair
  4. Lenient
  5. Inconsistent
13. How would you describe your father's method of discipline? (1 answer)
1. Strict
  2. Fairly Strict
  3. Fair
  4. Lenient
  5. Inconsistent
14. What fears did you have as a child (0 to 12 years of age)? (Answer all that apply)
1. No significant fears
  2. Death
  3. Might Fail
  4. Might be seriously injured or become ill
  5. Strangers
  6. Might be laughed at
  7. Might be abandoned - lose my parents
  8. Animals
  9. Other children
15. How far did you go in school? (1 answer)
1. Completed less than 6 grades
  2. Completed elementary school
  3. Completed junior high (9<sup>th</sup> grade)
  4. Attended high school but did not receive a diploma
  5. Received a G.E.D.
  6. Graduated from high school
  7. Vocational or Business school training beyond high school
  8. Attended college but did not graduate
  9. Graduated from college - four year degree
  10. Completed college course work at the graduate level
  11. Earned a Master's Degree
  12. Earned a Doctoral Degree
16. How would you rate your intellectual ability? (1 answer)
1. Below average
  2. Average
  3. Above average
  4. Superior/gifted
17. Were you ever held back in school? (1 answer)
1. No
  2. Yes
19. In general, what grades did you make in school? (1 answer)
1. Many D's and F's
  2. Mostly C's
  3. Mostly A's and B's
  4. Mostly A's
20. Did you ever get in trouble while in school? (1 answer)
1. No
  2. Occasionally
  3. Often
21. Did you have any problems learning to read? (1 answer)
1. No
  2. Yes
22. Did you have any problems learning math? (1 answer)
1. No
  2. Yes
23. Did your peers ridicule, tease or make fun of you more than other kids? (1 answer)
1. No
  2. Yes
24. Rate your family's economic status during childhood and adolescence: (1 answer)
1. Poverty level (received welfare)
  2. Working Class
  3. Middle Class
  4. Upper Middle Class
  5. Wealthy
25. Who provided the main source of income for your family? (1 answer)
1. Mother
  2. Father
  3. A Relative
  4. Social Service (Welfare, Unemployment, Disability)
  5. A Friend of the Family
  6. Other
26. Did your parents agree on how money should be spent? (1 answer)
1. Agreed most of the time
  2. Disagreed
  3. Disagreed frequently
27. Did your family experience any financial problems? (1 answer)
1. No
  2. Occasionally
  3. Often
28. Currently, how much money does the household earn that you now live in? (1 answer)
1. Less than \$8,000
  2. \$8,000 - \$20,000
  3. \$20,000 - \$40,000
  4. \$40,000 - \$75,000
  5. \$75,000 - \$125,000
  6. \$125,000 - \$200,000
  7. More than \$200,000
29. Have you had any major changes in income during the last 2 years? (1 answer)
1. No
  2. Decreased significantly
  3. Increased significantly
30. What is your family's primary source of income? (1 answer)
1. My Earnings
  2. My Partner's Earnings
  3. Relatives
  4. Disability Payments
  5. Unemployment
  6. Welfare
  7. Investments
  8. Other
31. Is providing enough income for your family a big stress in your life? (1 answer)
1. No
  2. Yes
32. Are you presently employed? (1 answer)
1. No
  2. Yes
33. How long have you been working at this job? (1 answer)
1. Less than 6 months
  2. 6 months to one year
  3. 1 to 3 years
  4. 3 to 5 years
  5. 5 to 10 years
  6. 10 to 15 years
  7. 15 to 20 years
  8. More than 20 years
  9. Does not apply
34. How many hours per week do you work? (1 answer)
1. Less than 10
  2. 10 to 20
  3. 20 to 30
  4. 30 to 45
  5. More than 45
  6. Does not apply
35. In general, how do you enjoy your work? (1 answer)
1. Enjoyable
  2. Neutral
  3. Unenjoyable
  4. Does not apply
36. Have you ever been fired? (1 answer)
1. No
  2. Yes
37. Have you ever been laid off? (1 answer)
1. No
  2. Yes
38. What is the longest period of time you held one job? (1 answer)
1. Less than 1 year
  2. 1 to 3 years
  3. 3 to 5 years
  4. 5 to 10 years
  5. More than 10 years
39. Since starting full-time work, what is your longest non-work period? (1 answer)
1. Less than 1 month
  2. 1 to 6 months
  3. 6 months to 1 years
  4. 1 to 3 years
  5. 3 to 5 years
  6. 5 to 10 years
  7. More than 10 years



40. Do you have any problems at work? (1 answer)
1. No
  2. Yes
41. What kinds of work have you performed in the past? (Answer all that apply)
- |                         |  |
|-------------------------|--|
| 1. A Homemaker          | 8. An Unskilled Laborer                        |
| 2. A Professional       | 9. Have Never Worked                           |
| 3. An Owner of Business | 10. In Government Service                      |
| 4. A Skilled Craftsman  | 11. Personal Service (e.g. Hair Stylist, Maid) |
| 5. An Office Worker     | 12. An Executive                               |
| 6. A Salesperson        | 13. Other                                      |
| 7. A Skilled Laborer    |  |
42. Have you ever served in the military? (1 answer)
1. No
  2. Yes
43. Which branch did you serve in? (1 answer)
- |                   |                |
|-------------------|----------------|
| 1. Does not apply | 4. Navy        |
| 2. Air Force      | 5. Marines     |
| 3. Army           | 6. Coast Guard |
44. How long did you serve? (1 answer)
- |                       |                       |
|-----------------------|-----------------------|
| 1. Does not apply     | 6. 4 to 6 years       |
| 2. Less than 3 months | 7. 6 to 10 years      |
| 3. Less than 1 year   | 8. 10 to 15 years     |
| 4. 1 to 2 years       | 9. More than 15 years |
| 5. 2 to 4 years       |                       |
45. What kinds of problems did you experience while in the military? (Answer all that apply)
1. Getting used to following rules and regulations
  2. Taking orders
  3. Nerves
  4. Began using drugs
  5. Began using alcohol to excess
  6. Was reprimanded by my superiors for my conduct
  7. Had to perform special duty because of my conduct (K.P., Latrine, etc)
  8. Did time in the stockade/brig
  9. Was court marshaled
  10. Went AWOL
  11. Other
  12. Does not apply/none
46. Were you stationed in a combat zone? (1 answer)
- |                                |                                 |
|--------------------------------|---------------------------------|
| 1. Does not apply              | 6. Yes, for 1 to 2 years        |
| 2. No                          | 7. Yes, for 2 to 3 years        |
| 3. Yes, for less than 3 months | 8. Yes, for 3 to 4 years        |
| 4. Yes, for 3 to 6 months      | 9. Yes, for longer than 4 years |
| 5. Yes, for 6 months to 1 year |                                 |
47. What was the highest rank you attained? (1 answer)
1. Does not apply
  2. Enlisted person
  3. Noncommissioned Officer
  4. Officer
48. What were the terms of your discharge? (1 answer)
1. Does not apply
  2. Still on active duty
  3. Honorably discharged due to mental problems
  4. Honorably discharged due to physical problems
  5. Honorable discharge
  6. Dishonorably discharged
49. Did you ever see a psychologist or psychiatrist while in the military? (1 answer)
1. Does not apply
  2. No
  3. Was hospitalized for mental problems
  4. For evaluation and treatment (outpatient)
  5. For evaluation only
50. Do you have a service-connected disability? (1 answer)
- |                   |                        |
|-------------------|------------------------|
| 1. Does not apply | 4. Mental              |
| 2. No             | 5. Physical and Mental |
| 3. Physical       |                        |
51. Which of the following have you used? (Answer all that apply)
- |                    |  |
|--------------------|--|
| 1. None            | 8. Heroin                              |
| 2. Cocaine         | 9. Marijuana                           |
| 3. Barbiturates    | 10. Tranquilizers without prescription |
| 4. Amphetamines    | 11. Pain pills without prescription    |
| 5. Hallucinogenics | 12. PCP                                |
| 6. Opium           |  |
| 7. Qualludes       |  |
52. Have you ever felt there was a time you drank too much alcohol? (1 answer)
1. No
  2. Yes, on one occasion
  3. Yes, on several occasions
  4. Yes, on more than several occasions
53. On the average, how often do you drink alcohol? (1 answer)
- |                         |                         |
|-------------------------|-------------------------|
| 1. Never                | 4. Once a week          |
| 2. Once or twice a year | 5. Several times a week |
| 3. Once a month         | 6. Daily                |
54. How would you describe your illegal drug usage? (1 answer)
- |                          |                            |
|--------------------------|----------------------------|
| 1. Never used drugs      | 4. Once a week             |
| 2. Once or twice a year  | 5. A couple of time a week |
| 3. Once or twice a month | 6. Daily                   |
55. Have you ever been involved in an alcoholism or drug treatment program? (1 answer)
1. No
  2. Yes
56. Did your parents have a problem with alcohol when you were a child? (1 answer)
- |                |                                 |
|----------------|---------------------------------|
| 1. No          | 4. Both parents did             |
| 2. Mother only | 5. The person who raised me did |
| 3. Father only |                                 |
57. Do you smoke cigarettes? (1 answer)
1. No, never have
  2. No, I quit smoking
  3. Yes, a pack a week or less
  4. Yes, approximately one-half pack a day
  5. Yes, a pack a day
  6. Yes, more than a pack a day
58. Have any family members ever experienced mental illness? (Answer all that apply)
- |           |   |
|-----------|---|
| 1. No     | 5. Sibling(s) [brother(s) and sister(s)]            |
| 2. I have | 6. Grandparents                                     |
| 3. Mother | 7. Outside the immediate family (uncle, aunt, etc.) |
| 4. Father |   |
59. Did you have any bad illnesses as a child (e.g., hospitalizations)? (1 answer)
1. No
  2. Yes
60. Have you had any significant accidents in the past 3 years? (1 answer)
1. No
  2. Yes
61. Have you had any major illnesses or hospitalizations in the past 3 years? (1 answer)
1. No
  2. Yes
62. Rate your general level of health. (1 answer)
- |              |                   |
|--------------|-------------------|
| 1. Excellent | 4. Poor           |
| 2. Good      | 5. Extremely Poor |
| 3. Fair      |                   |
63. Are you currently under the care of a physician? (1 answer)
1. No
  2. Yes

64. What medications are you currently taking? (Answer all that apply)
1. None
  2. Pain pills
  3. Antibiotics
  4. Anti-inflammatory pills
  5. Anticonvulsant pills
  6. Hear pills
  7. High blood pressure pills
  8. Tranquilizers
  9. Antidepressants
  10. Vitamins
  11. Insulin
  12. Allergy Pills
  13. Stomach pills
  14. Other
65. What is your marital status? (1 answer)
1. Single, but involved in an intimate relationship
  2. Single
  3. Divorced
  4. Separated
  5. Married
  6. Widowed
66. Have you ever been divorced? (1 answer)
1. No
  2. Yes
67. How long have you been with your current partner? (1 answer)
1. Not involved in an intimate relationship at this time
  2. Less than 1 year
  3. 1 year
  4. 2 years
  5. 3 years
  6. 4 years
  7. 5 years
  8. More than 5 years
  9. More than 10 years
  10. More than 15 years
  11. More than 20 years
  12. More than 25 years
  13. More than 30 years
68. How many children do you have? (1 answer)
1. 1
  2. 2
  3. 3
  4. 4
  5. 5
  6. 6
  7. 7
  8. More than 7
  9. None
69. How would you describe your partner? (Answer all that apply)
1. Warm
  2. Unhappy
  3. Distant
  4. Uncaring
  5. Happy
  6. Unpleasant
  7. Enjoyable
  8. Abusive
  9. Faultfinding
  10. Understanding
  11. Perfect
  12. Indifferent
  13. Argumentative
  14. Boring
  15. Stimulating
  16. Unforgiving
  17. Tense
  18. Affectionate
  19. Does not apply
70. Are you having problems with your child(ren)'s behavior? (1 answer)
1. No
  2. Yes
  3. Does not apply
71. Is the frequency of sex a problem? (1 answer)
1. No
  2. Yes
72. What are your living arrangements? (1 answer)
1. Living with relatives in their home
  2. Living with friends in their home
  3. Renting a home
  4. Renting an apartment
  5. Buying a home
  6. Own my own home
  7. Boarder
  8. Living in a dorm
  9. Other
73. How often do you and your partner argue? (1 answer)
1. Never
  2. Rarely
  3. Once a month
  4. Once a week
  5. Several times a week
  6. Daily
  7. Several times a day
  8. Does not apply
74. Has your relationship ever been threatened by an affair? (1 answer)
1. No
  2. Yes, my affair
  3. Yes, my partner's affair
  4. Does not apply
75. What interests do you and your partner share? (Answer all that apply)
1. None
  2. Children
  3. Work-related
  4. Sports
  5. Hobbies or crafts
  6. Movies
  7. Theater
  8. Music
  9. Politics
  10. Socializing with friends
  11. Television
  12. Religious activities
  13. Club activities
  14. Talking
  15. Games
  16. Camping
  17. Hunting/fishing
  18. Other
  19. Does not apply
76. How well do you feel your partner fulfills his/her role with you? (1 answer)
1. Very well
  2. Fairly Well
  3. Poorly
  4. Very poorly
  5. Does not apply
77. Do you eat a balanced diet? (1 answer)
1. No
  2. Yes
78. Do you participate in a regular exercise program? (1 answer)
1. No
  2. Yes
79. How would you characterize your size? (1 answer)
1. Very thin
  2. Thin
  3. About average
  4. A little heavy
  5. Heavy
  6. Very heavy
80. Which of the following have you experienced in the past two years? (Answer all that apply)
1. Marital reconciliation
  2. Jail term
  3. Retirement
  4. Fired at work
  5. Change in health of family member
  6. Marital separation
  7. Divorce
  8. Death of spouse/ partner
  9. Pregnancy
  10. More or less arguments with partner
  11. None
81. Which of the following have you experienced in the past two years? (Answer all that apply)
1. Death of a close friend
  2. Marriage
  3. Death of a close family member
  4. Change in financial state
  5. Personal injury or illness
  6. Change to different line of work
  7. Business readjustment
  8. Gain a new family member
  9. Sexual worries
82. How would you rate your ability to cope with life? (1 answer)
1. Very good
  2. Good
  3. Fair
  4. Poor
83. How would you describe yourself? (Answer all that apply)
1. Quiet
  2. Outgoing
  3. Talkative
  4. Shy
  5. Active
  6. Aggressive
  7. Temperamental
  8. Self-confident
  9. Wild
  10. Carefree
  11. Stubborn
  12. Easygoing
  13. Friendly
  14. Smart
  15. Impatient
  16. Responsible
  17. Rebellious
  18. Unassertive

84. How would you describe your mental state? (Answer all that apply)
- |                   |                       |
|-------------------|-----------------------|
| 1. Tense          | 10. Disappointed      |
| 2. Depressed      | 11. Regretful         |
| 3. Forgetful      | 12. Irritable         |
| 4. Sad            | 13. Calm              |
| 5. Worried        | 14. Scared            |
| 6. Fearful        | 15. Hyperactive       |
| 7. Angry          | 16. Nervous           |
| 8. Unenthusiastic | 17. Happy             |
| 9. Confused       | 18. None of the above |
85. Have you ever had legal problems? (Answer all that apply)
- |                          |              |
|--------------------------|--------------|
| 1. No                    | 3. Arrested  |
| 2. Civil (e.g., Divorce) | 4. Convicted |
86. What is the primary problem bothering you? (1 answer)
- |                        |                         |
|------------------------|-------------------------|
| 1. Marriage            | 8. Physical (ill/tired) |
| 2. Family              | 9. Alcohol              |
| 3. Loneliness          | 10. Drugs               |
| 4. Moodiness           | 11. Sex                 |
| 5. Depression          | 12. Memory              |
| 6. Anxiety             | 13. Work                |
| 7. Low self-confidence | 14. Other               |
87. How long ago did you begin to be troubled by this problem?  
(1 answer)
- |                            |                           |
|----------------------------|---------------------------|
| 1. Within the past month   | 6. Between 5 and 10 years |
| 2. Between 1 and 6 months  | 7. Over 10 years          |
| 3. Between 6 and 12 months | 8. All my life            |
| 4. Between 1 and 2 years   | 9. Does not apply         |
| 5. Between 2 and 5 years   |                           |
88. Rate the degree to which this problem has affected your life.  
(1 answer)
- |                  |                   |
|------------------|-------------------|
| 1. Very little   | 4. A good deal    |
| 2. A little      | 5. A great deal   |
| 3. A fair amount | 6. Does not apply |
89. How often do you experience this problem? (1 answer)
- |                         |                          |
|-------------------------|--------------------------|
| 1. Many times a day     | 6. Several times a month |
| 2. Several times a day  | 7. Monthly               |
| 3. Daily                | 8. Several times a year  |
| 4. Several times a week | 9. Less than once a year |
| 5. Once a week          | 10. Does not apply       |
90. What other kinds of problems are bothering you? (Answer all that apply)
- |                         |                    |
|-------------------------|--------------------|
| 1. Marriage             | 9. Alcohol         |
| 2. Family               | 10. Drugs          |
| 3. Loneliness           | 11. Sex            |
| 4. Moodiness            | 12. Memory         |
| 5. Depression           | 13. Work           |
| 6. Anxiety              | 14. Other          |
| 7. Low self-confidence  | 15. Does not apply |
| 8. Physical (ill/tired) |                    |

## THE TRAUMA SYMPTOM CHECKLIST (TSC-40)

How often have you experienced each of the following in the last two months?

	NEVER	1	2	OFTEN
1. Headaches	0	1	2	3
2. Insomnia (trouble getting to sleep)	0	1	2	3
3. Weight loss (without dieting)	0	1	2	3
4. Stomach problems	0	1	2	3
5. Sexual problems	0	1	2	3
6. Feeling isolated from others	0	1	2	3
7. "Flashbacks" (sudden, vivid, distracting memories)	0	1	2	3
8. Restless sleep	0	1	2	3
9. Low sex drive	0	1	2	3
10. Anxiety attacks	0	1	2	3
11. Sexual overactivity	0	1	2	3
12. Loneliness	0	1	2	3
13. Nightmares	0	1	2	3
14. "Spacing out" (going away in your mind)	0	1	2	3
15. Sadness	0	1	2	3
16. Dizziness	0	1	2	3
17. Not feeling satisfied with your sex life	0	1	2	3
18. Trouble controlling your temper	0	1	2	3
19. Waking up early in the morning and can't get back to sleep	0	1	2	3
20. Uncontrollable crying	0	1	2	3
21. Fear of men	0	1	2	3
22. Not feeling rested in the morning	0	1	2	3
23. Having sex that you didn't enjoy	0	1	2	3
24. Trouble getting along with others	0	1	2	3
25. Memory problems	0	1	2	3
26. Desire to physically hurt yourself	0	1	2	3
27. Fear of women	0	1	2	3
28. Waking up in the middle of the night	0	1	2	3
29. Bad thoughts or feelings during sex	0	1	2	3
30. Passing out	0	1	2	3
31. Feeling that things are "unreal"	0	1	2	3
32. Unnecessary or over-frequent washing	0	1	2	3
33. Feelings of inferiority	0	1	2	3
34. Feeling tense all the time	0	1	2	3
35. Being confused about your sexual feelings	0	1	2	3
36. Desire to physically hurt others	0	1	2	3
37. Feelings of guilt	0	1	2	3
38. Feeling that you are not always in your body	0	1	2	3
39. Having trouble breathing	0	1	2	3
40. Sexual feelings when you shouldn't have them	0	1	2	3

## Fear Inventory

This questionnaire is designed to help your therapist understand what kinds of things you are afraid of. After each item, check the one box that best describes how much you are disturbed by it these days.

	Not at All	A Little	A Fair Amount	Very Much
Noise of vacuum cleaners .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open wounds .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being alone .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being in a strange place .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loud voices .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dead people .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking in public .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossing streets .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People who seem insane .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falling .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automobiles .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being teased .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentists .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thunder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sirens .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Entering a room where other people are already seated .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High places on land .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking down from high buildings .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worms .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imaginary creatures .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strangers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receiving injections .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bats .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Journeys by train .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Journeys by bus .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Journeys by car .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling angry .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People in authority .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flying insects .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing other people injected .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden noises .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dull weather .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crowds .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Large open spaces .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cats .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One person bullying another .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tough looking people .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birds .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sight of deep water .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being watched working .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dead animals .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weapons .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OVER

Dirt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling insects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sight of fighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sick people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being criticized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strange shapes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being in an elevator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Witnessing surgical operations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angry people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Human blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animal blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parting from friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enclosed places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prospect of a surgical operation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling rejected by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Airplanes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical odors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling disapproved of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harmless snakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cemeteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being ignored	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Darkness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature heartbeats (missing a beat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nude men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nude women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with deformities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking foolish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Losing control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming nauseous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spiders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being in charge or responsible for decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sight of knives or sharp objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming mentally ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being with a member of the opposite sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking written tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being touched by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling different from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lull in conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being overpowered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suffocating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confined spaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## INSTRUCTIONS FOR COMPLETING THIS ACTIVITY ASSESSMENT FORM

On the next page is a form that helps your therapist understand how you use your time. Fill it out using the last seven days' activities. So, for instance, if today were Monday, you would start with the day before, Sunday, and work your way backwards until all seven days are filled in. Fill in as much as you can remember.

Time	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1:00 am							
2:00 am							
3:00 am							
4:00 am							
5:00 am							
6:00 am							
7:00 am							
8:00 am							
9:00 am							
10:00 am							
11:00 am							
12:00 pm							
1:00 pm							
2:00 pm							
3:00 pm							
4:00 pm							
5:00 pm							
6:00 pm							
7:00 pm							
8:00 pm							
9:00 pm							
10:00 pm							
11:00 pm							
12:00 pm							



## THE MICHIGAN ALCOHOLISM SCREENING TEST

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1.	Do you feel you are a normal drinker?	Yes	No
2.	Have you ever awakened in the morning after some drinking the night before and found that you could not remember part of the evening?	Yes	No
3.	Does your wife/husband or parents ever worry or complain about your drinking?	Yes	No
4.	Can you stop drinking without a struggle after one or two drinks?	Yes	No
5.	Do you ever feel badly about your drinking?	Yes	No
6.	Do you ever try to limit your drinking to certain times of the day or to certain places?	Yes	No
7.	Do your friends or relatives think that you are a normal drinker?	Yes	No
8.	Are you always able to stop when you want to?	Yes	No
9.	Have you ever attended a meeting of Alcoholics Anonymous?	Yes	No
10.	Have you gotten into fights when drinking?	Yes	No
11.	Has drinking ever created problems with you and your wife/husband?	Yes	No
12.	Has your wife/husband or other family members ever gone to anyone for help about your drinking?	Yes	No
13.	Have you ever lost friends or girlfriends/boyfriends because of your drinking?	Yes	No
14.	Have you ever gotten into trouble at work because of drinking?	Yes	No
15.	Have you ever lost a job because of drinking?	Yes	No
16.	Have you ever neglected your obligations, your family or work for two days or more in a row because of drinking?	Yes	No
17.	Do you ever drink before noon?	Yes	No
18.	Have you ever been told you have liver trouble?	Yes	No
19.	Have you ever had DT's (delirium tremens), severe shaking, heard voices or seen things that weren't there after heavy drinking?	Yes	No
20.	Have you ever gone to anyone for help about your drinking?	Yes	No
21.	Have you ever been in a hospital because of drinking?	Yes	No
22.	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?	Yes	No
23.	Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor or clergyman for help with an emotional problem in which drinking played a part?	Yes	No
24.	Have you ever been arrested, even for a few hours, because of drunken behavior?	Yes	No
25.	Have you ever been arrested for drunken driving or driving after drinking?	Yes	No

# Instructions for Health Insurance Claim Form

**Please fill out all sections that apply to you on the top portion of this form.** Generally this means you will need to answer questions #1 through #13. Leave #14 through #33 blank.

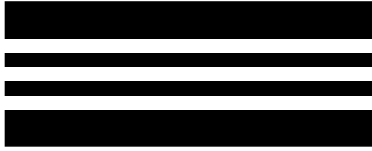
The term "patient," as in section #2, means you. "Insured" means the employee whose job provides the insurance for the employee and additional family members. Therefore you might be both the "insured" and the "patient," or you might be the "patient" and your spouse the "insured."

Fill out section #9 only if you are covered under a second insurance policy. For instance, you might be insured through your work and also be covered under your spouse's policy. You would fill out **your** information in section #11, and your **spouse's** insurance information in section #9. If you are not an employee yourself with insurance, but you are covered under your spouse's or parent's insurance, the "insured" would be your spouse or parent.

Please be sure to sign in both places - sections #12 and #13.

**Thank You.**

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ( )		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		23. PRIOR AUTHORIZATION NUMBER		24. TABLE	
1. _____		3. _____		24. TABLE	
2. _____		4. _____		24. TABLE	
24. TABLE		24. TABLE		24. TABLE	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____			

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

**REFERS TO GOVERNMENT PROGRAMS ONLY**

**MEDICARE AND TRICARE PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

**BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

**SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)**

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE:** Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)**

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872, and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Addition disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed, Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USES(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency of Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.