Folder Checklist

LEFT SIDE OF FOLDER:
_____ Counseling and Non-Counseling Contacts
_____ Informed Consent
_____ Notice of Privacy Practices
_____ Listing of Disclosures of Confidential Information
_____ Release/Obtain of Information Form

RIGHT SIDE OF FOLDER:
_____ Session Notes
_____ Initial Treatment Plan
_____ Intake Summary
_____ Confidential Intake Form
COUNSELING AND NON-COUNSELING CONTACTS

Please keep an accurate, chronological record of contacts (other than counseling sessions) with the client on this form. For example, if the client misses an interview and you contact him/her by phone or letter, state that here. If you ask for or release information regarding a client, list that here, etc.

NOTE: Always date and CLEARLY print your name on the entry.

<table>
<thead>
<tr>
<th>DATE</th>
<th>YOUR NAME</th>
<th>TIME CALLED</th>
<th>ACTION TAKEN</th>
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# AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

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<th>NAME:</th>
<th>DATE OF BIRTH:</th>
<th>DATE OF AUTHORIZATION:</th>
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Authorization is hereby voluntarily granted to the UCO Psychology Clinic by the below signee/guardian to exchange information with the following persons or organizations:

<table>
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<tr>
<th>Name of Persons or Organization</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Telephone</th>
<th>Fax</th>
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**INFORMATION TO BE RELEASED COVERS THE DATES OF:**

**METHOD FOR RELEASING:** (Check all that apply) ☐ Oral  ☐ Written  ☐ Fax (fax cover sheet required)  ☐ E-mail

**INFORMATION TYPE:** Please check all that apply

- ☐ Release  ☐ Request  ☐ Request/Release
- ☐ Psychological Testing/Assessments  ☐ Summaries of Treatment
- ☐ Treatment/Service Plans  ☐ Other (Please Specify): __________________________

**PURPOSE OF INFORMATION:**

- ☐ Treatment/Service Coordination  ☐ Evaluation  ☐ Treatment/Service Planning
- ☐ Other (Please Specify): __________________________

I understand that this authorization is subject to revocation at any time, except to the extent that the UCO Psychology Clinic has already taken action on its authorization. If not revoked earlier by written notice to the UCO Psychology Clinic, this authorization shall expire as follows:

- ☐ One year from date of authorizing signature.
- ☐ Upon reaching: (Specify date, event, or condition on which this consent for expires)

Once the requested information is disclosed pursuant to this authorized consent form, UCO Psychology Clinic will no longer have control over the information, and there is a potential that it may be re-disclosed by the recipient and no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA).

<table>
<thead>
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<th>Student/Authorized Signature</th>
<th>Date</th>
<th>Clinician/Witness Signature</th>
<th>Date</th>
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Parent/Guardian Signature (if needed) | Date |
Listing of Disclosures of Confidential Information

_____ There were no applicable disclosures made of your protected health information for the period you specified.

_____ Disclosures of your protected health information were made by this office to:

<table>
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<tr>
<th>Date of Disclosure</th>
<th>Person to Whom Client Information was Discussed</th>
<th>Agency and Address</th>
<th>Description of Information Disclosed</th>
<th>Purpose of Information Disclosed</th>
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We are temporarily unable to process the accounting for disclosures you have requested due to:

_____ A suspension required by law.

_____ Other, specify: ___________________________________________________________________________

However, your request will be provided by __________________________________________________________
(Month/Day/Year)

If you have any questions concerning this accounting for disclosures, please contact:

_______________________________________________ at 405/974-5707.

Printed Name of Counselor

_______________________________________________ Date: ________________________________
Counselor’s Signature
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information
We, University of Central Oklahoma Psychology Clinic (UCO), are committed to protecting the privacy of patient personal and health information. Applicable Federal and State laws require us to maintain the privacy of our patients’ personal and health information. This Notice explains our clinic’s privacy practices, our legal duties, and your rights concerning your personal and health information. In this Notice, your personal health information (PHI) is referred to as “health information” and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income, or other financial information. We will follow the privacy practices described in this Notice while it is in effect. This Notice takes effect May 1, 2005 and will remain in effect until replaced.

How We Protect Your Health Information
We protect your health information by
- Treating all of your health information that we collect as confidential.
- Stating confidentiality policies and practices in our UCO staff handbooks, as well as disciplinary measures for privacy violations.
- Restricting access to your health information only to those UCO staff that need to know your health information in order to provide our services to you.
- Only disclosing your health information that is necessary for an outside service company to perform its function on the clinic’s behalf; such companies have, by contract, agreed to protect and maintain the confidentiality of your health information.
- Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

Uses and Disclosures for Treatment, Payment, and Health Care Operations
UCO may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes, as long as you consent to receive evaluation or treatment services from the clinic. To help clarify these terms, here are some definitions.

“Treatment, Payment, and Health Care Operations”
- Treatment occurs when a Psychological Associate provides, coordinates, or manages your health care and other services related to your health care. An example of treatment: a Psychological Associate consults with another health care provider, such as your family physician.
- Payment occurs when a Psychological Associate obtains reimbursement for your healthcare.
- Health Care Operations activities relate to the performance and operation of the UCO. Examples of health care operations: quality assessment and improvement activities, business-related matters, such as audits and administrative services, case management and care coordination, conducting training and educational programs, or accreditation activities.
• “Use” applies only to activities within UCO, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
• “Disclosure” applies to activities outside UCO, such as releasing, transferring, or providing access to information about you to other parties.

**Uses and Disclosures Requiring Authorization**
UCO may use or disclose PHI for purposes outside treatment, payment, or healthcare operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when UCO is asked for information for purposes outside treatment, payment or healthcare operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization (1) to the extent that UCO has relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy

**Uses and Disclosures with Neither Consent nor Authorization**
The UCO may use or disclose PHI without your consent or authorization in the following circumstances.

• **Abuse** – If we have reason to believe that a minor child, elderly person or disabled person may have been abused, abandoned, or neglected, the UCO must report this concern or observations related to these conditions or circumstances to the appropriate authorities.

• **Health Oversight Activities** – If the Board of Examiners in Psychology, Council on Accreditation, or other oversight body, is investigating a Psychological Associate or UCO as part of a formal complaint you have filed, UCO may be required to disclose PHI regarding your case.

• **Judicial and Administrative Proceedings as Required** – If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof; we may be compelled to provide the information. Although courts have recognized a therapist-patient privilege, there may be circumstances in which a court would order UCO to disclose personal health or treatment information. UCO will not release information without your written authorization, or that of your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party (e.g., law enforcement agency, Social Security Administration) or when the evaluation is court ordered.

• **Serious Threat to Health or Safety** – If you communicate to UCO personnel an explicit threat of imminent serious physical harm or death to identifiable victim(s), and we believe you may act on the threat, we have a legal duty to take the appropriate measures to prevent harm to that person(s), including disclosing information to the police and warning the victim. If we have reason to believe that you present a serious risk of physical harm or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.

• **Worker’s Compensation** – The UCO may disclose PHI regarding you as authorized by, and to the extent necessary, to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

• **National Security** – We may be required to disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may be required to disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may be required to disclose health information to a correctional institution or law enforcement official having lawful custody of PHI of an inmate or patient under certain circumstances.

• **Research** – Under certain limited circumstances, we may use and disclose health information for research purposes. All research projects, however, are subject to scrutiny and approval by an institutional review board.

**Patient’s Rights and Clinician’s Duties**
Patient’s Rights

- Rights to Request Restrictions – You have the right to request additional restrictions on certain uses and disclosures of PHI. UCO may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are being seen at UCO. On your request, UCO will send your bills to another address.

- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of your clinic health records. A reasonable fee may be charged for copying or, if necessary, redacting the record(s). Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.

- Right to Amend – You have the right to request, in writing, an amendment of your health information as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.

- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

- Electronic vs. Paper Copy – If you received this notice electronically (e.g., accessing a website), you have the right to obtain a paper copy of the notice from the UCO upon request.

UCO Duties

UCO, and all associated persons, are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices. UCO reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, the UCO is required to abide by the terms currently in effect.

Other Restrictions

UCO must also conform to Federal regulations (42 CFR, Part 2) regarding the release of alcohol/drug treatment records and confidentiality standards related to such treatment.

Changes to this Notice

UCO reserves the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility. You may request a copy of the Notice at any time.

Questions and Complaints

For questions regarding this Notice or our privacy practices, please contact the UCO Director. If you are concerned that your privacy rights may have been violated, you may contact Caleb W. Lack, Ph.D. to make a complaint. You may also make a written complaint to the U.S. Department of Health and Human Services.
If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.

**Department of Health and Human Services**
Office for Civil Rights
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX
Toll free: 1-800-368-1019
http://www.hhs.gov/ocr/hipaa/
CLIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign this Acknowledgement)

I, ________________________________________, have received a copy of the Notice of Privacy Practices.

_______________________________________
Name (Print)

_______________________________________
Signature

_______________________________________
Date

For Office Use Only

University of Central Oklahoma Psychology Clinic has made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

_____ Patient/Individual refused acknowledgement; Date of refusal: ________________

_____ Communication barriers prohibited obtaining an acknowledgement

_____ Emergency situation prevented obtaining an acknowledgement

_____ Other ___________________________________________________

Attempt was made by: ___________________________ Date: ___________________

Explanation: ___________________________________________________

Psychological Associate: ___________________________ Signature

or Clinician

Supervisor: ___________________________ Signature

(if needed)
SERVICES CONSENT FORM

Client name: ____________________________ Date: ___ / ___ / _____

I hereby voluntarily consent to utilize the services provided by University of Central Oklahoma Psychology Clinic (hereafter referred to as UCO). Possible services include: individual, group, marital, or family therapy, assessment and/or consultation. As a client utilizing the services of UCO, I understand that I have a right to ask any questions I may have about the process, methods, duration, and goals of my treatment and/or assessment; the right to discuss any concerns I may have about my progress in services provided; and the right to terminate services if I feel I am not making progress.

I have read and hereby certify that I understand the following:

UCO operates as both an independent facility and a training and research facility for the Master’s program at UCO. This program requires supervision of all services provided by psychological associates. Supervision is provided by a licensed clinical psychology and faculty of the Psychology program.

There is a possibility that the clinician, psychological associate, and/or supervising faculty may change during the course of services.

For training or research purposes, services may be audio or video taped, and/or observed by supervisors or other psychological associates of UCO. All such individuals are bound by confidentiality.

Tapes, tests, and other information obtained during contacts with the clinic may be used for research and/or training purposes. I give consent for my individual data to be presented anonymously at professional meetings and/or published in a scientific journal.

I understand that one of my rights involves confidentiality. Within certain limits, information revealed by me will be kept strictly confidential, and will not be revealed to any other person or agency without my written permission. If I give my written permission to release information to my health insurance company, employee assistance program, or other health benefits program, I understand that clinicians or psychological associates may disclose the nature of services, the diagnosis, the dates of services, the fees charged, and other relevant information specifically requested by other mental health professionals and/or clinics.

I understand that a new federal law, HIPAA, provides new privacy protections for medical records and new patient rights with regard to the use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that the clinic provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that the clinic has provided you with this information.

I understand that there are certain limits to confidentiality, in which it is required by law and/or professional ethics that a clinician or psychological associate reveal information to other persons or agencies, without my permission. These limits to confidentiality are as follows:
A. If I threaten grave bodily harm or death to a reasonably identified person, the clinician or psychological associate is required (1) to inform appropriate legal authorities and the intended victims; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

B. If I express a serious intent to grievously harm myself, it may be necessary for the clinician or psychological associate (1) to reveal information to family members and/or persons authorized to respond to such emergencies, in order to protect me from harm; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

C. If a court of law issues a legitimate court order, the clinician or psychological associate may be required to provide information that is specifically described in the court order.

D. If I am being evaluated or treated by order of a court of law, the results of the evaluation or treatment ordered may be revealed to the court.

E. If the clinician or psychological associate has good reason to suspect that a child, elderly person, or disabled person is a victim of physical abuse, sexual abuse, or neglect, he/she is required to report the abuse or neglect to the Department of Human Services and/or law enforcement authorities.

F. If I use psychological treatment and/or records on my behalf in a legal proceeding, the records must be made available to both parties by written consent.

G. UCO is required to provide information requested by a legal guardian of a minor child, including a non-custodial parent who has maintained parental status.

H. If a government agency is requesting information for health oversight activities or to prevent terrorism (Patriot Act), UCO may be required to provide it.

I. If I file a worker’s compensation case, UCO may be required, upon appropriate written request, to provide all clinical information relevant to or bearing upon the injury for which the claim was filed.

J. If I file a complaint or lawsuit against UCO or the professional staff, UCO may disclose relevant information regarding myself in order to defend itself.

If any of these situations were to arise, UCO would make every effort to fully discuss it with me before taking action, and would limit disclosure to what is necessary.

I understand these limitations to confidentiality as outlined above.

I also understand that the fee for psychological services is $________________. I must give twenty-four hours notice if I wish to cancel an appointment. For therapy services, the full session fee will be charged if less than 24 hours notice is provided. Information and assistance regarding scheduling of appointments and payment for fees for psychological services are provided by the UCO Director.

I am expected to pay for services at the time they are provided, unless other arrangements have been made in advance. For assessment services, half of the fee is due at the first appointment; with the balance due before the report will be written.

I have been given a copy of this consent form for my personal records.

I understand and agree that my responsibilities as a client include the following:


2. Attempt any therapeutic assignments I have agreed to perform.
3. Disclose to my clinician or psychological associate whenever I feel in crisis and/or suicidal, to work with them to come up with a crisis plan, and to give UCO discretion regarding needed disclosures in a crisis situation both while waiting to obtain services, and while in treatment.

4. Not to come to the clinic under the influence of alcohol or other drugs. If I were to appear intoxicated, I agree to refrain from driving. Failure to do so would require UCO to make a DUI report.

5. Never bring a weapon of any sort to UCO.

6. Ask the clinician or psychological associate questions right away if I am uncertain about any aspect of my services or UCO policies.

7. Pay the agreed upon fees as scheduled.

Client or Parent/Legal Guardian (if under 18) ____________________________

Signature

Psychological Associate: ____________________________

Signature

or Clinician ____________________________

Signature
DEMOGRAPHIC FORM
(To be completed by each person receiving therapy, assessment, or consultation services through UCO)

Date of Intake: _____ / _____ / _____

Name of person completing form: ______________________  ______________________  ___
                                           Last Name                               First Name                           MI

Name of client:
(if different from above) ______________________  ______________________  ___
                                           Last Name                               First Name                           MI

Birth Date: _____ / _____ / ____
            Month           Day           Year
Age: ______
Gender (circle one):   Male       Female

Mailing Address: ____________________________   ____________________________
                                                                                   Street
                                                                                   City                                      State     Zip

Telephone: ________________
                   Home
                   Cell
                   Work

May we leave a message stating that we are calling from UCO? (circle one):    YES        NO

Years of Education: ______
Highest Degree Completed: ___________________________

Marital Status:   ______
Years Married: _____
Number of previous marriages: _____

Ethnicity:        Caucasian _____ African American _____
                  Native American ______
                  Asian _____     Pacific Islander _____
                  Multiracial ______

Other (please complete) ______________________________________

Height (in.): _____________ Weight (in lbs.): __________

Client
Occupation: _______________
            Title
            Company Name
            City                                     State

Spouse
Occupation: _______________
            Title
            Company Name
            City                                     State

Client Annual Income: $ __________
Spouse Annual Income: $ __________

Total Combined Income for Past Year (include financial aid, SSDI, etc.): $_______________

Person responsible for payment of services (if not you):

                                                                                   ______________________  ______________________  ___
                                                                                                           Name                                                                                           Relation to you
                                                                                                           Address                                                                       City                                        State      Zip
                                                                                                           ______________________________________     __________________
                                                                                                           Home Phone number                            Cell Phone number
Emergency Contact: ______________________

Name ______________________  Relationship to you ______________________

Address ______________________  City ______________________  State ______________________  Zip ______________________

Home Phone number ______________________  Cell / Work Phone number ______________________

Please list the names, age, gender, and relationship of all individuals living at your current residence.

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Please list all the individuals who you think will be involved in therapy.

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Please list all living members of your family of origin (parents, brothers, sisters, step-siblings, etc.)

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Physician /:

Clinic Name
___________________________________________________________
______________________    ______________    ____    _______
Address                                                City                                   State        Zip
______________________

Office Phone Number

List all prescription and non-prescription medications/drugs taken within the last 6 months.
Name of Med. | Quantity/Frequency | Reasons Taken | Start Date to Finish Date

Are you currently receiving services from another therapist/counselor? (circle one)    YES        NO
If yes, name of counselor and clinic name: ______________________  ___________________

Have you ever been treated by another therapist/counselor? (circle one)    YES        NO
If yes, who and when?  _______________________     ______________

Why did you seek services then?

Who referred you to UCO? If self-referred, how did you find out about our services?

Briefly describe the major reasons for seeking our services at this time.

How would you rate the present state of your physical health? (circle one number)
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

How would you rate the present state of your emotional health? (circle one number)
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

How serious would you say this problem is right now? (circle one number)
Not at all 1 2 3 4 5 6 7 8 9 10 Very

How likely do you think the problem is to change? (circle one number)
Not at all 1 2 3 4 5 6 7 8 9 10 Very
How stressful has your life been in the past six months? (circle one number)
Not at all   1      2  3 4 5 6   7     8 9 10 Very

Is there any other information you would like us to be aware of at this time? If so, please write it below.

________________________________________________________________________
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Client name: ___________________________  DOB: ___ / ___ / ______
Client ID: ___________________________  Date: ___ / ___ / ______

Summary of presenting problem:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Diagnosis:

Axis I  _____:__  _______________________________
       _____:__  _______________________________
       _____:__  _______________________________

Axis II  _____:__  _______________________________
       _____:__  _______________________________

Axis III  _______________________________

Axis IV  _______________________________

Axis V  GAF =  _______________________________

Services recommended:

☐ Therapy  ____________________________________

☐ Diagnostic assessment  ___________________________

☐ Referral  ________________________________

Psychological Associate:

or Clinician  ______________________________  Signature

Supervisor:

(if needed)  ______________________________  Signature
“Before we go further today, I want to ask you about some common problems that people who seek our services might have. Afterwards, I’ll ask you about what specifically brings you into the clinic today. Do you have any questions?”

Previous Diagnoses

___ 1. Have you ever been previously diagnosed with an emotional or behavioral problem?
   What? __________________________________________________________________________
   When? __________________________________________________________________________
   By who? __________________________________________________________________________

___ 2. Have you ever sought psychological services or counseling in the past?
   When? __________________________________________________________________________
   By who? __________________________________________________________________________

Adjustment Problems

___ 1. Have you experienced any significant stressors within the last six months?
   Please describe __________________________________________________________________________
   __________________________________________________________________________

___ 2. Do you think your behavior has significantly changed over the last six months?
   (if yes) How so? __________________________________________________________________________
   __________________________________________________________________________

Mood Disorders

A. Depressive Episode

___ 1. In the last month has there been a period of time when you felt depressed or irritable most of the day nearly every day?

___ 2. What about being a lot less interested in most things you used to enjoy?
   Have you had any of the following symptoms during the last month?
   ____ Weight change ____ Psychomotor agitation / retardation
   ____ Worthlessness / guilt ____ Hypersomnia / Insomnia
   ____ Energy loss ____ Concentration difficulties
   ____ Suicidal ideation ____ Thinking about death

B. Manic Episode

___ 1. In the last month, has there been a period of time when you were feeling so good or hyper that other people thought you were not your normal self?

___ 2. What about a time when you were so irritable that you shouted started arguments?
   Have you had any of the following symptoms during the last month?
___ Grandiosity ___ Need for little to no sleep
___ Racing thoughts ___ Starting lots of different projects
___ Distractibility ___ Reckless behavior

Anxiety Disorders

A. General Anxiety Disorder

___ 1. In the last six months have you been particularly anxious or nervous?
___ 2. Do you worry a lot about things that may happen?
   Have you had any of the following symptoms during the last month?
   ___ Restlessness ___ Concentration difficulties
   ___ Fatigue ___ Sleep disturbances
   ___ Muscle tension ___ Irritability

B. Specific Phobia

___ 1. Is there any specific thing that you are especially afraid of, such as heights, blood, enclosed
   spaces, or certain animals or insects?
___ 2. Does this fear interfere with your life in any way?
   What are you very afraid of?
   __________________________________________________________

C. Obsessive-compulsive Disorder

___ 1. Do you ever have thoughts that you cannot get out of your mind, such as being
   contaminated by germs or fears?
___ 2. Do you ever do something over and over again, such as washing your hands or
   checking something several times to make sure you did it right?
   Please describe these thoughts or behaviors.
   _________________________________________________________
   _________________________________________________________
   _________________________________________________________
   _________________________________________________________

D. Panic Disorder

___ 1. Have you ever had a panic attack when you suddenly felt frightened, anxious, or you
   were going to die?
   (if yes) How many times? _________
___ 2. Were any of these attacks “out of the blue”?
   How long did the attack last? ________________
   During the attack did you experience any of the following?

UCO Intake – Adult – page 3
___ Pounding heart   ___ Sweating
___ Trembling / chills   ___ Shortness of breath / difficulty breathing
___ Feeling of choking   ___ Chest pain
___ Dizziness   ___ Nausea / abdominal pain

E. Posttraumatic Stress Disorder
___ 1. Have you ever experienced or witnessed an event that involved actual or threatened
death or injury to yourself or others?
   (if yes) What event? ____________________________________________
   (if yes) When? _________________________________________________
___ 2. Did your response involve intense fear, helplessness, or horror?
___ 3. Have you had any of these symptoms since the event?
   ___ Recurrent recollections/distressing dreams
   ___ Acting/feeling like event is recurring
   ___ Intense distress or reactivity to cues
   ___ Avoidance of trauma related thoughts, feelings, people, places
   ___ Inability to recall aspects of trauma
   ___ Diminished interest in activities
   ___ Withdrawal / seeming detached
   ___ Restricted range of affect
   ___ Increased arousal (e.g., sleep difficulties, irritability, difficulty concentrating,
hypervigilance, exaggerated startle response)

Developmental History
___ 1. Were there any perinatal issues during your birth such as low birth weight or other complications?
   (if yes) What? _________________________________________________
___ 2. Did you meet the physical/social milestones that would indicate a normal development such as talking and walking?
___ 3. Did you suffer from any childhood illness or physical injuries that you would deem abnormal or out of the ordinary?
   (if yes) What? _________________________________________________

Social History
___ 1. Have you ever been married before?
   (if so) How many times? _________________________________________
___ 2. Are you currently married at this time?
   (if so) How long? ______________________________________________
3. Would you describe your relationships with your family members as:
   ____ Great
   ____ Good
   ____ Fair
   ____ Poor

4. Are there any family members that you have a particularly poor/great relationship with?
   (if so, please indicate poor/great) Who? _________________________________

5. How would you describe your social life?
   ____ Great
   ____ Good
   ____ Fair
   ____ Poor
   Why? _________________________________

Medical History
   ____ 1. Do you suffer from any chronic physical illness?
       (if so) What? _________________________________

   ____ 2. Have you ever experienced any serious physical accidents?
       (if so) What? _________________________________
       (if so) When? _________________________________

   ____ 3. In the past, have you suffered from any major illnesses?
       (if so) What? _________________________________

Attention-deficit / Hyperactivity Disorder
   ____ 1. Do you demonstrate any of these symptoms more than people around you?
       __ Careless errors in work
       __ Difficulty sustaining attention to tasks
       __ Failing to listen when spoken to directly
       __ Failing to follow through on instructions
       __ Avoiding tasks that require concentration
       __ Often losing things
       __ Forgetfulness in daily activities
       __ Being distracted by outside stimuli
       __ Difficulty organizing tasks

   ____ 2. __ Feeling like you need to stand up or move
       __ Restlessness / fidgeting / squirming
       __ Talking excessively
       __ Blurt out answers before questions are finished
       __ Often interrupting others
       __ Often feeling “on the go”

   ____ 3. Where do you demonstrate the above behaviors?
___ Home ___ School / Work
___ With friends ___ In the community

Substance Use

___ 1. Do you consume alcohol?
   ___ How many times per week? ___ How many drinks per time?

___ 2. Have you taken any of the following drugs within the last 12 months?
   ___ Sedatives / Hypnotics / Anxiolytics (e.g., Quaalude, Valium, Xanax)
   ___ Cannabis (i.e., marijuana)
   ___ Stimulants (e.g., amphetamine, crystal meth)
   ___ Opioids (e.g., heroin, morphine, opium, darvon)
   ___ Cocaine (e.g., snorting, IV, freebase, crack)
   ___ Hallucinogens (e.g., LSD, PCP, mescaline)
   ___ Other (e.g., steroids, Ecstasy, huffing)

___ 3. Have you ever tried to cut down or stop drinking or taking drugs?
___ 4. Have you ever been so drunk or high that you could not remember something important that happened?
___ 5. Have you ever found that when you started drinking you ended up drinking much more than intended?
___ 6. Do you spend a lot of time drinking, being high, or hung over?
___ 7. Have you ever drunk or used drugs in a situation in which it might have been dangerous (e.g., drunken driving)?
___ 8. Have you ever drunk so often that you started to drink instead of working or spending time at hobbies or with friends/family?

Academic History

___ 1. How far did you get in school? What were your grades?

___ 2. Were you in any special classes?
   (if yes) Which one(s) and why?

___ 3. Did you ever repeat a grade?
   (if yes) Which one and why?

___ 4. In which classes did you excel? Struggle?
Work History
___ 1. Are you currently employed?
   (if yes) Where? __________________________________________________________
___ 2. Is this job typical of the work you generally do?
   (if no) What do you usually do? ___________________________________________
___ 3. What was the reason you left your last job?
   ____________________________________________________________

Risk Management (if any of the below are endorsed, complete Suicidality Interview)
___ 1. Do you feel as though you are at risk of harming yourself?
   (if yes) Why and how? ___________________________________________________
   ____________________________________________________________
___ 2. Have you ever attempted to harm yourself in the past?
   (if yes) When and how? _______________________________________________  
   ____________________________________________________________
___ 3. Do you feel as though you are at risk of harming other people?
   (if yes) Why and how? _______________________________________________
   ____________________________________________________________
___ 4. Have you ever attempted to harm other people in the past?
   (if yes) Why and how? _______________________________________________
   ____________________________________________________________

Strengths
___ 1. What would you describe as your special talents or strengths?
   ____________________________________________________________
___ 2. (if applicable) What are your family’s greatest strengths or assets when confronting a problem?
   ____________________________________________________________
   ____________________________________________________________
___ 3. Who do you turn to or what actions do you take when things become difficult?
   ____________________________________________________________
"I'm now going to ask you about some areas of daily functioning. Please tell me if you have had any problems in these areas over the last six months."

### Assessment of Functioning in Life Domains (Describe strengths and needs in each area.)

<table>
<thead>
<tr>
<th>Area</th>
<th>Adequate</th>
<th>Decreased</th>
<th>Increased</th>
<th>Other</th>
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<tr>
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<tr>
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<tr>
<td><strong>Finances / income</strong></td>
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<tr>
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<tr>
<td>Describe</td>
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<td><strong>Personal safety</strong></td>
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<td>Describe</td>
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<tr>
<td><strong>Transportation</strong></td>
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<tr>
<td>Describe</td>
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<tr>
<td><strong>Social life / family</strong></td>
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<tr>
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<tr>
<td>Describe</td>
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</tbody>
</table>

UCO Intake – Adult – page 8
“Now, I would like you to describe for me what has caused you to seek services at this time. In your own words, what is the problem? Why now?”
Mental Status Examination (Complete immediately after intake interview.)

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Thought Processes</th>
<th>Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Age / culture appropriate</td>
<td>□ Age / culture appropriate</td>
<td>□ Age / culture appropriate</td>
</tr>
<tr>
<td>□ Meticulous</td>
<td>□ Circumstantial</td>
<td>□ Disoriented to</td>
</tr>
<tr>
<td>□ Unkempt</td>
<td>□ Concrete</td>
<td>□ Time</td>
</tr>
<tr>
<td>□ Inappropriate</td>
<td>□ Tangential</td>
<td>□ Place</td>
</tr>
<tr>
<td>□ Eccentric</td>
<td>□ Aggressive</td>
<td>□ Date</td>
</tr>
<tr>
<td>□ Age / size congruent</td>
<td>□ Obsessive</td>
<td>□ Situation</td>
</tr>
<tr>
<td>□ Slumped</td>
<td>□ Phobias</td>
<td></td>
</tr>
<tr>
<td>□ Relaxed</td>
<td>□ Blocking</td>
<td></td>
</tr>
<tr>
<td>□ Rigid / tense</td>
<td>□ Paranoid ideation</td>
<td></td>
</tr>
<tr>
<td>□ Other __________</td>
<td>□ Delusions</td>
<td></td>
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<td></td>
<td>□ Other __________</td>
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<tr>
<td>Comments __________</td>
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<td>Comments __________</td>
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<thead>
<tr>
<th>Mood / Affect</th>
<th>Cognitive Functioning</th>
<th>Motor Activity</th>
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<tbody>
<tr>
<td>□ Age / culture appropriate</td>
<td>Remote memory</td>
<td>□ Age / culture appropriate</td>
</tr>
<tr>
<td>□ Flat / blunted</td>
<td>□ Present</td>
<td>□ Agitated</td>
</tr>
<tr>
<td>□ Labile</td>
<td>□ Limited</td>
<td>□ Hyperactive</td>
</tr>
<tr>
<td>□ Incongruent</td>
<td>Recent memory</td>
<td>□ Lack of movement</td>
</tr>
<tr>
<td>□ Depressed</td>
<td>□ Present</td>
<td>□ Tremors</td>
</tr>
<tr>
<td>□ Expansive</td>
<td>□ Limited ability to abstract</td>
<td>□ Tics</td>
</tr>
<tr>
<td>□ Anxious / fearful</td>
<td>□ Present</td>
<td>□ Mannerisms</td>
</tr>
<tr>
<td>□ Angry</td>
<td>□ Limited</td>
<td>□ Facial grimacing</td>
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<tr>
<td>□ Other __________</td>
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<tr>
<td>Comments __________</td>
<td>Comments __________</td>
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UCO Intake – Adult – page 10
<table>
<thead>
<tr>
<th>Perceptual Processes</th>
<th>Behavior</th>
<th>Speech</th>
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</thead>
<tbody>
<tr>
<td>□ Age / culture appropriate</td>
<td>□ Age / culture appropriate</td>
<td>□ Age / culture appropriate</td>
</tr>
<tr>
<td>□ Imagination</td>
<td>□ Poor eye contact</td>
<td>□ Slow</td>
</tr>
<tr>
<td>□ Depersonalization</td>
<td>□ Attends to task</td>
<td>□ Rapid</td>
</tr>
<tr>
<td>□ Other ____________</td>
<td>□ Distractable</td>
<td>□ Soft</td>
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<tr>
<td>Hallucinations (specify)</td>
<td>□ Cooperative</td>
<td>□ Loud</td>
</tr>
<tr>
<td>□ Auditory</td>
<td>□ Friendly</td>
<td>□ Mute</td>
</tr>
<tr>
<td>□ Visual</td>
<td>□ Withdrawn / passive</td>
<td>□ Profuse</td>
</tr>
<tr>
<td>□ Tactile</td>
<td>□ Suspicious</td>
<td>□ Pressured</td>
</tr>
<tr>
<td>□ Olfactory</td>
<td>□ Guarded</td>
<td>□ Age intelligible</td>
</tr>
<tr>
<td>□ Somatic</td>
<td>□ Ingratiating</td>
<td>□ Unintelligible</td>
</tr>
</tbody>
</table>

Insight / Judgment

- □ Age / culture appropriate
- □ Understands consequences
- □ Denial / resistance
- □ Blames others
- □ Aware of problem
- □ Poor impulse control
- □ Discerns right from wrong

Comments ____________

Verbally

- □ Interacts
- □ Initiates
- □ Interrupts
- □ Redirects

Comments ____________

Speech

- □ Age intelligible
- □ Slurred
- □ Mumbled
- □ Clear
- □ Whiny
- □ Blocked
- □ Preservations
- □ Stuttering
- □ Impaired by medical condition

Comments ____________
SUICIDALITY INTERVIEW

Client name: ___________________________  DOB: __ / __ / ____  
Therapist: ____________________________  Date: __ / __ / ____

Review confidentiality and limits of confidentiality. Be sure you have obtained informed consent.

**Important Note:** If, during the course of this interview, the client endorses recent (within the past three to six months) or current suicidal intentions or attempt(s), and has either a plan or the means necessary to carry out an attempt, you should initiate a suicide contract and contact your supervisor for consultation **before allowing the client to leave the clinic.**

History of suicidal behavior

___ 1. Have you ever attempted to injure or kill yourself in the past?  
   (if yes) When and how? ________________________________________________

___ 2. Were you hospitalized? When, where and for how long? ________________

___ 3. How have you been doing since your last attempt? (e.g., medications, therapy, support)
   ________________________________________________________________

___ 4. What led to your previous suicidal ideation or attempt? (e.g., depression, pain, to hurt someone else, while on drugs, during a manic episode)
   ________________________________________________________________

___ 5. (Assess for current and past levels of depression, administer a BDI-II if currently endorsed)
   On a scale of 1 to 10, with “1” meaning “not at all” and “10” meaning “the worst depression you can imagine”, please rate
   ___ Your depression today.
   ___ The highest your depression has been in the last 3 months.
   ___ The highest your depression was at its worst.
   ___ When at its worst, did you have any thoughts of hurting or killing yourself?
   ___ How high was it when you attempted to kill or injure yourself in the past?
Current suicide behavior

“You told me earlier you had considered harming yourself recently.”

___ 1. (Ideation frequency) How often do you have these thoughts? When was the last time?
___________________________________________________________________________
___________________________________________________________________________

___ 2. (Method) Have you thought about how you would do it? What method would you use?
___________________________________________________________________________
___________________________________________________________________________

___ 3. (Availability) Do you have access to _________? Where is it?
___________________________________________________________________________
___________________________________________________________________________

___ 4. (Place) Have you thought about where you would go to do this?
___________________________________________________________________________
___________________________________________________________________________

___ 5. (Protective factors) What has kept you from hurting yourself? What are the reasons you have not done so? Have you ever acted out any part of the plan? How did you decide not to follow through?
___________________________________________________________________________
___________________________________________________________________________

Assessing the suicidal crisis

___ 1. (Triggers) What events in your life have led you to want to hurt yourself? Why has this become a problem now?
___________________________________________________________________________
___________________________________________________________________________

___ 2. (Functioning) Have you been able to go to school/work/social activities? Do you think your ability to take care of yourself or others has changed? (make note of personal hygiene)
___________________________________________________________________________
___________________________________________________________________________

___ 3. (Sleep) Have you had any sleep problems, such as difficulty in falling asleep, repeated awakenings, or early morning awakenings?
___________________________________________________________________________
___________________________________________________________________________
4. (Eating) Have your eating habits changed recently? Have you lost or gained weight recently?

5. (Somatic symptoms) Have you been experiencing any physical illness or problems lately?

6. (Coping) How have you tried to cope with these problems so far? What has been effective in helping you feel better? What has not helped?

7. (Intention) “On a ten point scale, with “1” meaning “no intention at all” and “10” meaning “I plan to kill myself as soon as I can”, how likely do you feel it is that you will harm yourself before our next session?

8. (Support system) Who is currently available to help you out? Friends? Family? Get permission to call or contact them, now or in the future.

Name: ___________________________ Relationship: ___________________________ Phone Number: ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________

*If there is recent or current suicidal ideation or intent, let the client know you are concerned about them. Inform them that you want to consult with your supervisor to make sure you have assessed the situation appropriately. Ask them to wait and get assurance that they will do so.*

Notes and Disposition of Case:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Psychological Associate: ___________________________ Name ___________________________ Signature ___________________________

or Clinician

Supervisor: ___________________________ Name ___________________________ Signature ___________________________

(if needed)
Considerations in Determining the Urgency of the Situation

Specificity
- How specific is the suicide plan? In general, the more specific, concrete, and well-thought out the plan, the greater the risk.

Lethality
- How lethal is the suicide plan? Does the plan include a high-lethality method which is readily available and a secluded location? The greater the overall lethality, the greater the risk. The rough outline of the RELATIVE lethality of various methods is as follows:
  - High Lethality - Shooting, Hanging
  - Moderate to High Lethality - Drugs, Toxins, Gasses
  - Low Lethality - Slashing wrists

High-Risk Factors
- The following list contains factors which, if present, increase the risk of suicide. The greater the number of factors present, the greater the risk.
  1. Previous suicide attempts
  2. Alcohol or substance use/abuse
  3. Isolation or withdrawal from others
  4. Cognitive disruption -- confusion, disorientation
  5. Hostility directed toward self or external objects
  6. Open expression of a wish for death
  7. Depression co-occurring with any of the following:
    - Recent lessening of profound depression
    - Excessive guilt
    - Feelings of worthlessness and loss of hope
    - Anxiety and psychomotor agitation
    - Recent significant weight loss
    - Sleep disturbances
    - Eating disturbance

SAD PERSONS Scale
- **Sex**          1 if patient is male, 0 if female
- **Age**         1 if patient is (25-34; 35-44; 65+)
- **Depression**  1 if currently or in recent past
- **Previous attempt**  1 if present
- **Ethanol abuse** 1 if present
- **Rational thinking loss** 1 if patient is psychotic for any reason
- **Social support lacking** 1 if this is lacking, especially with recent loss of a significant other
- **Organized Plan** 1 if plan made and method lethal
- **No spouse**    1 if divorced, widowed, separated, or single (for males)
- **Sickness**     1 especially if chronic, debilitating, severe

Total score: ______ / 10

0-2 equals little risk, 3-4 equals follow patient closely, 5-6 equals strongly considering hospitalization, and 7-10 equals a very high risk, hospitalize or commit.