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

<table>
<thead>
<tr>
<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:

**Name of Persons or Organization**

<table>
<thead>
<tr>
<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>
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<tr>
<th>Student/Authorized Signature</th>
<th>Date</th>
<th>Clinician/Witness Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>Parent/Guardian Signature (if needed)</td>
<td>Date</td>
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</table>
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>
<thead>
<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/
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
DEMENOGRAPHIC 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: ____________________  _________________  ___
Last Name                               First Name                           MI
(if different from above)

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

UCO – Demographic Form – Page 1
Emergency Contact:  

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<th>Name</th>
<th>Relationship to you</th>
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<th>City</th>
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<th>Home Phone number</th>
<th>Cell / Work Phone number</th>
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Please list the names, age, gender, and relationship of all individuals living at your current residence.

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<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Relationship</th>
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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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<tr>
<th>Name</th>
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List all prescription and non-prescription medications/drugs taken within the last 6 months.

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<tr>
<th>Name of Med.</th>
<th>Quantity/Frequency</th>
<th>Reasons Taken</th>
<th>Start Date to Finish Date</th>
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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.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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
Name ___________________________ Signature ___________________________

Supervisor:
(if needed) Name ___________________________ Signature ___________________________

UCO Intake – Youth – page 1
“Before we go further today, I want to ask you about some common problems that children and families who seek our services might have. Afterwards, I’ll ask you about what specifically brings you and your child into the clinic today. Do you have any questions?”

Previous Diagnoses

___ 1. Has your child ever been previously diagnosed with an emotional or behavioral problem?
   What? ________________________________
   When? ________________________________
   By who? ________________________________

___ 2. Have you ever sought psychological services or counseling for your child in the past?
   When? ________________________________
   By who? ________________________________

Adjustment Problems

___ 1. Has your child experienced any significant stressors within the last six months?
   Please describe ________________________________
   ________________________________

___ 2. Has his/her behavior changed significantly 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 your child appeared to be feeling depressed or irritable most of the day nearly every day?
___ 2. What about being a lot less interested in most things s/he used to enjoy?

Has your child 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 ___ Talking about death

B. Manic Episode

___ 1. In the last month, has there been a period of time when your child was feeling so good or hyper that other people thought s/he was not normal, or s/he was so hyper that s/he got into trouble?
2. What about a time when s/he was so irritable that s/he would shout at people or start arguments?

Has your child 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 has your child appeared particularly anxious or nervous?
___ 2. Does s/he report worrying a lot about terrible things that may happen?

Has your child 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 your child is especially afraid of, such as heights, blood, enclosed spaces, or certain animals or insects?
___ 2. Does this fear interfere with his/her home, school, or social life?

What is your child very afraid of?

_____________________________________________________________

C. Separation Anxiety Disorder

___ 1. Does your child ever become fearful or anxious when separated from you / primary caregiver?
___ 2. Does this happen more often than you would expect?

Has your child had any of the following symptoms during the last month?

___ Worry about separation
___ Nightmares about separation
___ School refusal
___ Refusal to sleep alone
___ Physical symptoms / illness when separated (describe: __________________________)

D. Obsessive-compulsive Disorder

___ 1. Does your child ever complain of thoughts that s/he cannot get out of her/his mind, such as being contaminated by germs?
___ 2. Does your child ever do something over and over again, such as washing his/her hands or checking something several times to make sure s/he did it right?
Please describe these thoughts or behaviors.

E. Panic Disorder

___ 1. Has your child ever had a panic attack when s/he suddenly felt frightened, anxious, or like s/he was 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 s/he experience any of the following?
   ___ Pounding heart   ___ Sweating
   ___ Trembling / chills   ___ Shortness of breath / difficulty breathing
   ___ Feeling of choking   ___ Chest pain
   ___ Dizziness   ___ Nausea / abdominal pain

F. Posttraumatic Stress Disorder

___ 1. Has your child ever experienced or witnessed an event that involved actual or threatened death or injury to him/herself or others?
   (if yes) What event? _________________________________
   (if yes) When? _________________________________

___ 2. Did your child’s response involve intense fear, helplessness, or horror?

___ 3. Has your child 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)
Elimination Disorders
___ 1. Does your child urinate in clothes or in bed?  
   How often? ____________
___ 2. Does your child defecate in inappropriate places or at inappropriate times?  
   How often? ____________

Disruptive Behavior Disorders
A. Attention-deficit / Hyperactivity Disorder
   ___ 1. Does your child demonstrate any of these symptoms more than his / her peers?
   ___ Careless errors in school work
   ___ Often losing things
   ___ Difficulty sustaining attention to tasks
   ___ Forgetfulness in daily activities
   ___ Avoiding tasks that require concentration
   ___ Failing to listen when spoken to directly
   ___ Being distracted by outside stimuli
   ___ Failing to follow through on instructions
   ___ Difficulty organizing tasks/activities
   ___ 2. ___ Leaving seat in classroom
   ___ Restlessness / fidgeting / squirming
   ___ Running / climbing in inappropriate situations
   ___ Difficulty waiting his / her turn
   ___ Difficulty playing quietly
   ___ Talked excessively
   ___ Often interrupting others
   ___ 3. Where does your child demonstrate the above behaviors?
   ___ Home      ___ School
   ___ With friends ___ In the community

B. Conduct Disorder
   ___ 1. Is your child ever deliberately cruel to other people or to animals?
   Please describe: ____________________________________________________________
   ____________________________________________________________
   ___ 2. Does your child ever deliberately destroy property?
   Please describe: ____________________________________________________________
   ____________________________________________________________
   ___ 3. Does your child ever deliberately steal or lie to obtain favors / goods from others?
   Please describe: ____________________________________________________________
   ____________________________________________________________
4. Does your child deliberately break serious rules (e.g., run away from home, be truant from school)?
Please describe: _______________________________________________________

C. Oppositional Defiant Disorder

1. Does your child demonstrate any of these symptoms more than his / her peers?
   ___ Losing temper               ___ Arguing with adults
   ___ Deliberately annoying others ___ Defying the rules
   ___ Being easily annoyed by others ___ Blaming others for mistakes
   ___ Being angry / resentful       ___ Being spiteful / vindictive

2. Where does your child demonstrate the above behaviors?
   ___ Home       ___ School
   ___ With friends ___ In the community

Substance Use (Adolescents only – attempt to confirm with self-report)

1. To your knowledge, does your child consume alcohol?
   ___ How many times per week? ___ How many drinks per time?

2. To your knowledge, has your child 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. Has s/he ever tried to cut down or stop drinking or taking drugs?

4. Has s/he been so drunk or high that s/he could not remember something important that happened?

5. Has s/he often found that when s/he started drinking they ended up drinking much more than they intended?

6. Does s/he spend a lot of time drinking, being high, or hung over?

7. Has s/he ever drunk or used drugs in a situation in which it might have been dangerous (e.g., drunken driving)?

8. Has s/he ever drunk so often that s/he started to drink instead of working or spending time at hobbies or with friends/family?
Academic Questions

1. Is your child in special classes?
   (if yes) Which one(s) and why?

2. Has your child ever repeated a grade?
   (if yes) Which one and why?

3. How does your child do in school? In which classes does s/he excel? Struggle?

Risk Management

1. Do you feel as though your child is at risk of harming him/herself?
   (if yes) Why and how?

2. Has your child ever attempted to harm him/herself in the past?
   (if yes) When and how?

3. Do you feel as though your child is at risk of harming other people?
   (if yes) Why and how?

4. Has your child ever attempted to harm other people in the past?
   (if yes) Why and how?

Family / Child Strengths

1. What would you describe as your child’s special talents or strengths?

2. What are your family’s greatest strengths or assets when confronting a problem?
3. Who do you and your child turn to or what actions do you take when things become difficult?

BASC-2 Self-report of Personality

<table>
<thead>
<tr>
<th>School Probs</th>
<th>T-Score</th>
<th>Internalizing</th>
<th>T-Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Att School</td>
<td></td>
<td>Atypicality</td>
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<td>Att Teachers</td>
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<td>Locus of Control</td>
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<td>Sensat Seeking</td>
<td></td>
<td>Social Stress</td>
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</tr>
<tr>
<td>Composite</td>
<td></td>
<td>Anxiety</td>
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<tr>
<td></td>
<td></td>
<td>Somatization</td>
<td></td>
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<tr>
<td><strong>Personal Adj.</strong></td>
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<td>Sense of Inadeq</td>
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<tr>
<td>Rel w Parents</td>
<td></td>
<td>Depression</td>
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<tr>
<td>Interper Rel</td>
<td></td>
<td>Composite</td>
<td></td>
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<tr>
<td>Self-Esteem</td>
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<tr>
<td>Self-Reliance</td>
<td></td>
<td>Attention Probs</td>
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<tr>
<td>Composite</td>
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<td>Hyperactivity</td>
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BASC-2 Parent Rating Scales

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<thead>
<tr>
<th>Externalizing</th>
<th>T-Score</th>
<th>Internalizing</th>
<th>T-Score</th>
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</thead>
<tbody>
<tr>
<td>Hyperactivity</td>
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<td>Anxiety</td>
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</tr>
<tr>
<td>Aggression</td>
<td></td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Conduct Probs</td>
<td></td>
<td>Somatization</td>
<td></td>
</tr>
<tr>
<td><strong>Composite</strong></td>
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<td>Composite</td>
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**Additional Scales**

<table>
<thead>
<tr>
<th>Adaptive Skills</th>
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<tbody>
<tr>
<td>Withdrawal</td>
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<tr>
<td>Adaptability</td>
<td></td>
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<tr>
<td>Attention Problems</td>
<td></td>
</tr>
<tr>
<td>Social Skills</td>
<td></td>
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<tr>
<td>Atypicality</td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td></td>
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<tr>
<td>ADLs</td>
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</tbody>
</table>

**Total Composite**

<table>
<thead>
<tr>
<th>Functional Comm</th>
<th>T-Score</th>
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</thead>
<tbody>
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</tr>
</tbody>
</table>

Note: An asterisk (*) indicates a clinically significant elevation in BASC-2 scores.
“I’m now going to ask you about some areas of daily functioning. Please tell me if your child has had any problems in these areas over the last six months.”

<table>
<thead>
<tr>
<th>Assessment of Functioning in Life Domains (Describe strengths and needs in each area.)</th>
<th>Adequate</th>
<th>Decreased</th>
<th>Increased</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Food / appetite</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Employment / school</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Finances / income</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Legal issues</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Housing</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Other ADLs</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Cultural / spiritual</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Personal safety</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Transportation</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Social life / family</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Self-care</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Medical needs</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Medications</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
<tr>
<td>Dental care</td>
<td>No issues</td>
<td>Needs</td>
<td>Impaired by MH</td>
<td>N/A for client</td>
</tr>
</tbody>
</table>
“Now, I would like you to describe for me what has caused you to seek services for your child 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>
</tr>
<tr>
<td></td>
<td>□ Other __________</td>
<td></td>
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</table>

| Comments __________ |
| Comments __________ |
| Comments __________ |

<table>
<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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| Comments __________ |
| Comments __________ |
| Comments __________ |

<p>| Comments __________ | Comments __________ | Comments __________ |</p>
<table>
<thead>
<tr>
<th>Perceptual Processes</th>
<th>Behavior</th>
<th>Speech</th>
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<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>□ Distractible</td>
<td>□ Soft</td>
</tr>
<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>
<tr>
<td></td>
<td>□ Hostile</td>
<td>□ Slurred</td>
</tr>
<tr>
<td></td>
<td>□ Bizarre</td>
<td>□ Mumbled</td>
</tr>
</tbody>
</table>

Insight / Judgment

| □ Age / culture appropriate | □ Poor eye contact | □ Slow |
| □ Understands consequences | □ Attends to task | □ Rapid |
| □ Denial / resistance | □ Distractible | □ Soft |
| □ Blames others | □ Cooperative | □ Loud |
| □ Aware of problem | □ Friendly | □ Mute |
| □ Poor impulse control | □ Withdrawn / passive | □ Profuse |
| □ Discerns right from wrong | □ Suspicious | □ Pressured |

Comments __________

Verbally

| □ Interacts | □ Age intelligible |
| □ Initiates | □ Unintelligible |
| □ Interrupts | □ Slurred |
| □ Redirects | □ Mumbled |

Children only

| □ Separation reaction |

Comments __________

Comments __________

Speech

| □ Age / culture appropriate |
| □ Slow |
| □ Rapid |
| □ Soft |
| □ Loud |
| □ Mute |
| □ Profuse |
| □ Pressured |
| □ Age intelligible |
| □ Unintelligible |
| □ 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.