Genesis/Holistic Solutions Center of Baton Rouge
778 Chevelle Dr. Baton Rouge, LA 70806

Patient Information

Patient's Name: _____
(Last) (First) (M)

Parent/Guardian: _____
(Last) (First) (M)

Home Address: _____
(Street) (City) (State) (Zip Code)

Parent/ Guardian Cell Phone Number: _____

Client Phone Number: _____

Parent/Guardian Email: _____

Client Date of Birth: _____ **Age:**_____ **Sex:**_____

Parent Employer:_____ **Work Phone:**_____

Marital Status: Married ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐

Emergency Contact: _____ **Phone:**_____

Relation:_____

Responsible Party; If different from above:_____

Relation: _____

Address: _____
(Street) (City) (State) (Zip Code)

Referral Sources:_____

Notice of Privacy Practices (Brief Version)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached. full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**. to arrange **payment** for our services. and for some other business activities that are called. in the law. **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways If you do not consent and sign this form, we cannot treat you If we want to use or send. share, or release your information for other purposes. we will discuss this with you and ask you to sign an authorization form to allow this

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat
2 When we are required to do so by lawsuits and other legal or court proceedings
3 If a law enforcement official requires us to do so
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home. and not at work. to schedule or cancel an appointment. We will try our best to do as you ask.
2 You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends
3. You have the right to look at the health information we have about you such as your medical and billing records. You can get a copy of these records. but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.

4 If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes
5. You have the right to a copy of this notice. If we change this notice. we will post the new version in our waiting area. and you can always get a copy of it from the privacy officer
6. You have the right to file a complaint if you believe your privacy rights have been violated You can file a complaint with our privacy officer and with the Secretary of the U S Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way Also. you may have other rights that are granted to you by the laws of our state. and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise If you have any questions regarding this notice or our health information privacy policies. please contact our privacy officer, who is and can be reached by phone at or by e-mail at

Name: _____ Date: _____

Genesis Behavioral Health Services

Patient -Therapist Telehealth Video Conferencing Information and Agreement

This agreement adds to the information and agreements from the Patient-Therapist Agreement which you have previously read and signed during your initial intake.

Virtual "face-to-face" sessions or VC (Video Conferencing) is a real-time interactive audio and visual technology that enables a clinician to provide mental health services remotely. Treatment delivery via VC may be a preferred method due to convenience, distance, or other special circumstances. The VC system used in my practice doxy.me meets HIPAA standards of encryption and privacy protection. You will not have to purchase a plan when you "join" an online meeting.

Instructions to sign in will be given to each client by their therapist or a staff member.

Please read and note that:

- There are many benefits and some risks of video-conferencing that differ from in-person sessions.
- Confidentiality agreements that are always integral to your care, are the same for telepsychology services.
- Recording of sessions is NOT permitted.
- A webcam or a smartphone needs to be used during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is imperative that no family member or friend is in hearing or visual proximity to you or to your electronic device during the session.
- It is important to have a secure internet connection rather than public/free Wi-Fi.

- In order to be punctual please set up for the appointment at least 5 minutes before it is due to begin. You will be admitted to a virtual waiting room.
- A back up plan in the event of technical problems may include restarting the session, or more likely supplementing with a phone for audio.
- Our safety plan includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, the permission and contact information of your parent or legal guardian is required for you to participate in telepsychology sessions.
- It is recommended that you confirm with your insurance company that video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, telepsychology is no longer appropriate for you, and that we should resume our sessions in-person.

By signing this document, you are stating that you are aware that I may contact the necessary authorities in case of an emergency. You are also acknowledging that if you believe there is imminent harm to yourself or another person, you will seek care immediately through your own local health care provider or at the nearest hospital emergency department or by calling 911.

Below, please include the names and telephone numbers of your local emergency contacts (including local physician; crisis hotline; trusted family, friend, or confidant).

Physician or Psychiatrist Name & Contact Info:

Crisis Hotline or Crisis Center Phone #s:

Family Member Name & Relationship Contact Info:

_____

Friend's Name and Contact Info:

_____

Thank you

Your signature here below indicates that you have read and understood this Telehealth Informed Consent Agreement.

Client name: _____ Date of birth _____

Client signature _____ Date _____

If you are a minor:

Parent's name: _____

Parent's signature _____ Date _____

STATEMENT OF CONFIDENTIALITY

By participation in a program and/or by your presence at this facility, you will be privileged to certain confidential information regarding clients involved in the program.

Confidentiality, a right entitled to each client, begins at admission to a program or upon the making of a request for admission. Any and all information imparted to you during the time that you are at this facility and/or your knowledge of any person or persons here is strictly confidential. The privacy of our clients and their rights are to be treated with total confidentiality is protected by law. This disclosure of any information pertaining to a client and their treatment may be in direct violation of Federal Regulations and may be punishable by fine or imprisonment or both. By signing this statement of confidentiality, you are acknowledging that you have read, understand and agree to the terms stated above and that all information and the presence of others at this facility will remain confidential.

_____ _____

Client Signature Date

_____

Parent/Guardian Signature

CONFIDENTIALITY OF PATIENT RECORDS (42 CFR PART 2)

Your insurance company requires that patient consent be obtained by the provider including consent to disclose information to your insurance company for claims payment purposes and for the provision of healthcare operation activities as provided for in 42 CFR part 2. Part 2 regulations cover any information, including information on referral and intake about patients receiving diagnosis, treatment or referral for treatment for a substance use disorder, created by a part 2 program. By signing below, you are acknowledging you have read, understand and consent to have your information shared with your insurance company.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

OUT OF NETWORK

Genesis Holistic Solutions is in network with the following insurance companies:

Blue Cross Blue Shield
Beacon Health Options

_____ _____

_____ _____

Any insurance outside of the listed companies above will NOT be billed by the facility. Genesis will provide a-superbill, for services rendered and paid, in order for the policy holder to submit through insurance. Genesis will NOT be responsible for the determination of decision for reimbursement. It is the responsibility of the card holder to contact their insurance company and clarify if an authorization is needed to file an out of network claim.

This is agreed upon with the policy holder that it will be their responsibility to seek reimbursement and/or coordinate with their claims department.

_____

_____
Genesis Representative

Date: _____

Drug Screening Payment Information

I am aware that Genesis Behavioral Health Services will submit the drug screen for payment on my behalf through my insurance company. I understand that it is my responsibility to understand what my insurance policy covers in reference to lab work.

I acknowledge that I am responsible for any payments owed to CPL Labs.

_____ _____

Client/Guardian **Date**

_____ _____

Witness **Date**

I,_____, understand that confidentiality is important for the therapeutic process to be successful. The information that is being discussed in group is to remain in group. Parents/Guardians will not be given specific information that is disclosed in the group, this includes drug use. However, if the client is at risk for self-harm, harming others or engaging and dangerous behavior (that will be the determination of the facilitator) this will be disclosed to the parent/guardian and the client will be transported to a higher level of care. It is the responsibility of the client to disclose to their parents the results of the drug screenings. This will take place in the office, phone or a copy of the screening will be given to the parent/guardian. The counselor will be present when the information is given to the parent/guardian to support the adolescent and being accountable.

_____ _____

_____ _____

INFORMED CONSENT FOR PROGRAM EVALUATION

Genesis Behavioral Health Services, LLC is interested in developing the highest quality programming possible, therefore, we are interested in evaluating program activities and services.

We are asking for your permission to include some or all of the following information in our evaluation efforts:

- Statements or comments that you may offer in response to interventions or programming
- Diagnosis, assessment measures, and/or evaluation forms
- Treatment goals
- Surveys or interviews about the program
- Overall satisfaction with the IOP experience

Your participation in program evaluation is completely voluntary. If you give your permission, you may withdraw your participation at any time without penalty. Your name or identifying information will not be attached to any report of program evaluation and all data used for program evaluation will be de-identified.

Your permission to include your responses in our evaluation of programming will assist us in providing you and subsequent clients with the highest quality programs and services. We do not anticipate that your participation in this program evaluation will include any greater risk than regular participation in an Intensive Outpatient Program. If you have any questions or concerns about program evaluation or would like to withdraw from program evaluation at any point (either completely or partially), please contact Tanya Stuart at tanstuart@gmail.com or notify a member of the Genesis clinical team.

By signing below, you are giving permission for your information as outlined above to be used in program evaluation for Genesis Behavioral Health Services, LLC.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

CHIEF COMPLAINT

Presenting Problems: (check all that apply)

- ____ Very Unhappy
- ____ Irritable
- ____ Withdrawn
- ____ Daydreaming
- ____ Fearful
- ____ Clumsy
- ____ Overactive
- ____ Slow
- ____ Short attention span
- ____ Distractable
- ____ Lacks initiative
- ____ Undependable
- ____ Peer conflict
- ____ Phobic
- ____ Dependency on illegal, prescribed, over the counter drugs
- ____ Temper outbursts
- ____ Disobedient
- ____ Infantile
- ____ Mean to others
- ____ Destructive
- ____ Trouble with the law
- ____ Running away
- ____ Self-mutilating
- ____ Head hanging
- ____ Rocking
- ____ Shy
- ____ Strange behavior
- ____ Strange thoughts
- ____ Suicide talk
- ____ Lying
- ____ Sexual trouble
- ____ School performance
- ____ Truancy
- ____ Bed-wetting
- ____ Soiled pants
- ____ Eating problems
- ____ Sleeping problems
- ____ Sickly
- ____ Tobacco use
- ____ Alcohol use
- ____ Impulsive
- ____ Stubborn
- ____ Fire-setting
- ____ Stealing

How long have these problems occurred? (number of weeks, months, years)

_____

_____

What happened that makes you seek help at this time?

_____

_____

Problems perceived to be: ☐ very serious ☐ serious ☐ not serious

What are your expectations for your child in the program?

_____

_____

What changes would you like to see in yourself (parent)?

_____

_____

_____

What changes would you like to see in your family?

_____

_____

_____

Religion or cultural affiliations that may affect therapy?

_____

_____

What strengths does your child/family have?

_____

_____

_____

What are you (and your family) already doing to improve the current situation? _____

_____

Current Suicidal Ideation? ☐ **Yes** ☐ **No**

Current Suicidal Attempt? ☐ **Yes** ☐ **No**

History of Prior Suicide Attempts? ☐ **Yes** ☐ **No**

Current Self-Harming Behavior? ☐ Yes ☐ No

Current Homicidal Ideation? ☐ Yes ☐ No

Current Homicide Attempt(s)? ☐ Yes ☐ No

Current physically aggressive behavior or threats of physically aggressive behavior? ☐ Yes ☐ No

Current Psychosis? ☐ Yes ☐ No

Does the member have a current eating disorder? ☐ Yes ☐ No

Does the member have a current substance use disorder? ☐ Yes ☐ No

Is there a history of suicide in your child's immediate and/or extended family? ☐ Yes ☐ No

If yes, please explain:

_____

Alcohol/Drug Assessment:

Does your child use tobacco or smokeless tobacco? ☐ Yes ☐ No ☐ Do Not Know

Does your child use alcohol or drugs? ☐ Yes ☐ No ☐ Do Not Know

RECENT LOSSES:

☐ Family Member ☐ Friend ☐ Health ☐ Lifestyle ☐ Job ☐ Income
☐ Income ☐ Housing ☐ None

Who? _____ **When?** _____ **Nature of loss?** _____

Other Losses: _____

Additional information (if needed):

_____

_____

Family Mental Health

Please identify if any members of your family have had a history of any of the following mental health/drug abuse/legal concerns.

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ ADD	Trama History	Abuse Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Self	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Biological Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

To your knowledge has your child ever used medication (prescription or over the counter) recreationally? ☐Yes ☐No ☐Do Not Know
Please Explain:

_____

_____

Is your child currently being seen by a counselor? ☐ **Yes** ☐ **No**

If yes, name of current counselor _____

Length of treatment _____

Is your child currently being seen by a psychiatrist? ☐ **Yes** ☐ **No**

If yes, name of current psychiatrist _____

Length of treatment _____

Has your child ever been diagnosed with a mental health, emotional or psychological condition?

☐ **Yes** ☐ **No**

If yes, what diagnosis was your child given?

_____

When?

_____

By Whom?

_____

Has your child received counselling services or been hospitalized for mental health or drug and alcohol concerns in the past? ☐ **Yes** ☐ **No**

If yes, please list previous counseling/hospitalizations for mental health/drug and alcohol concerns below

Dates of Service	Place/Provider	Reason for Treatment	Were the services helpful

Name and telephone number of primary care doctor:

List child's special interests, hobbies, skills:

Has the child ever had difficulty with the police? (if yes, explain) ☐ **Yes** ☐ **No**

Has the child ever appeared in juvenile court? (if yes, explain) ☐ **Yes** ☐ **No**

Has the child ever been on probation? ☐ **Yes** ☐ **No**

From **To** **Reason** **Probation Officer**

Has the child ever been employed? ☐ **Yes** ☐ **No**

Job **Employer** **How long?**

PARENT/CHILD RELATIONSHIP

Describe parenting your child (e.g. challenging, easy):

What do you find most challenging in parenting your child?

_____

What kind of discipline works best with your child?

_____

EDUCATION

Is your child currently enrolled in school? ☐ Yes ☐ No
Name of School _____
What grade is your child currently in (if summer, what grade is your child going into)?

_____

How would you describe your child's attendance (currently)? (check ALL that apply)

☐ Attending regularly ☐ Home-schooled ☐ Some truancy ☐ Alternative School

☐ Expelled ☐ Dropped out ☐ GED program

How would you describe your child's achievements/grades in school?

_____

How would you describe your child's attitude towards school/education?

_____

_____

Disciplinary or behavioral issues at school? ☐ Yes ☐ No If yes, describe:

_____

_____

Please check if your child has any of the following?

☐ Special Education Accommodation or a 504? Please describe:

_____

☐ As Individual Educational Plan (IEP)? Please describe:

☐ Diagnosed Learning Disability? Please describe:

☐ Receiving special services at school? Please describe:

Legal Issues? ☐ Yes ☐ No ☐ N/A ☐ Unknown

Support system?

Parents ☐ Spouse/Partner ☐ Behavioral Health Provider ☐ Mother ☐ Father ☐

Other relative ☐ Guardian ☐ Sibling ☐ Adult Children ☐ Probation Officer ☐

Employee Assistance Program ☐ Other Sources of Support ☐ None ☐

Describe Support system/family identified above and bow they will be integrated into the treatment plan:

Describe Current living situation and will this be the anticipated living situtation at the time of discharge:

Describe any social/interpersonal functional concerns/impairment - including duration/frequency if applicable:

Describe any occupational/educational concerns/impairment - including duration/frequency:

What else do you feel is important for us to know?

Medication List

Medication	Dosage	Frequency

Credit Card Authorization Form

The card will be charged in accordance with our office and cancellation policies.

Today's date_____/_____/_____

Patient Name:_____

Credit Card Information

Name as is appears on the card: _____

Type of Card: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ■ AMERICAN EXPRESS

Credit Card Number_____

Expiration Date____/_____

Security Code BACK of Visa OR Master Card: (3 digits) _____

Security Code FRONT of Amex Card: (4 digits) _____

Credit Card Billing Address:

Street: _____

City: _____ State:_____

Zip Code: _____ Telephone: _____

****I hereby authorize this card to be used for payment of services rendered.**

Cardholder's Signature:_____ Date: _____/_____/_____

I hereby authorize this card to be used for payment of future services rendered (please sign again for future authorization):

Cardholder's Signature:_____ Date: _____/_____/_____

Consent to Release of Information

I _____ residing at:

_____

Hereby give my consent for **Genesis Behavioral Health Services** to:
(Name of Provider)

1. Talk with and/or
2. Release written documentation

Regarding my treatment with _____
(Person or Agency receiving information)

I understand that my records are protected under HIPAA and Federal Regulation 42 CFR. Confidentiality of mental health and substance use, under the general laws of my state, cannot be redisclosed without my written consent, except when:

1. There is indication of child abuse or abuse of disabled adults,
2. Given the best clinical judgment, there is indication of danger to self or to others (suicidal or homicidal), or
3. Required to present records to comply with a court order.

I understand that federal and state laws and regulations do not protect any information about suspected child abuse or neglect from being reported to appropriate state or local authorities. I understand that state laws and regulations may require disclosure of information if there is indication of danger to myself or to others (suicidal or homicidal).

This authorization expires one year from today's date. I understand that I may revoke my authorization to release information at any time verbally or in writing, and such revocation will be effective on the date the revocation is received. In the event action has already been taken prior to said revocation, such prior actions are covered by the pre-existing release.

_____ _____
Client Signature Date

_____ _____
Signature of Witness Date

Outcome Rating Scale (ORS)

Name _____ Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Overall:
(General sense of well-being)

I----------I

Individually:
(Personal well-being)

I----------I

Interpersonally:
(Family, close relationships)

I----------I

Socially:
(Work, School, Friendships)

I----------I

Institute for the Study of Therapeutic Change

www.talkingcure.com

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

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

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless that it's hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Outcome Rating Scale (ORS)

Name _____ Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Overall:
(General sense of well-being)

I----------I

Individually:
(Personal well-being)

I----------I

Interpersonally:
(Family, close relationships)

I----------I

Socially:
(Work, School, Friendships)

I----------I

Institute for the Study of Therapeutic Change

www.talkingcure.com

LEVEL 2—Substance Use—Child Age 11–17*

*Adapted from the NIDA-Modified ASSIST

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

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you have been bothered by "having an alcoholic beverage"; "smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco"; "using drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)"; and/or "using any medicine ON YOUR OWN, that is, without a doctor's prescription, to get high or change the way you feel." The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms **during the past two (2) weeks. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
		Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day	Item Score
During the past TWO (2) weeks, about how often did you …							
a.	Have an alcoholic beverage (beer, wine, liquor, etc.)?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
b.	Have 4 or more drinks in a single day?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
c.	Smoke a cigarette, a cigar, or pipe or use snuff or chewing tobacco?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
During the past TWO (2) weeks, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription or in greater amounts or longer than prescribed?							
d.	Painkillers (like Vicodin)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
e.	Stimulants (like Ritalin, Adderall)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
f.	Sedatives or tranquilizers (like sleeping pills or Valium)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
Or drugs like:							
g.	Steroids	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
h.	Other medicines	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
i.	Marijuana	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
j.	Cocaine or crack	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
k.	Club drugs (like ecstasy)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
l.	Hallucinogens (like LSD)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
m.	Heroin	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
n.	Inhalants or solvents (like glue)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
o.	Methamphetamine (like speed)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	

Self-Injury Craving Questionnaire (SICQ)

If you have ever self-injured frequently, please write the behavior you have performed most often on the line below (e.g., cutting, hitting, burning).

_____

1. **Regardless of whether I'm having a good day or a bad day, I would want to self-injure.**

   0 (strongly disagree) 1 (disagree) 2 (neither agree not disagree) 3 (agree) 4 (strongly agree)

2. **There are days when my desire to self-injure is all I can think about.**

   0 (strongly disagree) 1 (disagree) 2 (neither agree not disagree) 3 (agree) 4 (strongly agree)

3. **Just thinking about self-injure makes me crave it.**

   0 (strongly disagree) 1 (disagree) 2 (neither agree not disagree) 3 (agree) 4 (strongly agree)

4. **I often spend time making plans about when I can self-injure next.**

   0 (strongly disagree) 1 (disagree) 2 (neither agree not disagree) 3 (agree) 4 (strongly agree)

5. **When I am in a good mood, I often want to self-injure.**

   0 (strongly disagree) 1 (disagree) 2 (neither agree not disagree) 3 (agree) 4 (strongly agree)

6. **Even when things are going well, I have trouble controlling the urge to self-injure.**

   0 (strongly disagree) 1 (disagree) 2 (neither agree not disagree) 3 (agree) 4 (strongly agree)

7. **It would be easy to pass up the chance to self-injure, even when I am able to.**

   0 (strongly disagree) 1 (disagree) 2 (neither agree not disagree) 3 (agree) 4 (strongly agree)

Please note that email is not an entirely secure or confidential form of communication. Submitting this form via email to Genesis Behavioral Health Services DBA Holistic Solutions Center of Baton Rouge, constitutes understanding and implied consent of the risks of electronic communication.

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