FACES Professional Services LLC

I_____ authorize _____ at the

above address to:

___ Release of any records regarding results in alcohol & drug assessments, mental health evaluations, urine drug screens, treatment diagnosis and recommendations and information to sent to the following people listed below. I understand these individuals may communicate through fax/email/phone with the above facility and (therapists, specialists, family members, probation officers, state workers or legal entities).

I give permission to release my information to:

1) Name, Address: _____

_____

Email Address: _____

2) Name, Address: _____

_____

Email Address:_____

For the purpose of:

___ A&D Assessment ____ Other: _____

___ Mental Health Evaluation _____

___ Probation or Court Referral _____

___ DCS Referral

Signed :_____ Date:_____

Release of Records:

I am requesting a service provided and agree the service will be provided. I have been invoiced by D. Deneen Bunch through paypal and will be paying for this service provided through paypal. I understand documentation may be provided to prove the service was provided. I understand there are no refunds for this service provided.

Name:_____

Date:_____

Email:_____

Phone:_____

PERSONAL INFORMATION

NAME: _____ AGE: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ SS#: _____

MAILING ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

SCHOOL/EMPLOYER: _____

ADDRESS: _____ TELEPHONE: _____

DUE TO PRIVACY REGULATIONS, WE CANNOT LEAVE MESSAGES ON ANSWERING MACHINES, OR WITH ANY PARTY WITHOUT YOUR AUTHORIZATION. MAY WE CONTACT YOU BY PHONE? YES NO

PLEASE LIST WHOM WE MAY SPEAK TO: _____

MARRIED: YES/NO; IF MARRIED, NUMBER OF TIMES: _____; NUMBER OF TIMES DIVORCED: _____; WIDOWED: _____

NAMES AND AGES OF CHILDREN: _____

WITH WHOM DO YOU LIVE (RELATIONSHIP, IF ANY): _____

NAME/RELATIONSHIP OF PERSON FILLING OUT FORM, IF NOT PATIENT: _____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Depression						
Anxiety						
Panic Disorder						
Manic Depression						
Schizophrenia						
Alcohol Abuse						
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Diabetes						
Epilepsy						
Thyroid Disorder						
Parkinson's Disorder						
Alzheimer's Disorder						
Occupation						
Age at Death						
Cause of Death						

We request a 24 hour advance cancellation notice to avoid a missed appointment charge. Our phone is answered 24 hours a day, seven days a week to take urgent calls and cancellations. Calls for medication refills will be answered the next business day, when your chart is available for review. Please check y our medication regularly and make appointments before the supply is exhausted to discuss any changes and obtain the necessary new prescription. We will file your insurance as a courtesy to you. However, payment is ultimately the responsibility of the patient or the responsible party named below.

I authorize the release of any medical information necessary to process this claim. Additionally, I request payment of payment of medical benefits to the physician or supplier for services rendered to the above named patient.

Signed: _____ Date: _____

Patient Name or Guarantor of Patient

Patient Stress Questionnaire*

Name: _____

Date:_____ **Birthdate**_____

Over the ***last two weeks*** , how often have you been bothered by any of the following problems? (please circle your answer & **check the boxes that apply to you**)	Not at all	Several days	More than half the days	Nearly Every day	
1. Little interest or pleasure in doing things	0	1	**2**	**3**	
2. Feeling down, depressed, or hopeless	0	1	**2**	**3**	
3. ☐ Trouble falling or staying asleep, or ☐ sleeping too much	0	1	**2**	**3**	
4. Feeling tired or having little energy	0	1	**2**	**3**	
5. ☐ Poor appetite or ☐ overeating	0	1	**2**	**3**	
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	**2**	**3**	
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	**2**	**3**	
8. ☐ Moving or speaking so slowly that other people could have noticed, or ☐ the opposite - being so fidgety or restless that you've been moving around a lot more than usual	0	1	**2**	**3**	
9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way	0	**1**	**2**	**3**	**Total**
(10)		add columns:			

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 is 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**	**Total**
(8)		add columns:			

*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 1/24/11

Please also complete back side →

Provider:_____

Are you currently in any physical pain?	No	Yes

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, ***in the past month***, you:

1. Have had nightmares about it or thought about it when you did not want to?	No	Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
3. Were constantly on guard, watchful, or easily startled?	No	Yes
4. Felt numb or detached from others, activities, or your surroundings?	No	Yes

(3) | |

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.

These questions are about your drinking habits. We've listed the serving size of one drink below.

Please circle your answer	0	1	2	3	4
How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times per week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the ***last year*** have you.....					
...found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
...failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
...needed a first drink in the morning to get yourself going after heavy drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
...had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
...been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	0		2		4
Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last year			Yes, during the last year
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year			Yes, during the last year

(8) | | | |

Total:

Standard serving of one drink:

12 ounces of beer or wine cooler
1.5 ounces of 80 proof liquor
5 ounces of wine
4 ounces of brandy, liqueur or aperitif

Name:_____Date of Birth:_____Date of visit:_____

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers:_____This is your ACE Score.

Liebowitz Social Anxiety Scale (LSAS-SR)

Name _____ Date _____

Fill out the following questionnaire with the most suitable answer listed below. Base your answers on your experience in the past week and, if you have completed the scale previously, be as consistent as possible in your perception of the situation described. Be sure to answer all items.

Fear or Anxiety	Avoidance
0 = None	0 = Never (0%)
1 = Mild	1 = Occasionally (1%-33% of the time)
2 = Moderate	2 = Often (33%-67% of the time)
3 = Severe	3 = Usually (67%-100% of the time)

Understanding the situations:	FEAR OR ANXIETY	AVOIDANCE
1. **Telephoning in public** - speaking on the telephone in a public place		
2. **Participating in small groups** - having a discussion with a few others		
3. **Eating in public places** - do you tremble or feel awkward handling food		
4. **Drinking with others in public places** - refers to any beverage including alcohol		
5. **Talking to people in authority** - for example, a boss or teacher		
6. **Acting, performing or giving a talk in front of an audience** - refers to a large audience		
7. **Going to a party** - an average party to which you may be invited; assume you know some but not all people at the party		
8. **Working while being observed** - any type of work you might do including school work or housework		
9. **Writing while being observed** - for example, signing a check in a bank		
10. **Calling someone you don't know very well**		
11. **Talking with people you don't know very well**		
12. **Meeting strangers** - assume others are of average importance to you		
13. **Urinating in a public bathroom** - assume that others are sometimes present, as might normally be expected		
14. **Entering a room when others are already seated** - refers to a small group, and nobody has to move seats for you		
15. **Being the center of attention** - telling a story to a group of people		
16. **Speaking up at a meeting** - speaking from your seat in a small meeting or standing up in place in a large meeting		
17. **Taking a written test**		
18. **Expressing appropriate disagreement or disapproval to people you don't know very well**		
19. **Looking at people you don't know very well in the eyes** - refers to appropriate eye contact		
20. **Giving a report to a group** - refers to an oral report to a small group		
21. **Trying to pick up someone** - refers to a single person attempting to initiate a relationship with a stranger		
22. **Returning goods to a store where returns are normally accepted**		
23. **Giving an average party**		
24. **Resisting a high pressure salesperson** - avoidance refers to listening to the salesperson for too long		

The Providence Center

PBHCI - Mental Health Screening

Client Name

Client Number

Date of Scheduled Appt.

Interview Date: Gender: ○ Male ○ Female DOB:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1a. Little interest or pleasure in doing things

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

1b. Feeling down, depressed or hopeless

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

1c. Trouble falling asleep, staying asleep or sleeping too much

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

1d. Feeling tired or having little energy

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

Poor appetite or overeating

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

1e. Feeling bad about yourself, feeling that you are a failure or feeling that you have let yourself or your family down

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

1f. Trouble concentrating on things such as reading the newspaper or watching television

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

1g. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

1i. Thinking that you would be better off dead or that you want to hurt yourself in some way. If "More than hal the days" or "Nearly every day" is indicated send reminder to nurse to contact team leader and primary

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

2. If you have checked off any problem on this questionnaire so far, how difficult have these problems made i for you to do your work,, take care of things at home or get along with other people

○ Not at all difficult ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Scoring for diagnosis:
- 5 or more are circled as at least "More than half the days"
- Either item 1a or 1b is at least "More than half the days"

Scoring for planning and monitoring treatment:
- To score the first question, tally each response by the number value of each response
- Add the numbers together to total the score

^^^^^^^^{//my:myFields/my:BarClientID}^^^^^^^{/my:myFields/my:BarDocumentDate}^^{//my:myFields

Kessler Psychological Distress Scale (K10)

K10 Test

These questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been .

1. During the last 30 days, about how often did you feel tired out for no good reason?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

2. During the last 30 days, about how often did you feel nervous?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

4. During the last 30 days, about how often did you feel hopeless?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

5. During the last 30 days, about how often did you feel restless or fidgety?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

6. During the last 30 days, about how often did you feel so restless you could not sit still?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

7. During the last 30 days, about how often did you feel depressed?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

8. During the last 30 days, about how often did you feel that everything was an effort?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time