Crosspointe Family Services--Patient Demographics
Please fill out front and back of Form.

Patient Information

Last Name: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Soc. Sec. #: _____ Date of Birth: _____ Age: _____ Sex: **M F**

E-mail: Marital Status:

Custodian/Guardian Information FOR YOUTH 18 or Younger

Who does the client live with? Name: _____

Address: _____ Phone: _____

Does this person have the legal authority to consent for treatment? Yes No

If Yes, circle one: Biological/Adoptive Parent Legal Guardian Foster Parent IDHW Caseworker

If No, who has this authority? Name _____ Phone: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

****We are unable to see a youth client without the consent of the legal parent/guardian/custodian.**

Other Information

Occupation: _____

Employer: _____

Employer Address: _____

Work Phone:

Referring Source: _____

What are we seeing you for? _____

Preferred Language: _____

Communication Needs: _____

Spouse:

Race: Circle Answers **Ethnicity:**

1 American Indian/Alaskan Native 1 Hispanic

2 Asian 2 Non-Hispanic

3 Black or African American

4 Native Hawaiin/ Pacific Islander

5 White or Caucasian

6 Prefer not to answer

Responsible Party Information

Responsible Party: _____ D.O.B. _____ Soc. Sec. #: _____

Address: _____ Phone: _____

Relationship: _____ Occupation: _____

Employer: _____ Work Phone: _____

Insurance Information

Policy Holder: _____ D.O.B. _____

Medical Insurance: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Policy #: _____ Medicaid #: _____

Group #: _____ Medicare # _____

Emergency Information	IN CASE OF EMERGENCY CONTACT (Person NOT LIVING with patient).
	Contact Name: _____ Relationship to Patient: _____
	Address: _____ Phone: _____
	City: _____ State: _____ Zip: _____ Cell Phone: _____

Insurance payments are considered a method of reimbursment to the insured participant for fees paid to Crosspointe and is not a substitute for payment. We do not accept this amount as "payment in full" (unless otherwise restricted by law or agreement with your insurer). IN ORDER TO MAINTAIN COSTS WE ASK THAT OUR CHARGES AND COPAYS BE PAID AT THE TIME OF EACH VISIT. In the event the account is turned over for collection, you agree to pay all collection fees and/or legal fees including attorney fees.

I hereby assign all medical and mental health benefits to which I'm entitled including Medicaid, Medicare, private insurance and other health plans to Crosspointe Family Services. This assignment will remain in effect until revoked by me. A photocopy of this assignment is considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment for services I recieved via Facsimile, hard copy, or electronically.

Patient Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

CROSSPOINTE
FAMILY SERVICES

ACKNOWLEDGEMENT

I acknowledge that I have read, reviewed, and was offered a copy of the following Crosspointe Terms and Conditions for Treatment.

1. Notice of Privacy Practices
2. Informed Consent for Treatment
3. Participants Rights and Grievance Procedure
4. Patient Authorization for Third Party Payor Reimbursement of Provider and Other Verification
5. Other Terms and Conditions

Patient Name: _____

Patient Signature: _____Date:_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____Date:_____

Agency Witness:_____

07/2018

CROSSPOINTE FAMILY SERVICES

Patient Name: _____ **Date:** _____ **Birthdate:** _____

List all **ALLERGIES** you have: _____

List all **MEDICATIONS** you take: _____

List all Herbal **Supplements** and **Vitamins** you take: _____

List any previous significant **TRAUMA**: _____

Indicate any **SURGERIES** you have had:

- ☐ Appendix ☐ Hernia ☐ Uterus ☐ Heart
- ☐ Gallbladder ☐ Tonsils ☐ Tubes Tied ☐ None
- ☐ List Other: _____

Do **You** have any of the the following medical problems?

- ☐ Asthma/Lung ☐ Arthritis ☐ AIDS ☐ Diabetes
- ☐ High Blood Pressure ☐ Heart ☐ Stroke ☐ Cancer
- ☐ Depression ☐ Mood swings ☐ HIV
- ☐ List other: _____

Do any of the following Medical problems run in your **FAMILY**?

- ☐ Asthma/Lung ☐ Arthritis ☐ Psychiatric ☐ Diabetes
- ☐ High Blood Pressure ☐ Heart ☐ Stroke ☐ Cancer
- ☐ List Other: _____

Do you Smoke? ☐ Yes ☐ No

Packs per day? _____ Years? _____

Do you drink Alcohol ☐ Yes ☐ No

Type and Number of drinks per day _____

Do You now or have you ever used or taken any drugs not prescribed by a doctor?

- ☐ No
- ☐ Yes Please list: _____

Do You use smokless tobbaco/chew? ☐ Yes ☐ No

Form H 8/14

Check any you have had recently or concerns:

- ☐ Low Energy Level
- ☐ Excessive Energy
- ☐ Restlessness
- ☐ Excessive Sadness
- ☐ Irritability
- ☐ Chest Pain
- ☐ Comunicable Disease
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Victim of Crime
- ☐ Excessive Anger
- ☐ Self Injury
- ☐ Headache
- ☐ Dizziness
- ☐ Numbness
- ☐ Depression
- ☐ Hallucinations
- ☐ Mood Swings
- ☐ Excessive Hunger
- ☐ Weight Gain
- ☐ Heartburn
- ☐ # of Pregancies:
- ☐ Excessive Sleeping
- ☐ Weakness
- ☐ Recent Vision Changes
- ☐ Trembling/Shaking
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Over Use of Laxatives
- ☐ Aggression
- ☐ Easily Distracted
- ☐ Itching
- ☐ Hair Pulling
- ☐ Fainting
- ☐ Seizures
- ☐ Insomnia
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Nightmares
- ☐ Excessive Worry
- ☐ Panic
- ☐ Unexplained Pain
- ☐ Weight Loss
- ☐ Change of Libido
- ☐ # of Children:

Who is your primary care doctor/provider?

_____

When was your last vist with your primary provider?

_____

Who else manages your medical and/or behavioral health care: Provider Name/City

_____

_____

_____

Comments:

_____

_____

_____

_____

CROSSPOINTE
FAMILY SERVICES

At Crosspointe Family Services we want to ensure that we are coordinating your care with all of your providers. Please tell us who is involved in your medical and behavioral health care. We believe that working together as a care team on your behalf provides the greatest care to you.

Patient's Name _____ **B-Day** _____

Provider Name _____ Specialty _____

Facility Name _____ City _____

Provider Name _____ Specialty _____

Facility Name _____ City _____

Provider Name _____ Specialty _____

Facility Name _____ City _____

Provider Name _____ Specialty _____

Facility Name _____ City _____

Thank you for your help!

If you have any questions or concerns about how we coordinate your care or how we use the information please contact:

Mark Gritton
208-736-7090

We respect and protect your patient rights.

Crosspointe Family Services

1363 Fillmore St, Twin Falls, ID 83301
Office: (208)-736-7090 Fax: (208)-736-7089

MEDICAL-Release and/or Exchange of Protected Health Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

I DECLINE TO RELEASE ANY INFORMATION TO: _____

I authorize:

Name/Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

(Initial either or both as needed.) ____ **to release PHI information to:** ____**to obtain PHI information from:**

Crosspointe Family Services
1363 Fillmore St
Twin Falls, ID 83301
Office: (208)-736-7090 Fax: (208)-736-7089

A. The confidential Protected Health Information (PHI) to be released: (Initial)

___History and Physical	___ Laboratory Results	___Coordination of Care Communication
___Last Office Progress Note	___Pharmacy/Medication List	___Entire Medical Record
___Progress Notes: from____ to ____	___Medication List(s)	___Parent/Guardian Communication
___Discharge Summary	___Comprehensive Diagnostic Assessment	___Care Plan

____Other: _____

Such information may be freely exchanged by the above-designated parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of the client, unless otherwise specified. I release the parties involved from all liability arising from such exchange of PHI records. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of my PHI. I understand that this "Release of PHI" is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but no limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), Code of Federal Regulations (42, Part 2), and HIV records under Public Health Law article 27-F.

B. Effective date of authorization:

This authorization takes effect the day that you sign it and terminates on: _____ or one year from the date it is signed.

I understand that I have a right to revoke this authorization at any time. I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Crosspointe Family Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.

_____ _____

Participant/Guardian Signature Date Witness Signature Date

NO SHOW/MISSED APPOINTMENT POLICY

Definitions:

No Call/No Show: ***ANY*** *missed appointment that isn't canceled with at least 24 hours' notice.*

- If you call the day of your appointment, it is considered a No Call/No Show.
- If you do not show up for your appointment, it is considered a No Call/No Show.
- If you are more than 15 minutes late for your appointment, it is considered a No Call/No Show.

Adequate Communication: *Calling AT LEAST 24 hours in advance to cancel or change an appointment.*

- When you call with at least 24 hours' notice, we are able to allow another client to fill your appointment.

Emergency: An emergency is a situation in which you have absolutely no control or choice.

- If you are in a car accident, that is an emergency.
- If you are in the emergency room or at urgent care, that is an emergency.
- If your car battery is dead when you try to start your car, that is an emergency.
- If someone in your immediate family dies, that is an emergency.

We, at **Crosspointe Family Services**, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling **208-736-7090**.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call or text to you is made/attempted one (1) business day prior to your scheduled appointment. Please arrive for your appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. If necessary, please cancel or change your appointment with at least a 24 hours' notice; there is a waiting list to see the clinicians at **Crosspointe Family Services** and, whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than 24 hours is given to cancel or change an appointment, this will be documented as a "No Call/No Show" appointment.

3. If you do not show up to the office for your appointment, this will be a "No Call/No Show" appointment.

4. After the first "No Call/No Show" appointment, you will receive a phone call or letter warning that you have broken our "No Call/No Show" policy. **Crosspointe Family Services** will assist you to reschedule this appointment, if needed.

5. After the 2nd "No Call/No Show" appointment, you will be removed from your counselor's schedule and will only be able to make a return appointment with that counselor's approval. You will not be able to make an appointment with any other clinician in our office.

I have read and understand Crosspointe Family Services' No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify **Crosspointe Family Services** appropriately if I have difficulty keeping my scheduled appointments.

Patient Name	Date of Birth	Date
Patient Signature or Parent/Guardian if minor	Relationship to Patient	
Staff Signature	Date	

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:** _____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

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

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes			☐ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes			☐ No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes			☐ No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes			☐ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes			☐ No		
	25.	Have you EVER tried to kill yourself?	☐ Yes			☐ No		

Crosspointe Family Services

1363 Fillmore St, Twin Falls, ID 83301
Office: (208)-736-7090 Fax: (208)-736-7089

Release and/or Exchange of Protected Health Information

Patient's Name:_____ Date of Birth:_____

Parent/Guardian Name: _____

I authorize:

Name:_____

Address: _____

Phone: (____) _____ Fax: (____) _____

(Initial either or both as needed.) [ ] **to release PHI information to:** [ ] **to obtain PHI information from:**

Crosspointe Family Services
1363 Fillmore St
Twin Falls, ID 83301
Office: (208)-736-7090 Fax: (208)-736-7089

A. The confidential Protected Health Information (PHI) to be released:

___ Psychiatric test results	___ CBRS (PSR) Treatment Plans	___ Speech therapy reports
___ Psychological Test results	___ GAIN Assessment	___ Case Management Plans
___ Diagnostic Assessments	___ Substance Use Treatment Plan	___ Billing Information
___ Developmental assessments	___ Medical History/Physical	___ Aftercare Plans/Reports
___ Clinical Treatment Plans	___ Occupational therapy reports	___ Coordination of Care Communications
___ Behavioral health therapy reviews	___ Pharmacy/Medication List	___Parent/Guardian Communication

___ Other: _____

Such information may be freely exchanged by the above-designated parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of the client, unless otherwise specified. I release the parties involved from all liability arising from such exchange of PHI records. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of my PHI. I understand that this "Release of PHI" is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but no limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), Code of Federal Regulations (42, Part 2), and HIV records under Public Health Law article 27-F.

B. Effective date of authorization:

This authorization takes effect the day that you sign it and terminates on: _____ or one year from the date it is signed.

I understand that I have a right to revoke this authorization at any time. I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Crosspointe Family Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.

_____ _____

Participant/Guardian Signature Date Witness Signature Date

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

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

	(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?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only Severity score: _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)