# *Real Solutions Counseling*

*1011 W. Williams St., Suite G, Boise, Idaho 83706*
*Phone: (208) 991-0222 Fax: (208) 344-0014*


## *INTAKE INFORMATION SHEET*

**Student Name:** _____ ☐Male ☐Female

**Telephone Number:** _____ **DOB:** _____

**Address:** _____ **Age:** _____

**Parent or Guardian Name:** _____ **Cell Number:** _____

**Email address for Correspondence:** _____

**Brief explanation of why you would like to come in:** _____

**Are you on any kind of medication? If yes, who and what?** _____

**Do you have Medicaid?** ☐Yes ☐No **Medicaid ID#:** _____

**Primary Doctor?** _____ **Do you have the physical card? If not replacement #: 1-866-726-2237**

**Do you have insurance?** ☐Yes ☐No **(If Medicaid Skip this section)**

**Insurance Company:** _____ **Insurance Phone Number:** _____

**Primary Insured's Name:** _____ **Primary Insured's DOB:** _____

**Insurance ID#:** _____ **Group#:** _____

**Telephone Phone number for benefits on your Insurance card:** _____

**Employee Assistant Program?** ☐Yes ☐No **Employer:** _____

**Auth#:** _____ **No of Visits:** _____

**Have you had counseling in the last year:** ☐Yes **Where at:** _____

**I, as a Client or Insured Family Member, give consent and acknowledgement that this and other client information will be released to Insurance Carriers or Medicaid Agencies that provide financial reimbursement for requested services at Real Solutions Counseling:**

_____ _____
**(Client Signature)** **(Date)**

_____ _____
**(Parent or Guardians Signature)** **(Date)**

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# YOUR RIGHTS AS A CLIENT OF REAL SOLUTIONS COUNSELING

TO CONFIDENTIALITY of records. The Health Information Privacy Protection Act (HIPPA) states that information in your records may not be given to any other person without your written consent or a court subpoena. A copy of RSC's privacy rules are posted in the lobby and on our website: www.realsolutionsidaho.com

- Mental health professionals also have the right, when they deem necessary, to consult with another member of a supervisory and clinical team regarding treatment.
- Mental Health Professionals are required by law to report all incidents of child abuse.
- Mental Health Professionals may seek additional help for you if you are deemed to be a danger to yourself and others.
- Under no other circumstances may the therapist communicate information about you outside of RSC without a written consent.
- HIPPA Privacy rules are posted in the lobby and you may have a copy upon request.

TO HAVE ACCESS to your records. HIPPA provides that if you request that your records be sent to another professional or agency, your request will be fulfilled with promptness upon receipt of your written request for transfer of information and provided there is no outstanding balance on your RSC account. There may also be an additional fee associated with this request. You may also request a personal copy of your medical records, excluding therapist progress notes, with a signed request form. You may be subject to a 7-day waiting period before receiving your records and there may be a nominal fee associated for cost of copying records.

TO BE INFORMED that there are risks and benefits which may occur while in counseling. The risks to therapy often involve discussing unpleasant aspects of your life, and you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behavior can be scary, and sometimes as you change, the relationships around you may change. However, the benefits of counseling typically outweigh the risks.
The benefits from counseling may be an improved ability to relate with others, a clearer understanding of self, values, goals, increase productivity in work, school, and relationships, and an improved ability to deal with everyday stresses. Counseling may help relieve the stress and impaired functioning associated with trauma, grief and mental disorders. In fact, recent research has demonstrated that some types of psychotherapy offer better or equal treatment results at a lower cost than medication.

TO REFUSE any service which you do not want and to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notification to that effect could be placed your records. I understand that I have the right to refuse Counseling services and I have and have selected:
**Real Solutions Counseling**

My reason for selecting this agency is: _____

_____

I (We) have read, understand and accept the above statements concerning my (our) rights as clients of RSC including privacy practices and the scope of clinical services available.

_____ _____
(Client/Parent/Guardian Signature) (Date)

# *Real Solutions Counseling, LLC*

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## Disclosure and Consent

I (Jim Grigg) obtained a Master's of Science degree in Marriage and Family Therapy (M.S.) from Oklahoma State University. I am a Licensed Marriage and Family Therapist (License #: LMFT-2743), and a Licensed Clinical Professional Counselor (License #: LCPC-407) in the State of Idaho. I am also a member of the Mental Health Providers Association of Idaho (MHPAI), and of the National Association for Addiction Professionals (NAADAC). Last, I am Licensed as a Drug & Alcohol Abuse Evaluator in the State of Idaho and a Substance Abuse Professional (SAP) for the Department of Transportation.

I have specialized as a marriage and family therapist, and have sought diverse training in both short and longer term therapy approaches. I work from a Solution Focused Strength Based approach to counseling. I also draw heavily from Cognitive Behavioral Therapy Techniques as well as Systems Theory Techniques. I enjoy working with couples and families and have 15 years experience at this working at Real Solutions Counseling and other counseling agencies.

### Confidentiality

The information you share in therapy is confidential. I cannot release information to another party without your written consent. Confidentiality laws do require that I make exceptions in some very limited circumstances and these exceptions are listed in the client rights section of the intake paperwork. If you have any questions about this please ask.

### Professional Fees

The fee is $100.^{00}$ for a fifty-minute (50) session. You will be charged for phone time with you or on you behalf, and letters or reports including preparation time. If I am required to appear in court you will be charged $120.^{00}$ per hour to cover the additional requirements of travel and being out of my office. **All fees are due and payable at the time of the service.** Make payment to Real Solutions Counseling. There will be a $20.^{00}$ service charge for any returned checks.

### Cancellations and missed appointments

Time is important to all of us. If you are unable to keep an appointment please notify KCC at least 24 hours in advance. Please see the Missed Appointment section of the intake paperwork for further details.

### Grievance/Complaints

Initial complaints should be addressed with your counselor. However, if you are unable to resolve your concern or do not feel safe to approach your counselor with your concern, you may notify the clinical director. Please refer to the Grievance/Complaints section of the intake paperwork for further details.

### Emergency and Crisis Availability

We ask you to be aware that RSC is not an emergency service, and that in an emergency situation if you cannot reach your therapist, we ask you to contact your local community mental health center or another crisis counseling hotline. Important local crisis numbers are:

| | |
|---|---|
| Mobile Crisis line | 334-0808 |
| Runaway Hotline | 1-800-621-4000 |
| Suicide Hotline | 1-800-234-0420 |
| Emergency | 911 |

PROFESSIONAL RESPONSIBILITY AND COMMITMENT

I am dedicated to the treatment of families and to providing you with the best care that I can. It is my firm conviction that for counseling to be effective, there needs to be a committed partnership between the counseling staff and clients. Clients are equal and indispensable partners in treatment. As such, it is expected that they will be actively involved in the development of a goal-oriented treatment contract. Additionally, this is a professional relationship and it is my policy to maintain only a professional relationship with you. I cannot accept gifts or invitations, or engage in a business or personal relationship with you. These guidelines are meant to insure the quality of your care.

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My signature signifies that I have read, understand and accept these conditions and policies and agree to enter therapy. I have been given a copy of these policies. I agree to pay for all services rendered and any legal expenses necessary for collection.

_____ _____

(Client/Parent/Guardian Signature) (Date)

_____ _____

(Counselor Signature) (Date)

# *Real Solutions Counseling, LLC*

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**TECHNOLOGY ASSISTED COUNSELING (TAC)**
**CONSENT, POLICIES, & AGREEMENT**

This form is in **addition** to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Technology Assisted Counseling (TAC) sessions. TAC incorporates phone and video counseling.

***Benefits:*** The benefits to TAC counseling are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from and office.
4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients, clients with limited mobility, clients with risk for contracting diseases, and clients without convenient transportation options.

***Limitations:*** It is important to note that there are limitations to TAC counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. If video is not used, I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the TAC counseling session.
4. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

***Logistics:*** When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at our scheduled time and are prepared, focused and engaged in the session. I am calling you from a private location where I am the only person in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others can hear you, I cannot be responsible for protecting your confidentiality. Every effort MUST be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. For the most effective treatment, please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment. Please know that per best practices and ethical guidelines I can only practice in the state(s) I am licensed in. That means wherever you reside I must be licensed. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

***Connection Loss During Phone Sessions:*** If we lose our phone connection during our session, I will call you back immediately. If we are unable to reach each other due to technological issues, I will attempt to call you 3 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should we resume contact, and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked please be sure to pick it up.

***Connection Loss During Video Sessions:*** If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. Please also attempt to call me through your doxey.me link if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you 3 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via phone or plan an alternate time to complete the remaining minutes of our session.

***Recording of Sessions:*** Please note that recording, screenshots, etc. of any kind of any session is not permitted and are grounds for termination of the client-therapist relationship.

***Payment for Services:*** Payments for services must be made **prior** to each session. I will charge your card on file or send you an invoice. Payment is to be completed prior to our session.

***Cancellation Policy:*** If you must cancel or reschedule an appointment, 24-hour advance notice is required, otherwise you will be held financially responsible. Should you cancel or miss an appointment with notification less than 24 hours this will result in being charged the ***no show*** for your missed appointment. Cancellations must be communicated by phone, NOT email or text. If the client cancels or misses the session with less than 24 hours notice and the session is pre-paid, this follows the cancelation guidelines and the payment will not be reimbursed for the missed or canceled session less than 24 hours. Video/Phone sessions should be treated as regular in office sessions. If you are late getting on the video session, are unable to talk at our scheduled time, your battery has died and you are unable to access another confidential place to talk, or any other variable that would have you not be able to attend our session please know that you will be charged for the session. Please make the necessary arrangements you need to be available and present for your session.

***Emergencies and Confidentiality:*** I request an emergency contact for you. Please list the person's first and last name, relationship and phone number(s) of your emergency contact:

_____

Full Name Relationship Number(s)

I also request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.

_____

Street Address

_____

City State Zip Code

_____

City and State of Local Police Department Phone Number

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433 or (800-273-TALK).

If I have concerns about your safety at ***any*** time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

***Consent to Participate in TAC Sessions:***

By signing below you agree that you have read and understand all of the above sections of TAC informed consent. You agree that you also understand the limitations associated with participating in TAC counseling sessions and consent to attend sessions under the terms described in this document.

_____

Client Name (Print)

_____ _____

(Client/Parent/Guardian Signature) (Date)

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# Grievance/Complaints Rights and Process

You have the right to have your concerns/grievances heard and addressed appropriately. Real Solutions Counseling, LLC has an open door policy and desires to help you resolve any concerns so that your experience here is positive. In addition, there are protection, advocacy, and legal services available including, but not limited to, the Idaho Mental Health Coalition (658-2000), the National Alliance for the Mentally Ill (673-6672), the Idaho Human Rights Commission (334-2873), Idaho Legal Aid (345-0103 ext. 0), and Idaho Volunteer Lawyers (800-221-3295). Last, as a client, you have the right to make complaints regarding ethical concerns of a counselor/service provider to the Bureau of Occupational Licenses at 208-334-3233.

If the complaint is a general issue regarding the building, lobby, or other issue outside of the therapeutic process, you may inform your counselor/service provider, any office staff, or leave the information in the suggestion box in the lobby. If the complaint or problem is with your counselor/service provider, we ask you to first inform them of the concern and attempt to address it with them. However, if you are unable to resolve your concern or do not feel safe to approach your counselor/service provider with your concern, you may notify the clinical director. This can be done by telling one of the administrative assistants that you have a concern that you would like to address with the clinical director. The clinical director will help you mediate a solution to your concern or will provide alternative services/providers to meet your needs. If you have a general concern and would like to make it anonymously we have a suggestion box in the lobby for you to make compliments or complaints.

In signing this I am acknowledging my understanding of this policy as a recipient of services through Real Solutions Counseling.

_____ _____

(Client/Parent/Guardian Signature) (Date)

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# Missed /Cancelled Appointment Policy

Thank you for your courage in taking the steps to seek counseling for you or your family's needs. In order to serve you and others with the highest quality of services we must be clear on our missed appointment policy. Time is important to all of us.

- It is the policy of Real Solutions Counseling that if you are unable to keep an appointment, you must contact the counseling center at least 24 hours in advance. You may cancel by calling 208-922-9001, which is available 24 hours a day, Monday through Friday and records the time of call.
- If you have a cancellation or missed appointment after the 24-hour deadline, you will be removed from the counselor's schedule and lose your access to that scheduled time in the future. You will be put on the counselor's waiting list and be scheduled at a time slot in the future that is available on the counselor's schedule.
- The second time you have a cancellation or missed appointment after the 24-hour deadline, you will be removed from the counselor's schedule and it will be up to the judgment of the clinical director of whether to assign you to another counselor or refer you to different counseling agency.

Medical emergencies will be taken into consideration for not making the 24hr deadline, if you provide as much notice as possible and you may be asked to provide a doctor's note. However, if a client misses three consecutive appointments for any reason they will be removed from the counselor's case load. They will only be re-admitted upon the clinical director's approval.

In signing this I am acknowledging my understanding of this policy and my commitment to abide by the policy as a recipient of services through Real Solutions Counseling.

_____ _____

(Client/Parent/Guardian Signature) (Date)

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# Medicaid Program Requirements Form

**Medicaid Program Requirements**: Idaho Medicaid requires all participants seeking mental health services to have coordination with their primary care Medical Doctor. This means we must receive information from your last visit with your doctor. A release allowing us to contact your doctor will be part of the initial paperwork to facilitate this process.

Additional requirements for participating in the Medicaid program are that you will need to complete a comprehensive assessment and treatment plan with your counselor at the start of counseling services. Reviews will also need to occur every 90 days of your treatment. If the client is under 18 years of age, parents will need to be involved in the initial treatment plan as well as the reviews every 90 days. This means that parents will be required to attend the initial session of counseling as well as a review session at least every 90 day. Last, it is an expectation of Medicaid that parents are active participants in the counseling process with their children.

In signing this document, I am acknowledging my understanding of this policy as a recipient of Medicaid services through Real Solutions Counseling.

_____ _____

(Client/Parent/Guardian Signature) (Date)

# *Real Solutions Counseling, LLC*

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## Request for Release of Confidential Information

Client:_____Date of Birth:_____

Client:_____Date of Birth:_____

Client:_____Date of Birth:_____

The undersigned, clients, parents, or legal guardians request:

SPECIFIC TYPE/EXTENT OF INFORMATION TO BE DISCLOSED: Client progress and other

Information that relates to school

I understand that this information may be sent by fax, mail or telephone.

| | | | |
|---|---|---|---|
| **To/From:** | Real Solutions Counseling | **To/From:** | School Information: |
| | 1011 W. Williams St. Ste. G | | |
| | Boise, ID 83706 | | |
| | Phone: (208) 991-0222 | | |
| | Fax: (208) 344-0014 | | |

PURPOSE OR NEED FOR THIS DISCLOSURE: To coordinate best care between school and agency.

I have carefully read, and understand, the foregoing. I voluntarily consent to the release of the above specified information about or medical records of my condition and the treatment and services I have received to those persons or agencies listed. I further release my counselor from any liability arising from the release of this information or records to such designated persons or agencies. This consent is subject to revocation at any time and will expire on _____ or if no date specified expires 1 year after date of signing.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

**NOTE TO AGENCY/PERSON IN RECEIPT OF INFORMATION:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CRF Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

# *Real Solutions Counseling*

***1011 W. Williams St., Suite G***
***Boise, Id. 83706 ◆ (208) 991-0222***

## Request for Release of Confidential Information

Client:_____Date of Birth:_____

Client:_____Date of Birth:_____

Client:_____Date of Birth:_____

The undersigned, clients, parents, or legal guardians request:

SPECIFIC TYPE/EXTENT OF INFORMATION TO BE DISCLOSED: Please supply us the notes from patient's most recent doctor's visit .

I understand that this information may be sent by fax, mail or telephone._____

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**To/From:** Real Solutions Counseling **From/To**_____

1011W. Williams St, Ste. G., _____

Boise, Id. 83634 _____

P: 208-991-0222 F: 208-344-0014 _____

PURPOSE OR NEED FOR THIS DISCLOSURE: To coordinate best care for the client. So that mental health providers can understand how the complete medical history and current medical issues and needs interact with the client's mental health issues. Medical records for children to also be included._____

I have carefully read, and understand, the foregoing. I voluntarily consent to the release of the above specified information about or medical records of my condition and the treatment and services I have received to those persons or agencies listed. I further release my counselor from any liability arising from the release of this information or records to such designated persons or agencies. This consent is subject to revocation at any time and will expire on _____ or if no date specified expires 1 year after date of signing.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____
(parent, guardian, or authorized representative of client)

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**NOTE TO AGENCY/PERSON IN RECEIPT OF INFORMATION:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CRF Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

# LEVEL 2—Depression—Child Age

*PROMIS Emotional Distress—Depression—Pediatric Item Bank

**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 little interest or pleasure in doing things" and/or "feeling down, depressed, or hopeless" at a mild or greater level of severity. 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 7 days. Please respond to each item by marking (✓ or x) one box per row.**

| | | | | | | | Clinician Use |
|---|---|---|---|---|---|---|---|
| **In the past SEVEN (7) DAYS…** | | | | | | | Item Score |
| | | **Never** | **Almost Never** | **Sometimes** | **Often** | **Almost Always** | |
| 1. | I could not stop feeling sad. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 2. | I felt alone. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 3. | I felt everything in my life went wrong. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 4. | I felt like I couldn't do anything right. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 5. | I felt lonely. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 6. | I felt sad. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 7. | I felt unhappy. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 8. | I thought that my life was bad. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 9. | Being sad made it hard for me to do things with my friends. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 10. | I didn't care about anything. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 11. | I felt stressed. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 12. | I felt too sad to eat. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 13. | I wanted to be by myself. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| 14. | It was hard for me to have fun. | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | |
| | | | | | | **Total/Partial Raw Score:** | |
| | | | | | | **Prorated Total Raw Score:** | |
| | | | | | | **T-Score:** | |

* The PROMIS measure was developed for and can be used with children ages 5-17 according to the DSM-5 Field Trials.

# ALERT ® Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can. Then review your responses with your child's clinician. Please shade circles like this ●

Child's Name | Child's Date of Birth

Subscriber ID | Authorization #

Clinician Name | Today's Date (mm/dd/yy)

Clinician ID/Tax ID: 27-1788436 | Clinician Phone: (208) 991-0222 | State: ID | *MRef* ☐

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

***For questions 1-21, please think about your experience in the past week.***

| **Fill in the circle that best describes your child:** | *Never* | *Sometimes* | *Often* |
|---|---|---|---|
| 1. Destroyed property | ○ | ○ | ○ |
| 2. Was unhappy or sad | ○ | ○ | ○ |
| 3. Behavior caused school problems | ○ | ○ | ○ |
| 4. Had temper outbursts | ○ | ○ | ○ |
| 5. Worrying prevented him/her from doing things | ○ | ○ | ○ |
| 6. Felt worthless or inferior | ○ | ○ | ○ |
| 7. Had trouble sleeping | ○ | ○ | ○ |
| 8. Changed moods quickly | ○ | ○ | ○ |
| 9. Used alcohol | ○ | ○ | ○ |
| 10. Was restless, trouble staying seated | ○ | ○ | ○ |
| 11. Engaged in repetitious behavior | ○ | ○ | ○ |
| 12. Used drugs | ○ | ○ | ○ |
| 13. Worried about most everthing | ○ | ○ | ○ |
| 14. Needed constant attention | ○ | ○ | ○ |

| **How much have your child's problems caused:** | *Not at All* | *A Little* | *Somewhat* | *A Lot* |
|---|---|---|---|---|
| 15. Interruption of personal time? | ○ | ○ | ○ | ○ |
| 16. Disruption of family routines? | ○ | ○ | ○ | ○ |
| 17. Any family member to suffer mental or physical problems? | ○ | ○ | ○ | ○ |
| 18. Less attention paid to any family member? | ○ | ○ | ○ | ○ |
| 19. Disruption or upset of relationships within the family? | ○ | ○ | ○ | ○ |
| 20. Disruption or upset of your family's social activities? | ○ | ○ | ○ | ○ |

21. How many days in the last week was your child's usual routine interrupted by their problems? ☐ Days

**Answer the following questions only if this is your first time completing this questionnaire for this child.**

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
24. In the past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days
25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days