New Client Forms

Client Information

Name: (Last, First, MI)_____ DOB: ____/____/_____

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

Gender:_____ Pronouns:_____ Race/Ethnicity:_____

Primary Phone: (_____) _____ - _____ Type (Home, Cell, Work):_____
Permission to leave voicemails? □ Yes □ No

Secondary Phone: (_____) _____-_____ Type (Home, Cell, Work):_____
Permission to leave voicemails? □ Yes □ No

Email Address: _____
Permission to contact via email? □ Yes □ No

Social Security #:_____ Preferred Language: _____

Referred by: _____

Emergency Contact

Name:_____ Phone: (_____) _____ - _____

Relationship to client: _____

Do you have medical insurance? □ Yes □ No (Self-Pay) If YES, answer all questions below

Primary Insurance Company:_____

Member ID #:_____ Group #:_____

Does your insurance require authorization prior to the first session? □ Yes □ No □ Not sure
If yes, have you contacted the company? □ Yes □ No

Policy Holder's Name & Relationship:_____

Policy Holder's Social Security #:_____ Policy Holder's DOB: ____/____/_____

Policy Holder's Employer Name:_____

Employer Phone: (_____) _____ - _____

Employer Address:_____

Dr. Jessica Grossnicklaus, Psy.D. – Licensed Psychologist
Jessica Grossnicklaus, Psy.D., LLC
2001 Pine Lake RD, STE 200, Lincoln, NE 68512
Phone: (402) 261-8313 Fax: (855) 308-2153

Secondary Insurance Company:_____

Member ID #:_____ Group #:_____

Does your insurance require authorization prior to the first session? □ Yes □ No □ Not sure
If yes, have you contacted the company? □ Yes □ No

Policy Holder's Name & Relationship:_____

Policy Holder's Social Security #:_____ Policy Holder's DOB: ____/____/_____

Policy Holder's Employer Name:_____

Employer Phone: (_____) _____ - _____

Employer Address:_____

Responsible Party or Guarantor (if other than patient): _____

Address:_____ Phone: (_____) _____ - _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my physician/provider to submit claims for benefits for services rendered and for services to be rendered without obtaining my signature on each claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Jessica Grossnicklaus, Psy.D., LLC that is otherwise payable to me for her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Jessica Grossnicklaus, Psy.D., LLC will be credited to my account in accordance with the above assignment.

_____

Client Name (Print)

_____ _____

Client/Guardian Signature **Date**

Office Policies, Information, & Agreements

Welcome! Before we begin our work together, it is important that you have information about my professional services and business policies. The following documents are our working agreement that we both understand the parameters of our work together.

CONFIDENTIALITY: The law protects the privacy of communication between patient and therapist. In most situations, information about your treatment can be released to others ONLY if you sign a written authorization form that meets HIPAA requirements. However, there are some situations in which I am legally bound to disclose information without a signed release of information. Please see the Informed Consent and Notice of Privacy Practices for full details.

LENGTH OF SESSION: The initial intake session is 60 minutes. Subsequent sessions are either 45-50 minutes (90834) or 55-60 minutes (90837). The length of subsequent sessions depends on the need and insurance coverage (if applicable).

FEES/PAYMENT: See Billing Policy

CANCELLATIONS/NO SHOW: If you need to reschedule or cancel your appointment, please provide as much notice as possible. There will be a $75.00 fee for appointments that are cancelled with less than 24-hour notice or if you fail to show up to your appointment. This fee is not covered by any insurance plan and must be paid prior to your next visit. Three (3) no-show/late cancellations in one year may be cause for an automatic discharge from the clinic. Appropriate referrals will be provided if necessary. Exceptions to this policy are solely based on provider's discretion.

OFFICE HOURS/PHONE CALLS/EMAIL: Office staff are available 9 AM – 4 PM Monday thru Thursday, and 9 AM – 12 PM on Friday to address any questions or concerns you may have. We will make every effort to return a phone call as soon as possible, but if your call is urgent, please note that with our office staff or when you leave a message on our confidential voicemail.

I can also be reached via email; however, it is important to note that email is NOT a confidential means of communication, therefore, *please ONLY use email to arrange, modify, or cancel appointments.*

EMERGENCIES: Provider is not available outside of regular office hours. Therefore, in case of an emergency, please utilize the following crisis resources, go to your nearest emergency room, or call 911:

Catalyst Behavioral Health Crisis Line: 1-800-247-4941
Center Pointe Crisis Response:
Crisis Line: 402-475-6695
Walk-In Crisis Counseling: 1000 S 13th St., Lincoln, NE (Mon – Fri, 8 AM – 5 PM)
Suicide Prevention Lifeline:
Phone: 1-800-273-8255
Text: HOME to 741741
Bryan West Mental Health Emergency Center:
Phone: 402-481-1111
Address: 2300 S 16th St., Lincoln, NE

INCLEMENT WEATHER: If Lincoln Public Schools are closed due to inclement weather, the Catalyst Behavioral Health office will be closed as well. You will not be billed for your appointment, should it be cancelled due to inclement weather. For individuals who do not use insurance and/or individuals whose insurance covers telehealth, your appointment may be moved to a telehealth session (instead of meeting in person) if you would like. These situations will be discussed between you and your provider when they arise.

PROFESSIONAL RECORDS: Upon written request you may review and/or receive a copy of your clinical record, unless I believe that access to your clinical record would be harmful to you. Reviews of clinical records are typically conducted with your therapist. For copies of your clinical record, you may be charged $0.25 per page up to 100 pages.

The laws and standards of this profession require that clinical records are maintained for 7 years past the date of your last contact. Records are stored electronically on secure servers.

Should I be required to provide your insurance company with your protected health information (PHI) from your clinical record, I will make every effort to release only the minimum information that is necessary for the purpose requested. This information will become part of the insurance company files.

ADDITIONAL DISCLOSURES: I may find it helpful and beneficial to your treatment to consult other health and mental health professionals about your case. During consultation, I will protect your identity. I will need to share PHI with the Catalyst Behavioral Health staff for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. These other professionals are bound by the same rules of confidentiality. Staff members have been given training about protecting your privacy.

PROVIDER VACATION/SICK TIME/EXTENDED LEAVE: If I will be unavailable for an extended period, I will provide you with resources and/or the name of a colleague to contact, if necessary.

Signing this document indicates that you have read, understand, and agree to the above policies.

_____

Client Name (Print)

_____ _____

Client/Guardian Signature **Date**

Billing Policy

PROVIDER RATES: The fees for services provided by Jessica Grossnicklaus, PsyD, LLC will be in accordance with the reasonable value set forth by established community guidelines and standards. Jessica Grossnicklaus, PsyD, LLC has the right to raise the fee at any time. At the present time, the fee for the initial **60-minute diagnostic session** (CPT code: 90791) is **$350**, after which the billing rate **$300 per 60-minute individual therapy session** (CPT Code: 90837), **$250 per 45-minute individual therapy session** (CPT Code: 90834), **$200 per 30-minute individual therapy session** (CPT Code: 90832), and **$250 per 45-minute family session with the client present** (CPT Code: 90847), **$250 per 45-minute family session without the client present** (CPT code 90846).

PAYMENT: Clients are required to provide a valid credit card at the time of their initial session for the office to keep on file. Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired. Client statements are available for viewing on the Client Portal. If no payment is received within 30 days of the statement date, payment will be automatically charged to the credit card on file. Credit cards will not be charged without prior notification, and the opportunity to provide alternate payment will be offered at that time. Balances that are 90 days past due will begin accruing 1.33% finance charges every 30 days. There is a $5 convenience fee for credit/debit/HSA card payments. Jessica Grossnicklaus, PsyD, LLC does offer financial assistance in the form of payment plans. Jessica Grossnicklaus, PsyD, LLC reserves the right to delay, defer, or discontinue services for any reason, including if the balance owed is not paid at the time it is due. Jessica Grossnicklaus, PsyD, LLC reserves the right to submit any unpaid balances to a collection agency for recovery. Billing policies may be updated or modified throughout the calendar year. Please direct any questions regarding billing and payment to Gina Pashby, our office manager.

INSURANCE AND CO-PAYS: Clients are responsible for finding out what mental health services your insurance policy covers. Co-payments, if appropriate, must be paid at the time of the visit. Clients are responsible for all fees not paid by their health insurance. Clients' contract with their health insurance company requires information relevant to the services provided, which includes a clinical diagnosis. Sometimes additional information may be requested, such as treatment plans, progress notes, or copies of your clinical record. Every effort will be made to release only the minimum information that is necessary for the purpose requested. Please direct any questions regarding insurance and co-pays to Gina Pashby, our office manager.

LATE CANCELLATION/NO-SHOW FEE: Jessica Grossnicklaus, PsyD, LLC requires 24-hour notice prior to all appointment cancellations. There will be a $75.00 fee for appointments that are cancelled with less than 24-hour notice or if the client fails to show up for their appointment. This fee is not covered by any insurance plan and must be paid prior to the next visit. Three (3) no-show/late cancellations in one year may be cause for an automatic discharge from the clinic. Exceptions to this policy are solely based on provider's discretion.

ADDITIONAL FEES: If additional reports or meetings not covered by the insurance company are needed, the client agrees to pay for the time it takes to write these reports and/or attend these meetings. Reports that would incur a fee include, but are not limited to disability claim, Workman's Compensation, or review of treatment for an attorney. Meetings that would incur a fee include but are not limited to speaking with an attorney or testifying in court. If I am needed for court, fees may include time lost for cancelled sessions, time for preparation, travel, or waiting.

I acknowledge that I have been given the opportunity to review my provider's billing policy. I understand that I am ultimately liable for the balance on my account for any services provided by Jessica Grossnicklaus, PsyD, LLC regardless of the status of my insurance. With my signature, I agree to adhere to the agency's billing policies and procedures, and to pay any fees that I owe the agency based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Jessica Grossnicklaus, PsyD, LLC for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

Credit/Debit/HSA Number

Expiration Date **Security Code**

Client Name (Print)

Client/Guardian Signature **Date**

Informed Consent

I, _____ (Client/Guardian) hereby give my consent to

Jessica Grossnicklaus, PsyD, LLC to provide _____ (Client) with mental health services.

Please initial the following:

_____ I understand that:

- Jessica Grossnicklaus, PsyD, LLC will send my medical record information to my insurance company.
- I must pay my share of the costs (e.g., co-pays, amount until a met deductible, etc.).
- If I am uninsured, or if my insurance does not cover mental health services, I must pay for these services in full.

_____ I understand that:

- I have the right to refuse any treatment.
- I have the right to discuss all treatments with my provider.
- I may be charged for late cancellations or no-show appointments.

_____ While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and mental health treatment; I realize that particular results cannot be guaranteed.

_____ Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions and I may experience new stressors during treatment and while attempting to make life changes.

_____ If I experience a life-threatening mental health emergency, I understand I am to contact 911 or go to my nearest emergency room. In the event of other emergencies outside of business hours, I am aware I can contact the after-hours crisis line at 1-800-247-4941 or the other crisis resources that were provided to me.

_____ Issues discussed with my provider will remain confidential, *with a few exceptions*. There are some special circumstances that limit confidentiality including: a) a statement of imminent intent to harm yourself or others; b) statements indicating potential harm or abuse of children or vulnerable adults; c) issuance of a subpoena from a court of law; d) when your insurance company is involved; and e) when you have signed a Release of Information allowing for your information to be discussed with an identified party.

I know of no reason why I should not or cannot undertake this mental health treatment and agree to participate fully and voluntarily.

_____ _____

Client Name (Print) **Date of Birth**

_____ _____

Client/Guardian Signature **Date**

_____ _____

Clinician Signature **Date**

Client Rights and Responsibilities

As a person receiving mental health services at Catalyst Behavioral Health, you have the right to:

- Be treated with dignity and respect.
- Ask questions and get answers about services offered to determine the most appropriate treatment. You can get information about treatment procedures, costs, and risks. You can also request a change in your treatment or service.
- Participate fully in decisions regarding your health care service, including having your family involved in your treatment.
- Not be subject to verbal, physical, sexual, emotional, or financial abuse; or harsh or unfair treatment.
- Make complaints, have them heard, get a prompt response, and not receive any retaliation or mistreatment as a result; or file a grievance if you are not satisfied with the response to a complaint.
- Be assisted by an advocate of your choice (e.g., a family member, friend, case manager, member of a consumer advocacy organization, etc.).
- Not be discriminated against on the basis of race, age, gender, religion, national origin, sexual orientation, disability, marital status, or other factors.

All clients, to the extent capable, have the responsibility to:

- Pursue healthy lifestyles. Clients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.
- Actively participate in decisions about their health care and cooperate on mutually accepted courses on treatment. Clients should comply with treatment regimens and regularly report on treatment progress. If serious side effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments they are pursuing simultaneously.

Acknowledgment of Receipt

Authorization for Treatment

I acknowledge that I have been given the opportunity to review the **Informed Consent** and **Client Rights & Responsibilities.** I may obtain a current copy upon request. I understand that Jessica Grossnicklaus, PsyD, LLC has the right to change the Authorization for Treatment at any time.

Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have been given the opportunity to review the **Notice of Privacy Practices.** I may obtain a current copy upon request. I understand that Jessica Grossnicklaus, PsyD, LLC has the right to change the Notice of Privacy Practices at any time.

Office Hours and Phone Calls

I have been advised that office staff is available Monday thru Thursday, 9 AM – 4 PM, and Friday, 9 AM – 12 PM to address any questions or concerns. I understand that every effort will be made to return my phone call as soon as possible. I understand that if I call outside of office hours or the Office Manager is not readily available, I can leave a voicemail. If my call is urgent, I will note this with the office staff or when I leave a voicemail. I understand that in an emergency I can contact the Catalyst Behavioral Health Crisis Line, utilize the other crisis resources that have been provided to me, call 911, or go to my nearest emergency room.

Appointment Late Cancel/No-Show Fee

I have been advised that his office requires a 24-hour prior notice on all appointment cancellations. I have been advised that there will be a $75.00 no-show fee for appointments that are cancelled with less than 24-hour notice. This fee is not covered by any insurance plan and must be paid prior to my next visit. I understand that three (3) late cancellations/no-show in one year may result in discharge from the clinic.

Billing Policy/Copayments

I acknowledge that I have been given the opportunity to review the **Billing Policy** for Jessica Grossnicklaus, PsyD, LLC. I understand that co-pays, if appropriate, must be paid at the time of visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after the receipt of the statement. I understand that Jessica Grossnicklaus, PsyD, LLC offers financial assistance in the form of payment plans. Uninsured clients or self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Jessica Grossnicklaus, PsyD, LLC reserves the right to submit any unpaid balances to a collection agency for recovery. Clients are required to provide a valid credit/debit card at the time of their initial session for the office to keep in their file. Cards will not be charged without prior notification and opportunity to provide an alternate payment will be offered. Please direct any questions about insurance, billing, and payment plans to our office manager, Gina Pashby.

_____

Client Name (Print)

_____ _____

Client/Guardian Signature **Date**

Client Rights and Responsibilities for Participation in Telehealth Services

Prior to starting video-conferencing services, we discussed and agreed to the following:

- Confidentiality still applies to telehealth services, and the session will not be recorded without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it.
- You will need to use a computer with a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phones, other devices, and other people) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your telehealth appointment, you must notify your provider in advance (see Cancellations/No Show policy).
- You must provide a phone number where you can be reached in the event of technical problems, wherein the session needs to be restarted or rescheduled.
- You should confirm with your insurance company that telehealth sessions will be covered or reimbursed. If they are not covered, you are responsible for the full payment.

What you can expect:

- Your provider is utilizing the HIPAA compliant telehealth platform, Valant IO.
- Clients will need to register for an online client portal account through Valant.
- Once the provider has initiated the session the client will see a yellow banner on their portal account page which, when clicked, will launch the session. If the client logs into their account prior to the provider starting the session, they will have the option to do a self-check-in.
- If the client attempts to log in more than 15 minutes prior to the scheduled appointment time, the self-check-in button will not be available.

Dr. Jessica Grossnicklaus, PsyD – Licensed Psychologist
Jessica Grossnicklaus, PsyD, LLC
2001 pine Lake RD, STE 200, Lincoln, NE 68512
Phone: (402) 261-8313 Fax: (855) 308-2153

Informed Consent for Telehealth Services

I, _____ (Client/Guardian), hereby give my consent to **Jessica Grossnicklaus, PsyD, LLC** to provide _____ (Client) with live, interactive video telehealth services located at the following distant site location: **2001 Pine Lake Road, STE 200, Lincoln, NE 68512.**

I understand that:

- There are potential benefits and risks of telehealth video services (e.g., limits to client confidentiality) that differ from in-person services.
- I retain the right to refuse telehealth video services at any time without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- All existing confidentiality protections shall apply to my telehealth video services and I agree to receive an email with a link attached to join telehealth video sessions as appropriate.
- I shall have access to all medical information resulting from the telehealth communication, as provided by law.
- Information from the telehealth video services (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.
- If I decline telehealth video services for any reason (e.g., technical difficulties), I will work with my provider to find alternative treatment options, including telephone sessions or in-person services on a case-by-case basis.
- I will be informed if additional people beyond my provider will be present during my telehealth session.
- I will be informed if telehealth sessions will be recorded.
- I retain the right to exclude anyone from either the originating or distant site.
- I am required to provide an emergency contact and will work with my provider to identify the closest emergency room to my location, in the event of a crisis situation.
- My provider may determine that due to certain circumstances, telehealth video services are no longer appropriate and that we should resume our services in-person or through other alternative options.
- This consent is valid for six months for follow-up telehealth video services with this health care provider.

I have read **this document** and the **Patient Rights and Responsibilities for Participation in Telehealth Services** document carefully and my questions have been answered to my satisfaction.

_____ _____

Client Name (Print) **DOB**

_____ _____

Client/Guardian Signature **Date**

_____

Emergency Contact **Relationship to Client** **Phone Number**

_____

Email Address (where link to sessions can be sent) **Phone Number (if problems occur)**

Client History

1. What is the primary reason(s) you are seeking services?

_____

_____

2. What are your goals for therapy?

_____

_____

Mental Health History

3. Have you ever participated in counseling/therapy before? □ Yes □ No
   If yes, please list approximate start/end date(s) and reason(s) for treatment:

_____

_____

4. Please list any previous mental health diagnoses and/or conditions (if applicable):

_____

_____

5. Please list any psychiatric medications you are currently taking/have taken in the past and approximate start/end dates of those medications (if applicable):

_____

_____

6. Have you ever been hospitalized for psychiatric/mental health reasons? □ Yes □ No
   If yes, please provide approximate date(s) and reason(s) for hospitalization:

_____

_____

7. Have you ever experienced any of the following?
   □ Physical Abuse □ Emotional Abuse □ Sexual Abuse □ Other Trauma □ None

8. Have you ever had thoughts (current or past) of harming yourself (or attempted to)? □ Yes □ No
   If yes, please elaborate:

_____

_____

_____

9. Have you ever had thoughts (current or past) of harming someone else (or attempted to)? □ Yes □ No
   If yes, please elaborate:

_____

_____

_____

10. Family history of mental health conditions/diagnoses:

_____

_____

Medical History

11. Current medications:

_____

_____

12. Please check any of the following medication conditions that apply:

___ Headaches	___ Dizziness	___ Hepatitis
___ High blood pressure	___ Faintness	___ Asthma
___ Head injury or concussion	___ Bone or joint problems	___ Arthritis
___ Hormone-related problems	___ Urinary tract problems	___ Thyroid issues
___ Fibromyalgia	___ HIV/AIDS	___ Gastritis or esophagitis
___ Angina or chest pain	___ Numbness and tingling	___ Cancer
___ Irritable bowel	___ Shortness of breath	___ Seizures
___ Chronic pain	___ Diabetes	___ Chronic fatigue
___ Loss of consciousness	___ History of heart attack	___ Kidney-related issues

___ Other _____

13. Family history of medical conditions (e.g., cancer, diabetes, hypertension):

_____

_____

Substance Use History

14. Do you use/have you used any of the following substances?
    □ Alcohol □ Tobacco (including vaping) □ Marijuana □ Illicit Substances
    □ Prescription Medications (for recreational use) □ Other □ None
    If yes, please specify past/current, frequency, and amount:

_____

_____

15. Have you ever received treatment for substance use? □ Yes □ No
    If yes, please elaborate:

_____

_____

Family/Social History

16. Where were you born/raised? _____

17. What is your current relationship status?
    □ Single □ Married □ Separated □ Divorced □ Widowed □ Engaged
    □ Other_____

18. Do you have children? □ Yes □ No
    If yes, please list names, ages, and if biological/adopted/etc.

_____

_____

19. Who currently resides in your home with you?

    _____

    _____

20. Which best describes your current social relationships? Select all that apply:
    - □ Supportive social network
    - □ Few friends
    - □ No friends
    - □ Supportive family relationships
    - □ Distant from family of origin
    - □ Family conflict

21. Do you have any religious and/or spiritual beliefs or practices? □ Yes □ No
    If yes, please specify: _____

Educational, Occupational, & Legal History

22. Highest Level of Education:
    □ Grade _____ □ High School Diploma □ Some College □ Associate's Degree □ Bachelor's Degree □ Master's Degree □ Doctorate Degree

23. What is your current occupation status?
    □ Employed full-time □ Employed part-time □ Unemployed □ Retired □ Student □ Disabled

24. Where are you employed and how long have you been employed at your current job (if applicable)?:

    _____

25. Do you have any past or current military service? □ Yes □ No
    If yes, please indicate if current/past and which branch:

    _____

26. Have you ever been arrested, convicted of any crimes, incarcerated, or on probation? □ Yes □ No
    If yes, please specify:

    _____

    _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

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

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

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 been bothered by the following problems?	**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. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	