Directions for completing the initial consultation paperwork

Hello,

Below you will find the consultation paperwork and directions to my office. If you have questions related to completing this paperwork, please feel free to email me at jd@sfbacct.com or call me at 510-652-4455 ext 2. As a reminder, I accept payment in the form of cash or check at the time of the visit. Checks can be made out to Dr. Davidson. I look forward to meeting you at the consultation appointment.

Included below:

1. Directions to my office (including the **door code** to get in the waiting room)
2. The SFBACCT Privacy Policy for you to read and keep for your records

Please print, sign, and bring with you to your session:

1. The Privacy Policy Consent
2. The Evaluation-Treatment Agreement (please also initial sections within this agreement and keep a copy for your records)

Please print, complete, and bring with you to your session:

1. Adult Questionnaire
2. Diagnostic Screening Tool
3. DASS
4. FSI
5. MOS Social Support Survey

Thank you!

Joan Davidson, Ph.D.

5435 College Avenue
Oakland, CA 94618-1502

Location: The office is about 3 blocks from the Rockridge BART. The office is located behind the Diesel Bookstore.

Entry Enter the office area after walking down an outdoor corridor just to the right of Diesel Books (as you face the bookstore). You'll encounter a blue gate near the beginning of the corridor. This gate is unlocked. You will see a keypad but you do not need to enter a code. It is locked after business hours. Notice the stairs towards the end of the corridor; our waiting room is to the left of the stairs. The door is labeled "102-108" and lists the practicing doctors. To enter the waiting room, enter the code **54635** on the panel (to the left of the door).

Parking: Generally, 4-hour and 2-hour parking are available on the residential side streets near the office. There is metered parking on College Avenue and you can park at The Levant rug store across the street from the office for $6 in quarters or bills (payable on exiting the lot).

Directions: *From BART*: Take the Concord line and exit at the Rockridge station. Take the stairs down to ground level to College Avenue. Walk South (away from Berkeley and toward Broadway Avenue) on College Avenue about 3 blocks.

From San Francisco: Take Highway 80 across the Bay Bridge East to Oakland. After exiting the Bay Bridge take East Highway 580 and follow the signs to Oakland. Take Highway 24 East to Walnut Creek. Exit at Claremont Avenue. Turn left at the stop sign onto Claremont Avenue. Go about 0.5 mile to College Avenue. Turn right onto College Avenue. Proceed South on College Avenue about 0.5 mile (8-9 blocks) to the intersection of Kales Avenue and College Avenue.

From East Bay: Take Highway 24 West to Oakland through the Caldecott Tunnel. Take the College Avenue exit. Proceed down Miles Avenue to College Avenue. Turn left onto College Avenue. Proceed South on College Avenue about 4-5 blocks to the intersection of Kales and College Avenues.

From South Bay: Take Highway 101 North and follow the *From San Francisco* directions.

From Marin: Take Highway 580 across the Richmond-San Rafael bridge East to Richmond. Follow the *From San Francisco* directions.

san francisco bay area
center for cognitive therapy
5435 college ave | oakland, ca 94618 tel 510.652 4455 | www.sfbacct.com

Treatment/Evaluation Agreement

This document contains important information about the professional services and business policies of Joan Davidson, Ph.D. and the San Francisco Bay Area Center for Cognitive Therapy (SFBACCT). Please read it carefully and discuss any questions you have with Dr. Davidson.

ASSESSMENT AND TREATMENT: Dr. Davidson will provide an assessment of your difficulties and available treatment options. If she recommends and you agree, she will provide cognitive-behavior therapy, which has been shown in controlled outcome studies to provide effective treatment for a number of problems and disorders. (Dr. Davidson will review the outcome data most pertinent to your situation upon request.) However, no guarantees can be made regarding the success of treatment. Treatment can be time-consuming and stressful; it can bring on strong feelings, such as anger, frustration, sadness, or anxiety, and may result in changes that were not originally intended (such as divorce or remaining in a relationship you believed you would leave). For people in some professions (e.g., politics, law enforcement), the fact of being in treatment may negatively affect their career. There is a small risk that your condition will worsen due to treatment. After meeting with you to assess your situation, Dr. Davidson will offer, if you would like, an estimate of the number of sessions of treatment she recommends for you. For most patients, this ranges between 5 and 40 sessions. Dr. Davidson's estimate of the duration of treatment is only an estimate, and no guarantees can be made as to the length of treatment required.

ALTERNATIVE TREATMENTS: Many options to the cognitive-behavioral treatment that Dr. Davidson can provide are available, including other types of psychotherapy, group, couple, or family therapy, and, in many cases, medications. Testing and other formal evaluation procedures can be helpful in some cases and if Dr. Davidson recommends this in your case, she will let you know what her recommendation is and the reasons for it.

You are entitled to ask questions about all aspects of treatment. Dr. Davidson will help you secure a consultation with another mental health professional whenever you request it or she recommends it.

TRAINING AND EXPERIENCE: Dr. Davidson is a psychologist licensed (PSY 14532) to practice in California. She received her Ph.D. from the California School of Professional Psychology in 1994. She is a founding partner of the SFBACCT. She is Assistant Clinical Professor, Department of Psychology, University of California, Berkeley and a Founding Fellow of the Academy of Cognitive Therapy. She has been trained to provide and has over 23 years of experience conducting cognitive-behavior therapy to treat depression, anxiety, and related problems in adults; she does not have extensive training or expertise in treating couples, families or children.

THE PATIENT'S ROLE: You are expected to play an active role in your treatment, including working with Dr. Davidson to outline treatment goals and completing

questionnaires at the beginning of treatment and periodically during treatment to assess progress. You will be asked to complete homework assignments between sessions and your willingness to do this is an integral part of successful treatment. If at any point you are unhappy about the progress, process, or outcome of the treatment, please discuss this with Dr. Davidson in an attempt to resolve any difficulties that have arisen and to arrive at a treatment plan that better meets your needs.

THE PATIENT'S RIGHTS: A document entitled *Patient's Bill of Rights*, adapted from a publication by the California Department of Consumer Affairs, is attached to the end of this document. Please read it carefully and raise with Dr. Davidson any questions you have about it.

HOURS/AVAILABILITY: Dr. Davidson is usually available for therapy sessions from 10:00 a.m. until 5:00 p.m. Tuesday through Friday. Therapy sessions are usually scheduled as 45-minute sessions weekly, or as your treatment needs dictate and you and Dr. Davidson agree. In the event of an emergency after business hours, please call 510-652-4455 ext 2 and leave a message identifying the call as an emergency. Then, hang up and dial Dr. Davidson's cell phone at 510-604-6627. In addition, in a crisis, you can call 911, contact your primary care physician, psychiatrist, the local emergency room, or crisis intervention services. When Dr. Davidson is out of town, she will let you know and she will give you the name and telephone number of another therapist who will be available.

CONFIDENTIALITY: The confidentiality of communications between the patient and therapist is important and, in general, is legally protected. Dr. Davidson will make every effort to keep the results of all your evaluation and treatment strictly confidential, as is required by law. Information regarding your evaluation and treatment may be disclosed to personnel of the SFBACCT unless you specify to the contrary in writing. Information about you will be released by Dr. Davidson only with your written permission, with the following exceptions:

- when there is suspected elder, dependent adult, or child abuse or neglect.
- when, in Dr. Davidson's judgment, you are in danger of harming yourself or another person, or are unable to care for yourself.
- If you communicate to Dr. Davidson a serious threat of physical violence against another person, Dr. Davidson is required by law to inform both potential victims and legal authorities.
- if Dr. Davidson is ordered by a court to release information as part of a legal proceeding.
- as otherwise required by law.

In the event group therapy services are provided, you are expected to keep materials shared in the group confidential. Dr. Davidson cannot be held responsible for a breach of confidentiality on the part of group members.

If you elect to seek reimbursement from an insurance company for your treatment, Dr. Davidson will provide you with a monthly statement you can submit to your insurance company. Most insurance companies require information about your diagnosis, the type of service provided (e.g., 50-minute individual psychotherapy session), the date of the session, and the fee, and Dr. Davidson will include this information on your statement

upon your request. Dr. Davidson will generally send this statement to you directly. In some cases, insurance companies will require that the provider send information about the patient's diagnosis and treatment plan, progress reports, and other records. Please be aware that when information is sent to an insurance company, Dr. Davidson has no control over who sees it. Almost all insurance companies state that they will keep the information confidential, but Dr. Davidson cannot assure that they will do so. Some share the information they receive with a national medical information data bank for the purposes of deciding eligibility for future life, disability, health, and other insurance. Before Dr. Davidson sends any information to an insurance company, she will talk with you about what she has written and she will obtain your written permission to provide information to your insurance company. You do have a choice about whether to release the information requested by an insurance company, but if you refuse to consent to release the information, most insurance programs will not pay for services.

You and Dr. Davidson may elect to communicate via e-mail. If you do, it is important to remember that confidentiality of communication through e-mail exchanges cannot be guaranteed. If Dr. Davidson is obtaining information only via e-mail, she is making clinical judgments on the basis of limited and imperfect information. Dr. Davidson may not receive e-mail in a timely fashion, so if your communication is urgent, it is best to use the telephone. If you choose to correspond with Dr. Davidson through e-mail, she will make every effort to keep the information she receives confidential, but she and the San Francisco Bay Area Center for Cognitive Therapy cannot guarantee confidentiality of e-mail communications. If you communicate with Dr. Davidson via e-mail, you agree to accept the risk that a breach of confidentiality may occur. _____
(initial)

RECORD-KEEPING: Dr. Davidson maintains a clinical chart for each patient. Information in the chart includes a description of your condition, your treatment goals, your treatment plan and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Dr. Davidson also keeps records of any consent, release, assessment, insurance, or other forms completed in the course of your treatment. Clinical records are kept in a locked file cabinet. Electronic copies of information from your clinical record are stored on memory sticks that are locked in a file cabinet in Dr. Davidson's office.

CONSULTATION: Dr. Davidson may wish to consult with other professionals, especially her colleagues at the San Francisco Bay Area Center for Cognitive Therapy, about treatment planning for your case. Your signature below gives Dr. Davidson permission to do this, provided that she takes reasonable efforts to protect your identity.

_____
(initial)

RESEARCH, WRITING, TEACHING: Dr. Davidson and others at the SFBACCT conduct research, training and supervision, and they write for professional and lay audiences. Your signature below gives Dr. Davidson and the SFBACCT permission to use information about you and your treatment provided they take reasonable efforts to protect your identity. _____
(initial)

FEES: Dr. Davidson's fee is $250 per 45-minute session. Longer or shorter consultation or treatment sessions are generally prorated from this base fee. You will be charged the

standard fee for telephone calls, prorated according to the length of the call. Of course, there will be no charge for brief telephone calls, such as those made to schedule appointments.

PAYMENT: Please make checks payable to Joan Davidson, Ph.D. Payment is due at the time of the session unless another arrangement has been made. Dr. Davidson will send you a monthly statement if you request one.

FOR MEDICARE BENEFICIARIES ONLY: If you are receiving insurance coverage through Medicare, please be aware that Dr. Davidson is not a Medicare provider and is excluded from Medicare. Your signature below indicates that you accept full responsibility for payment of Dr. Davidson's session fees. Additionally, your signature indicates that you will not submit claims to Medicare for Dr. Davidson's fees or ask Dr. Davidson to submit claims to Medicare. Please note that Medicare limits do not apply to these fees, Medigap plans will not cover the fees, and other insurance plans may not cover the fees. You have the right to obtain Medicare-covered services from providers who are covered by Medicare. If you see a provider who is covered by Medicare, you do not have to sign a private contract with that provider.

_____ *(Client signature)*

_____ *(Therapist signature)*

CANCELLATIONS AND MISSED APPOINTMENTS: If an appointment is missed or cancelled without 24 hours notice, you may be charged for the session. Please be aware that insurance companies will not generally reimburse for a cancelled session.

REIMBURSEMENT: You are responsible for collecting reimbursement from your insurance company or other source.

ENDING TREATMENT: You may withdraw from treatment at any time. Dr. Davidson recommends that you discuss your plan to terminate treatment with her before taking action, so that she has an opportunity to offer her recommendations and to offer referral options if they are needed.

If you discontinue meeting with Dr. Davidson for a period of four weeks or more, she will attempt to contact you. If she is unable to reach you, she will assume (unless other arrangements have been made) that you have elected to terminate your treatment and she will close your case. Of course, should you wish to resume your treatment, she will be happy to discuss that option with you at any time.

Should Dr. Davidson become incapacitated or die, one of her colleagues at the San Francisco Bay Area Center for Cognitive Therapy will know how to access her medical records and will contact you to let you know of her incapacitation or death, and to help you make arrangements for continuing your care with another provider if needed, and to discuss arrangements for handling your medical record.

I have read and understood this agreement and the "Patient Bill of Rights" and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment.

Name of patient (please print): _____

Signature of patient: _____

Date: _____

Patient Bill of Rights

You have the right to:

- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
- Receive respectful treatment that will be helpful to you.
- A safe environment, free from sexual, physical, and emotional abuse.
- Ask questions about your therapy.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request that the therapist inform you of your progress.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Refuse a particular type of treatment or end treatment without obligation or harassment.
- Refuse electronic recording (but you may request it if you wish).
- Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.
- Report unethical and illegal behavior by a therapist.
- Receive a second opinion at any time about your therapy or therapist's methods.
- Request the transfer of a copy of your file to any therapist or agency you choose.

Excerpted from "Professional Therapy Never Includes Sex," California Department of Consumer Affairs, 1997.5.24.01

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Privacy Policy Consent

Dr. Davidson and the San Francisco Bay Area Center for Cognitive Therapy (SFBACCT) are dedicated to maintaining the privacy of your Protected Healthcare Information (PHI). In addition, Dr. Davidson is required by law to inform you of how your PHI will be protected, how she and the SFBACCT may use or disclose PHI, and your rights regarding access to your PHI. The SFBACCT Privacy Policy is available with my other consultation forms on our website, www.sfbacct.com. Additional copies of the SFBACCT Privacy Policy are available in the waiting room.

I acknowledge receipt of the SFBACCT's Privacy Policy. I understand that it is my responsibility to read these documents and present any questions, concerns, or special requests to my therapist.

_____

Patient's Name

_____

Patient's Signature

_____

Date

Adult Questionnaire

This questionnaire will help your therapist understand your situation. If you feel uncomfortable answering any of the questions, you may leave them blank and discuss them when you meet with your therapist.

Name:

First _____ Middle Initial _____ Last _____

Home Address:

Street Address _____ City _____ State _____ Zip Code _____

Phone: (Home) _____ (Work) _____

(Cell) _____ (Other, please specify) _____

Email: _____ (*optional*)

Please circle preferred method of contact (home, work, cell, or e-mail)

Emergency Contact: (Name) _____

(Phone) _____ (Relationship) _____

Referral Source: How did you come to seek services at the Center? (Check all that apply)

_____ San Francisco Bay Area Center for Cognitive Therapy website

_____ Other websites or individuals (please specify)_____

_____ Health professional: Name _____ Phone _____

_____ Other (please specify)_____

Reimbursement: Would you like to receive a monthly statement that you can forward to your insurance company to request reimbursement? (circle one) Yes No

Please mail the statement to: (circle one) Home Other:

Street Address _____ City _____ State _____ Zip Code _____

Personal Information

1. Age: _____ 2. Date of birth: _____ 3. Gender (circle one): Male Female Transgender

4. Ethnicity (circle all that apply):

Caucasian Black/African-American Hispanic South Asian

Middle Eastern East Asian Southeast Asian Native American

Pacific Islander Other: _____

5. Religious background (circle one)

Protestant Catholic Jewish Muslim

Buddhist Hindu No affiliation Other: _____

6. Marital status (circle one):

Single, never married Cohabiting Married Widowed Divorced Separated

7. If you have a partner or spouse, how long have you been together? _____

8. If married, what year did you get married? _____

9. If you have a partner or spouse, what is your spouse/partner's occupation?_____

10. If you are divorced, how long were you married? _____

11. If you are widowed, when and how did your spouse die? _____

12. If applicable, please list names and ages of your children:

Name	Gender/Age	Where does s/he live?	Biological?
			Y/N
			Y/N
			Y/N

13. Names of persons living in your home and your relationship to them:

Name	Relationship	Name	Relationship

Family/Social History

1. Mother

Biological parent? Yes No (circle one) Her occupation_____

Where was she born? _____

If not US, did she immigrate to US? Yes No If yes, when?_____

If living, where does she live now? _____

If living, age and health status _____

If deceased, year and cause of death _____

2. Father

Biological parent? Yes No (circle one) His occupation _____

Where was he born? _____

If not US, did he immigrate to US? Yes No If yes, when? _____

If living, where does he live now? _____

If living, age and health status _____

If deceased, year and cause of death _____

3. Did your parents marry? Yes No (circle one)

4. Did your parents separate? Yes No (circle one) If yes, when? _____

5. Did your parents divorce? Yes No (circle one) If yes, when? _____

6. With whom did you primarily live while growing up? (circle one)

Both Parents Mother Father Other (please specify) _____

7. Siblings

Name	Gender/Age	Occupation	Where does s/he live?	Biological?
				Y/N
				Y/N
				Y/N
				Y/N

8. Where were you born? _____ 9. Where did you grow up? _____

10. Is English your first language? Yes No (circle one) If no, please specify first language _____

11. If no longer living with your parents, at what age did you move out of your parents' home? _____

Education and Employment History

1. Are you going to school now? Yes No (circle one) Full-time Part-time (circle one)

If yes, what are you studying? _____

2. Are you working toward a degree? Yes No (circle one) If yes, what degree? _____

3. Number of years of education completed _____ *(Please count 1st grade as the 1st y, so if you completed 4 years of high school that is 12 yrs, completed 4 years of college is 16, etc)*

4. What is your highest degree and when did you earn it? _____

5. Did you ever leave a school you were enrolled in prior to completion? Yes No (circle one)

If yes, give details:_____

6. Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations)?

Yes No (circle one) If yes, give details: _____

7. Are you working now? (circle one): Yes No Full-time Part-time (circle one)

If yes, your occupation: _____

8. Employment history:

Type of job	How long?

9. Are you receiving or have you applied for medical leave or disability benefits? Yes No (circle one)

10. Have you ever received medical or disability benefits? Yes No (circle one)

If yes, give details: _____

Current Problems and Treatment History

1. Please describe briefly the problem(s) that bring you in to see a therapist.

_____

_____

_____

a. When did you start having these problems? _____

b. Have you ever had problems like this before? Yes No (circle one)

c. If yes, when? _____

2. Are you currently seeing another therapist/psychiatrist? Yes No (circle one)

If yes, please provide the following information:

Therapist's name _____ Date treatment began _____

_____

Street Address City State Zip Code

3. Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy?

Yes No (circle one) If yes, please provide the following information:

Therapist's name(s)	Date(s) of treatment	Problem for which treatment was sought	Did you find it helpful? Y/N	If yes, in what way was it helpful?	If not, in what way was it unsatisfactory?

4. Has a health professional ever recommended hospitalization or partial hospitalization for mental or emotional difficulties or for drug or alcohol abuse? Yes No (circle one)

5. Have you ever been hospitalized in an inpatient or partial hospitalization program for mental or emotional difficulties or for drug or alcohol abuse? Yes No (circle one) If yes, please complete the following chart.

When were you hospitalized?	For how long?	Reasons for hospitalization or partial hospitalization	Was it voluntary? (Y/N)

6. Do you *currently* take medications to treat mental/emotional difficulties or substance abuse prescribed by a physician/psychiatrist? Yes No (circle one) If yes, please complete the following chart. (Later in the questionnaire, you will be asked to list medications for medical conditions.)

Medication Name	Dosage/ Frequency	When started?	Name of Prescriber	Prescribed for what symptoms?

7. Are you currently involved in any other activities to help with your symptoms (e.g., massage therapy, acupuncture, chiropractor, meditation classes)? If yes, please describe.

_____

8. Do you currently take any herbal supplements or medicines? Yes No (circle one)

If yes, what do you take? _____

How often?_____ For what reason? _____

10. Have you ever made a suicide attempt? Yes No (circle one)

11. Have you ever purposely harmed yourself (cutting, burning, or other)? Yes No (circle one)

12. Please list medications you have taken previously to treat mental or emotional difficulties or drug or alcohol abuse:

_____

_____

13. Do any biological relatives have any history of psychiatric, emotional and/or substance use problems? Yes No

If yes, which family members and what types of problems?

Hyperactivity/attention deficit disorder (ADHD) _____ Schizophrenia _____

Alcohol or drug abuse _____ Bipolar disorder_____

Panic attacks or phobias or anxiety _____ Other emotional problems _____

Depression _____ Neurological condition_____

Medical History

1. Do you now have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities?

Yes No (circle one) If yes, please describe:

_____

Is this problem past or current? Past Current (circle one)

2. Are you currently taking medications for any physical health problems? Yes No (circle one)

If yes, please complete the following chart.

Medication Name	When Started?	Name of Prescriber	Prescribed for what symptoms?

3. In addition to any medications you are taking, what other health care regimens have been prescribed for you (e.g., dietary restrictions, physical therapy, etc.)?

_____

_____

4. How much of the time do you follow medical recommendations regarding your medications and the regimens you listed above? (circle one)

None of the time A little of the time Some of the time Most of the time All of the time N/A

5. List dates of any hospitalizations for physical problems:

Date Problem

_____

_____

6. When was your last physical examination by a physician? _____What was the outcome? _____

7. How healthy are your eating habits on a scale of 0 to 10? _____

0 = no regular meals, unhealthy foods; 5 = moderately regular meals, moderately healthy foods; 10 = regular meals, very healthy foods

8. Do you exercise? Yes No (circle one) If yes, how many times per week do you exercise? _____

If yes, for how many minutes on average do you exercise each time? _____ mins.

9. How active is your lifestyle on a scale of 0 to 10? _____

0 = sedentary; 10 = very active

10. Height:_____ Weight: _____

Other Background

1. Have you ever been involved in a lawsuit? Yes No (circle one)

If yes, please describe the circumstances and give dates:

_____

2. Have you ever been arrested? Yes No (circle one)

If yes, please describe the circumstances and give dates:

_____

3. Have you experienced any particular sources of stress in the last year? Yes No (circle one)

If yes, please explain:

_____

_____

4. Are there any other health care professionals (e.g. physicians, psychotherapists) who have information that might help in your treatment? Yes No (circle one)

If yes, please provide that person's name and contact information:

_____

5. Is there any other information that would be helpful for me to know? Yes No (circle one)

If yes, please explain:

_____

_____

_____ _____

Signature Date

Diagnostic Screening Tool **Initials** _____ **Date** _____

Section I: Mood

	Yes	No
1. In the last month has there been a period of time lasting at least 2 weeks when you:		
a. Felt depressed or down most of the day nearly every day?		
b. Felt a loss of interest or pleasure in most things you normally enjoy for most of the day nearly every day?		

If you answered "Yes" to "a" or "b," indicate which of the following symptoms you experienced during the time you experienced "a" or "b."

___ Loss of appetite nearly every day
___ Increase in appetite nearly every day
___ Weight loss not due to dieting Amount lost (lbs) _____
___ Weight gain Amount gained (lbs) _____
___ Difficulty concentrating or indecisiveness nearly every day
___ Increase in number of hours slept nearly every day
___ Decrease in number of hours slept nearly every day
___ Feeling fidgety, agitated or restless nearly every day
___ Feeling slowed down, sluggish nearly every day
___ Recurring thoughts of suicide, death, or dying
___ Making a plan for suicide
___ Taking some action toward suicide
___ Fatigue or loss of energy
___ Feelings of worthlessness or excessive guilt nearly every day

	Yes	No
2. Prior to last month, did you ever have at least a 2 week period when you felt depressed or experienced a loss of interest or pleasure in most things you normally enjoyed?		
a. Approximately how many times has this happened? _____ b. Approximately how old were you when this happened for the first time? ____		
3. Have you experienced depressed mood most of the day nearly every day for at least 2 years?		
a. Is that happening now or was it in the past? Now ___ In the past___		
4. In the **last month**, has there been a period of time when you were feeling so good, high, excited, "hyper," or irritable that other people thought you were not your normal self or you got into trouble?		
a. How many days did that period of time last? ____		
5. Have you **ever** had a time when you were feeling so good, high, excited, "hyper," or irritable that other people thought you were not your normal self or you were so hyper that you got into trouble?		
6. Have you ever experienced periods in which your mood cycles from periods of low depressed mood and low energy to periods of elated mood with high energy?		

Section II: Substance Use

	Past (Yes/No)	Currently (Yes/No)
1. Have you ever consumed alcohol?		
2. Have you ever used illicit drugs?		
3. Have you ever used medications (prescription or non prescription) other than as directed?		

If no to all, please skip to Section III.
If yes to any of these questions, please specify quantity/frequency (e.g., 2 glasses of wine per day):

Substance	Past		Currently	
	Quantity	Frequency	Quantity	Frequency
Alcohol (e.g., beer, wine, hard liquor)				
Sedatives (e.g., Valium, Xanax, Klonopin, Ambien, Sonata, Lunesta, barbiturates, Ativan, Halcion, Restoril)				
Cannabis (e.g., marijuana, hashish, THC, pot, grass, weed)				
Stimulants (e.g., amphetamine, speed, crystal meth, dexadrine, Ritalin, ice)				
Opioids (e.g., heroin, morphine, opium, Methadone, Darvon, codeine, Percodan, Demerol, Dilaudid, oxycontin, oxycodone, hydrocodone, vicodin)				
Cocaine (e.g., crack, speedball)				
Hallucinogens (e.g., LSD, mescaline, peyote, psilocybin, STP, mushrooms, Ecstasy, MDMA)				
PCP (e.g., angel dust, Special K)				
Other (e.g., steroids, glue, ethyl chloride, paint, inhalants, nitrous oxide (laughing gas), amyl or butyl nitrate (poppers), nonprescription sleep or diet pills, cough syrup)				

	Yes	No
4. Have you ever felt you ought to cut down on your drinking or substance use?		
5. Have people annoyed you by criticizing your drinking or substance use?		
6. Have you ever felt bad or guilty about your drinking or substance use?		
7. Have you ever had a drink or used substances first thing in the morning to steady your nerves or to get rid of a hangover?		

8. Please indicate areas where your alcohol or substance use caused problems in the last six months:

Work ____ Legal ____ School _____ Health ____ Relationships ____
Leisure activities____ Financial ____

Section III: Anxiety

	Yes	No
1. Have you ever had a panic attack (a sudden onset of intense fear or discomfort accompanied by intense bodily sensations and an intense urge to flee that reached its peak intensity within 10 minutes)?		
a. If yes, please check symptoms experienced: ___Pounding, racing heart ___Fear of losing control, going crazy ___Chest pain or discomfort ___Sweating ___Nausea/abdominal distress ___Fear of dying ___Trembling, shaking ___Dizzy, lightheaded or faint ___Numbness or tingling sensations ___Shortness of breath ___Feelings of unreality or detached ___Chills or hot flushes ___Feelings of choking		
b. Have you ever had a panic attack that seemed to happen out of the blue (e.g., for no apparent reason)?		
c. Has the panic attack been followed by persistent concern about having additional attacks, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks?		
2. Do you avoid or feel afraid of being in places or situations in which you may experience panic symptoms (e.g., being in crowds, standing in line, or traveling on buses or trains or airplanes)?		
3. Do you avoid or feel very fearful in social or performance situations (e.g., public speaking, parties, dating) because you think you will humiliate or embarrass yourself or be judged negatively by others?		
4. Are there other things or situations of which you are extremely fearful, such as flying, seeing blood, getting an injection, heights, small enclosed places, or certain kinds of animals or insects?		
If yes, please specify:		
5. In the last six months, have you worried excessively more days than not about a number of future events or activities, and found it difficult to control that worry?		
6. Are you bothered by thoughts, impulses, or images that are extremely uncomfortable (e.g., hurting someone against your will or being contaminated by germs) and that keep coming back even when you try not to have them?		
7. Do you feel driven to continually repeat a behavior (e.g., washing, saying certain phrases in your mind, putting things in a particular order or checking locks, stoves, lights, etc.) and have difficulty resisting the urge to do so?		
8. Have you ever experienced or witnessed an event that involved actual or threatened death or serious injury to yourself or another person?		
If yes, did your response to the event involve intense fear, helplessness or horror?		

	Yes	No
9. Have you ever experienced sexual abuse or assault?		
10. Have you ever had sexual contact with someone that you did not want?		

Section IV: Other

	Yes	No
1. Have you had any unusual experiences such as hearing or seeing things that other people did not seem to hear or see?		
2. Have you ever believed that people were spying on you, out to get you, making plans to hurt you, or following you?		
3. Have you ever believed that people were sending you special messages through the newspaper, radio, TV or internet?		
4. Over the last several years, have you frequently gone to see your physician for physical problems?		
5. Do you frequently worry that you have a serious medical problem even when a doctor tells you otherwise?		
6. Are you preoccupied with a perceived defect in your appearance (e.g., your height, the shape of your nose, amount of hair loss, your complexion)?		
7. Have you ever had a time when you weighed much less than other people thought you ought to weigh?		
If yes, at that time were you very afraid that you could become fat?		
8. Have you often had times when you felt your eating was out of control?		
9. Have you ever made yourself vomit, used laxatives, or exercised a lot to prevent weight gain?		
10. Do you have a history of difficulties with paying attention, being easily distracted, losing things or organizing tasks or activities?		
11. Do you have a history of feeling restless when you're sitting still, interrupting others, blurting out things you wish you could take back, difficulty doing leisure activities quietly, or acting first without thinking?		
12. Do you experience problems with recurrently pulling out your hair or picking at your skin to the degree that you experience noticeable hair loss or bleeding or disfigurement from skin picking?		

13. Do you smoke cigarettes? Yes No (circle one)

If yes, how much do you smoke? _____cigarettes per _____

14. Do you drink caffeinated beverages? Yes No (circle one)

If yes, how many cups daily? _____

DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3
22	I thought about death or suicide	0	1	2	3
23	I wanted to kill myself	0	1	2	3

ID:_____

FSI Scale

This questionnaire asks you to rate various areas of life regarding how well you have functioned during the last month. Please answer every question.

1. **WORK/SCHOOL is your job, schoolwork, or other responsibility (e.g., homemaking, caregiving, or volunteer work). If you have more than one of these responsibilities, please include them all in your ratings.**

   How well have you **functioned** at WORK/SCHOOL **during the last month**? Functioning refers to how well you are getting things done, including whether you attend regularly, are punctual, meet deadlines, and get along with others.

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

   How many days **during the last month** did the symptoms for which you are seeking treatment cause you to miss WORK/SCHOOL? _____ days

   How many days **during the last month** did you feel so impaired by your symptoms that even though you went to WORK/SCHOOL, your productivity was reduced? _____ days

2. **LOVE RELATIONSHIP refers to an intimate relationship with another person that generally includes a sexual component.**

   How well have you **functioned** in your LOVE RELATIONSHIP **during the last month**? Have you spent time together, communicated well (e.g., without conflict), been physically intimate? If you are not currently in a LOVE RELATIONSHIP, have you been dating or taking the initiative to establish a love relationship?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

3. **RELATIONSHIPS WITH RELATIVES refers to all of your relatives, including your parents, grandparents, siblings, step-parents, aunts, uncles, children, and step-children. Include your ex-spouse if you share parenting responsibilities or if you consider that person to be a part of your family now.**

   How well have you **functioned** in your RELATIONSHIPS WITH RELATIVES **during the last month**? Have you spent time with relatives, been mutually supportive, communicated well and without conflict?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

4. **FRIENDSHIP refers to the number and quality of relationships you have with people who are not relatives. Friends are people with whom you feel some degree of closeness and share some activities.**

   How well have you **functioned** in your FRIENDSHIPS **during the last month**? Have you spent time with friends, been mutually supportive, communicated well and without conflict?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

5. **RECREATION refers to what you do to enjoy yourself or relax, such as watching movies or television, exercising or participating in sports, studying a language, gardening, visiting friends or relatives, or pursuing other hobbies and interests.**

How well have you **functioned** at RECREATION activities **during the last month**? Have you participated in recreation activities regularly?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

6. **HEALTH refers to wellness and freedom from physical and mental illness, pain or disability.**

How well have you **functioned** in maintaining your HEALTH **during the last month**? Have you eaten a healthy diet, exercised, engaged in healthy behaviors (e.g., safe sex), taken medications as prescribed, gotten the medical care you need?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

7. **STANDARD OF LIVING refers to your income, your possessions (e.g., car, home, clothing) and in general the amount of money you have.**

How well have you **functioned** in maintaining your STANDARD OF LIVING **during the last month**? Have you earned enough money, paid your bills on time, and handled money responsibly without accumulating too much debt?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

8. **HOME refers to the physical space in which you live and your neighborhood and community.**

How well have you **functioned** at maintaining your HOME (keeping it neat and in good repair), keeping good relationships with neighbors (and with roommates, if you have them), participating in neighborhood and community events, **during the last month**?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

Name:_____ Date:_____

MOS Social Support Survey

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? Circle one number on each line.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Emotional/Informational support					
Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you information to help you understand a situation	1	2	3	4	5
Someone to give you good advice about a crisis	1	2	3	4	5
Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
Some whose advice you really want	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
Someone who understands your problems	1	2	3	4	5
Tangible support					
Someone to help you if you were confined to bed	1	2	3	4	5
Someone to take you to the doctor if you needed it	1	2	3	4	5
Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
Someone to help with daily chores if you were sick	1	2	3	4	5
Affectionate support					
Someone who shows you love and affection	1	2	3	4	5
Someone to love and make you feel wanted	1	2	3	4	5
Someone who hugs you	1	2	3	4	5

Name:_____ Date:_____

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Positive social interaction					
Someone to have a good time with	1	2	3	4	5
Someone to get together with for relaxation	1	2	3	4	5
Someone to do something enjoyable with	1	2	3	4	5
Additional item					
Someone to do things with to help you get your mind off things	1	2	3	4	5

SFBACCT
PRIVACY POLICY

OUR COMMITMENT TO YOUR PRIVACY

We are dedicated to maintaining the privacy of your* Protected Healthcare Information (PHI). In addition, we are required by law to inform you of how your Protected Healthcare Information (PHI) will be protected, how SFBACCT may use or disclose PHI, and your rights regarding access to your PHI. Please review this information carefully. You will be asked to sign a receipt indicating that you have received and read this document. If you have any questions regarding this notice, please speak with your therapist, who acts as a "Privacy Officer" on your behalf.

We reserve the right to revise or amend this document. Any revision or amendments to this notice will be effective for all records. We will post a copy of the current Privacy Policy in the waiting room and on our website (www.sfbacct.com) for your easy access. You may also request a current copy from your therapist at any time.

**Parents and guardians of under aged patients, the terms "you" and "your" is intended to include your child throughout this document.*

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Every time you visit your therapist, a record of your visit is added to your clinical record. Typically, your clinical record contains a list of your session dates and payments, medications, symptoms, history, test results, diagnoses, treatment, and a plan for future care, as well as any information that you have authorized to have forwarded to your therapist from other healthcare professionals.

HOW WE MAY USE AND DISCLOSE YOUR PHI

Information in your medical record is used primarily for your treatment. It is also used for business activities, called "healthcare operations". These include:

- Accounting and billing activities;
- Collecting data that does not identify you in any way for research, educating mental health professionals, marketing, and public health;
- Collecting data that does not identify you in any way for our assessment so that we may improve our treatment options and techniques as well as improve business and facilities management functions.

We do not share your PHI with any requesting agency (such as insurance companies) or person (such as a physician) unless you sign an authorization form allowing us to do so. This gives you control over the distribution of your Protected Healthcare Information.

You have the right to request restrictions in our use or disclosure of your PHI for treatment, payment, or healthcare operations. For more information on requesting restrictions, please refer to page 4, item #6 under Your Rights Regarding Your PHI.

USE OF YOUR PHI IN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your PHI without prior consent; however, we will attempt to contact you in advance when the situation allows:

1. Health and Safety – When there is serious threat to your health and safety or the health and safety of another individual or the public. In this case, your PHI would be shared with any person or organization that might be able to prevent/reduce the threat.

2. Lawsuits and Similar Proceedings – We may be required to use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also be required to disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

3. Law Enforcement – We may be required by law to disclose PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, missing person, complying with a court order, warrant, grand jury subpoena, and other law enforcement purposes.

4. Military – We may be required to disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

5. National Security – We may be required to disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may also be required to disclose your PHI to officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.

6. Inmates – We may be required to disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide your health care services, (b) for the safety and security of the institution, and/or (c) to protect their health and safety or the health and safety of other individuals.

7. Workers' Compensation – If your treatment is being paid for through a Workers Compensation claim, then we are likely to be asked to disclose your PHI. We would not give this information without your written consent. However, be aware that if you do not consent to releasing this information, Workers Compensation will likely refuse to pay for the treatment.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights related to your records:

1. **Copies of this Notice** - You have the right to obtain a copy of this notice before or at your first visit. Thereafter, you may request a copy of this notice or any revisions from the waiting room, the website (www.sfbacct.com), or from your therapist.

2. **Authorization to use your PHI** – We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. You may revoke at any time, by submitting a request in writing, any authorization you provide to us regarding the use and disclosure of your PHI. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

3. **Inspection and Copies of your PHI** – You have the right to inspect and copy your PHI, with limited exceptions. To access your PHI, you must submit a written request detailing what information you want access to. You are entitled to view the modalities and frequencies of treatment sessions provided to you, the results of clinical tests and self report forms and symptom monitoring sheets, a written summary from your therapist explaining your diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. The only exception to your automatic right to view information in you medical chart is the viewing of psychotherapy session notes written by your therapist. There are specific laws governing psychotherapy session notes, because these notes are intended to assist the psychotherapist only, and have the potential for being misinterpreted by others. If you would still like to view the psychotherapy notes, please include this in your written request to your therapist. Your therapist will review with you the pros and cons of your request in the context of your treatment needs and situation.

   We may deny your request under limited circumstances, and we would only do this if we believe it would be reasonably likely to cause you substantial harm. You have the right to appeal our decision. If we deny your request to access psychotherapy notes, you have the right to request that they be transferred to another mental health professional.

   We may charge a reasonable administrative fee to reimburse us for the time and supplies required to provide you with your PHI.

4. **Amend your PHI** – You have the right to request that we add or correct information in your record at the Center. Your request must be in writing to your therapist and must include a reason that supports your request.

   We may deny your request if the information in your record is, in our opinion, (a) accurate and complete; (b) not part of the PHI kept by or for your therapist at the Center; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by your therapist at the Center.

5. **Confidential Communications** – You have the right to request that we communicate with you in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will make reasonable attempts to accommodate your requests.

6. **Requesting Restrictions** - You have the right to request restrictions in our use or disclosure of your PHI for treatment, payment, or healthcare operations. Please know that we are not required to comply with your request; however, if we do comply, we are bound by a restrictions agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat. In order to request a restriction in our use and disclosure of your PHI, you must make your request in writing to your therapist. Your request must describe in a clear and concise fashion: the information you wish restricted; whether you are requesting to limit our use, disclosure or both; and to whom you want the limits to apply.

7. **Accounting of Disclosures** – You have the right to request "an accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures your therapist has made of your PHI. Non-routine disclosures include disclosures made for purposes other than treatment, payment collection, or healthcare operations. In order to obtain an account of disclosures, you must submit your request in writing to your therapist. All requests must specify a time period (start and end dates). We may charge a reasonable administrative fee to reimburse us for time and supplies require to provide the accounting of disclosures.

8. **Right to File a Complaint** – You have the right to file a complaint with your therapist and/or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. All complaints must be submitted in writing. You will not be penalized by your therapist for filing a complaint. If you are not satisfied with the manner in which your therapist handles your complaint, you may submit a formal complaint to:

Department of Health and Human Services
Offices of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

9. **Other Rights** – You may have other rights granted to you by the laws of the State of California and these may be the same or different than the federal rights described above. For further information on California State Law protecting patient rights, please visit www.chcf.org (the California Healthcare Foundation website). If you have additional questions about this issue, please speak with your therapist.

   For further information on HIPAA (Health Insurance Portability and Accountability Act, 1996) regulations or your right to privacy regarding healthcare information, please visit www.hhs.gov/ocr/hipaa (the US Department of Health and Human Services website).

   For further information about your rights as a psychotherapy patient, please visit www.apa.org/publicinfo/rights (the American Psychological Association's website).