For official use only: _______________ _______________

CLIENT INFORMATION

This information will help me to better serve you. Please answer as completely and as honestly as possible.

Name: __________________________ **Date of Birth:** __________**Last 4 SS#:** _________ **Gender:** _____

Address: ____

City: _____________________________ **State:** ________ **Zip:** ___________**County:**_________________

Email: ____

Phone: (____)_____________________ (____)_____________________ (____)_______________________
Home **Cell** **Work**

If you live in Tarrant County, please circle one of the 37 areas within the four regions listed below:

1. Northwest Tarrant County:
Alliance Azle Blue Mound Carswell Fort Worth Haslet
Lake Worth River Oaks Saginaw Sansom Park White Settlement

2. Northeast Tarrant County:
Bedford Centerport Colleyville Euless Fort Worth
Grapevine Haltom City Hurst Keller North Richland Hills
Richland Hills Southlake Watauga Westlake

3. Southeast Tarrant County:
Arlington Everman Forest Hill Fort Worth Grand Prairie
Kennedale Mansfield

4. Southwest Tarrant County:
Benbrook Crowley Edgecliff Fort Worth Burleson

Were services easily accessible? Yes No
Are you or anyone in your family in the military or a Veteran? Yes No
Affiliation to you (please circle): 1. Self. 2. Spouse. 3. Child. 4. Parents. 5. Grandparents. 6. Significant other.
Current status (circle one): Active. Discharged. Reserve. Retired.

Primary race/ethnic group in which you identify yourself (please circle):
1. Caucasian/Anglo/European 2. Black/African American 3. Hispanic/Latin 4.Native American 5. Asian 6. East Indian 7. Alaskan Native 8. Hawaiian Native/ Pacific Islander 9. Mediterranean 10. Middle Eastern 11.Mixed Race/ethnicity

What is your primary language/dialect? ____

Will you need translation/interpretation services? ____

Do you have special communication needs? Specify: ____

Education (highest grade completed): ____

Current employment: __1.Full-time __2.Part-time __3.Temp __4.Unemployed __5.Disabled __6.Retired

What is your total household size? Please include in this number any and all persons living in your home full time, as well as any person who lives outside the home but can be claimed as a dependent for tax purposes. (Example: a full time college student who receive most or all their financial support from you): _________

Please check the option below where your annual household income falls under:
__Less than 20,750 __20,750-34,599 __34,600-55,349 __55,350+

What is your current total household income from all sources? Sources include but are not limited to the following: salary/wages, VA disability benefits, social security, unemployment benefits, retirement plan funds, child support, and alimony: _______________________________

Relationship Status (please check): ___1.Single ___2.Married ___4.Separated ___5.Divorced
___6.Remarried ___7.Widowed

Emergency Contact Information:
Name, number and relationship: ____

What is your goal for counseling? ____

Please indicate where I can leave a message (please check): ___ Home ____Cell ____Work _____email

Other specify: ____________________________________

How many months of Trade School or Business College? ____________or **Not Applicable:** _________

If currently in school, what is your academic performance or GPA (grade point average)? _____________

So far, have you achieved your educational goals? ______1. Yes or _______2. No

If not in school, would you consider attending school in the future? ______1. Yes or _______2. No

If not in school, are you interested in an education referral? ______1. Yes or _______2.No

If yes, what are your needs? ____

Do you live with (please circle as many as apply):
1. Spouse/ Significant Other
2.Children
3.Parents
4.Grandparents
5.Friends
6. Multi-Family
7. Alone

Spouse Name: ____

Dependent Names & Ages:

____

Military Information

Military branch you are affiliated (please circle): 1. Air Force 2. Army 3. Navy 4. Marines 5. **Other/ specify**_________________________.

Date Enlisted: ___________________

Date discharged: ____________________ **Rank at discharge:** _________________________

Years you have served? ___________________ **Unit of Deployment:** ____________________________

List locations and year of all deployments: Location ______________________________Year:_________

Location: ____Year: ______________________

Location: ____Year: ______________________

What was your job title/MOS? ____

Circle experiences you may have had:

1. Active theater 2. Hand-to-hand Combat 3. Sexual abuse/Harassment 4. Non-Combat

<u>Health Information</u>

Rate your health (please checkmark): ___1.Excellent ___2.Good ___3.Average ___4.Fair ____5.Declining

Please circle if you are: 1. Physically Disabled 2.Mentally Disabled 3. Physical + Mental Disability

List all current chronic medical and/or mental illness diagnoses: __________________________________

____

Date of most recent primary care physician exam? ____
Date of most recent specialist exam? _____________________ **Type of Doctor?** _____________________

In the past 120-days have you been admitted to an Emergency Room; if so what date? ______________

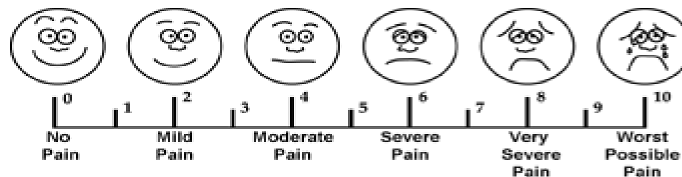
What illness or condition were you treated for in the Emergency Room? ___________________________

In the past 120-days have you been admitted to an inpatient hospital; if so what date? ______________

What illness or condition(s) were you treated for inpatient? ______________________________________

Are you experiencing any pain now? YES NO

If YES, please explain and rate your pain using the chart below:________________________________



Please list all *prescribed* medications you are currently taking: ____________________________________
____
____

Nutrition

Do you have any allergies to food or medication? Specify: _______________________________________

Have you lost or gained more than 10 pounds in the last 6 months? YES NO

Have you experienced unintentional weight loss or gain? YES NO

Have you had a recent change in appetite? YES NO

Substance Use Information

Do you smoke? ______1.Yes or _______2.No **If Yes, how many years have you chronically smoked?**_________

If Yes, how many cigarettes do you smoke in a 24-hour period?__________________________________

Substances Use
Please circle any and all *illegal substances* you have used in the past 12-months:

1. Cocaine 2.Marijuana 3.Opioids 4.Stimulants 5.Hallucinogens
6. Sedatives/Tranquilizers 7. Benzo(Xanax, Valium, etc)

How often do use these substances? ___1.Daily ___2.Weekly ___3.Monthly ___4.Rarely ___5.Never
____6. Mixed Use

Age of 1st use? ____

Do you have any legal problems arising from using these substances? _________1.Yes or __________2.No

Have you given up important social, work, or recreational activities from substance use? ____1.Yes or
_____2.No

Do you struggle with relapse? _____1.Yes or _____2.No

If yes, please explain:____

Do you have any family history of substance abuse? If so please explain: _________________________

____

Alcohol
How often do you drink alcohol? __1.Daily ___2.Weekly ___3.Monthly ___4.Rarely ___5.Never

How many ounces of alcohol do you consume each time you drink? ______________________________

Age of 1st use of alcohol? ____

Have you given up important social, work, or recreational activities from alcohol use? __1.Yes or __2.No

Do you have any legal problems arising from using alcohol? _________1.Yes or __________2.No

Legal Issues

Do you have any misdemeanors or felonies? If yes please explain: _______________________________

____

Do you have any other current or past legal issues? If so please explain: _________________________

____

Psychotherapy

Have you ever participated in any therapy/counseling programs? __1.Yes or __2.No

If Yes, what was it that did not work? ____

Did you attend all the recommended sessions offered/suggested/ or prescribed? ___1.Yes or ___2. No

How many sessions did you attend before stopping? _______________________________________

Are you currently receiving mental health counseling/therapy from any other sources? ___1. Yes or ___2. No

What are your preferences for counseling?

1. Individual 2.Couples 3.Family 4.Play Therapy 5.Groups

Does religion or spirituality play a role in your life? ___1.Yes or ___2. No

If yes, in what way? ____

Section for Child or Youth Clients Only

If this form is for a child or youth client (under the age of 18), please complete the following:

What is the legal custody status? ____

Please identify any legal guardian(s) ____

In the past month, how much of a problem has your child had with nutrition?

___1. Almost Always ___2. Often ___3. Sometimes ___4. Almost Never ___5.Never

"I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for grant-funded services."

Client and/or Parent/Guardian Signature ***Date***

____ -------------------------------

For official use only: ________________ ________________

Suicide Risk Assessment

Did you ever in your life make a suicide attempt?	YES	NO	1
In the past 30-days have you made a suicide attempt?	YES	NO	2
Do you feel that you would be better off dead or wish you were dead?	YES	NO	3
Do you want to harm yourself?	YES	NO	4
Do you think about suicide as an option for you to use?	YES	NO	5
Do you have a suicide plan?	YES	NO	6
Do you have the means in which to carry out a suicide plan?	YES	NO	7

Risks
1 + 3 or 4 = Low risk, create written suicide prevention contract, re-evaluate risk every week during study.
1 + 2 + 3 or 4 = Moderate, suicide prevention contract, refer out, do not enroll in study until stabilized.
1 + 5or 6 + 7 = Very high risk, call 911 and/or refer out for immediate medical help, do not enroll in study.

(Counselor comments below)

Preliminary/Crisis Plan:

____
____
____
____
____
____
____
____
____
____

Counselor Signature:____ **Date:** ____________________________

For official use only: ________________ ________________

PTSD Checklist (PCL)

If an event listed on the Life Events Checklist **happened to you** or you **witnessed it,** please complete the items below. If more than one event happened, please choose the one that is **most troublesome to you now.**

The event you experienced was ________________________________ on _______________
(EVENT) (DATE)

.

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then **circle** one of the numbers to the right to indicate how much you have been **bothered** by the problem **in the past month.**

BOTHERED BY	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Repeated disturbing memories, thoughts, or images of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing dreams of the stressful experience?	1	2	3	4	5
3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of the stressful experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?	1	2	3	4	5
7. Avoiding activities or situations because they remind you of the stressful experience?	1	2	3	4	5
8. Trouble remembering important parts of the stressful experience?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being “super alert” or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

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HHSC Texas Veterans + Family Alliance (TV+FA) Grant Program Survey

Please check all that apply:

1. **What services did you receive?**

- ☐ **Counseling or Therapy** (with physician/licensed counselor/clinician)
- ☐ **Individual Support Services** (employment, transportation, financial, education, housing)
- ☐ **Peer Support** (veteran peers, support group)
- ☐ **Referral Assistance** (case management, benefits)
- ☐ **Physical Health & Wellness** (Yoga, meditation, physical activity)
- ☐ **Other** (Please describe): ____________________

2. **Which of the following identifies you?**

☐ Veteran ☐ Family member

3. **Which branch of service did the veteran serve?**

☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps ☐ Navy

4. **Which military service did the veteran serve?**

☐ Active ☐ Guard ☐ Reserve

5. **When did the veteran serve in the U.S. Armed Forces?**

☐ 1947 - 1950 ☐ 1951 - 1955 ☐ 1956 - 1964 ☐ 1965 - 1975 ☐ 1976 - 1990 ☐ 1991 - 2001 ☐ 2002 or later

6. **Did the veteran serve in a war or area of armed conflict?**

☐ Yes ☐ No

7. **Do you feel better after receiving services at this program or organization?**

☐ Yes ☐ No

8. **Services helped me and my family: Circle all that apply.**

Sleep better	Get or keep a place to live	Improve family relationships	Get or keep a job	Improve my moods and emotions	Do better in school
Improve relationships with friends	Have more people/places in the community for support	Have more places in the community where I can help others	Other (Please describe):		

9. **Which were the most important areas for you to experience improvement? Circle all that apply.**

Sleep better	Get or keep a place to live	Improve family relationships	Get or keep a job	Improve my moods and emotions	Do better in school
Improve relationships with friends	Have more people/places in the community for support	Have more places in the community where I can help others	Other (Please describe):		

10. **How satisfied were you with the service you received?**

Not satisfied ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very Satisfied

11. **How satisfied were you with the process of finding and accessing these services?**

Not satisfied ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very satisfied

12. **What else would you like us to know? Please give us your feedback.**

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Recovery Resource Council to exchange the following information:

In case of emergency, whatever information is needed (Description of information to be released) with the following person(s) or organization(s) (please check):

_____Physician _____Psychologist/Psychiatrist _____School _____Referent

_X_Other (please specify): Emergency Contact___________________

Name or title of your Emergency Contact, including contact information, with which the exchange is to be made: (Please note: Exchange will not be made without complete information)

Name ____

Address ______________________________ City_________________ Zip____________________

Phone___________________________ Fax______________________

Name of client: ____ Date of Birth_____________

The purpose of this exchange or disclosure of information is:

To communicate with emergency contact if needed.

____

I understand that I may revoke this release at any time, except to the extent that the practice has taken action in the reliance of the consent. Such revocation must be in writing and submitted in person, by US mail or email. The consent is valid for **one year** following the date of issuance unless revoked in writing prior to such date. Please be advised this authorization does not protect the information from being disclosed by the recipient.

Signature of Client ____ Date___________________

Signature of Parent/Guardian ____________________________________ Date___________________
(Be advised this authorization will be revoked on the child's 18th birthday)

This form will be kept in the client's file and the signatory will receive a copy for their records.

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Recovery Resource Council to exchange the following information:

Progress in treatment, treatment plan, treatment summary, and session information with the following person(s) or organization(s) (please check):

_____Physician _____Psychologist/Psychiatrist _____School _____Referent

__Other (please specify):____________________

Name or title of the person or organization, including contact information, with which the exchange is to be made: (Please note: Exchange will not be made without complete information)

Name ____

Address ______________________________ City_________________ Zip____________________

Phone___________________________ Fax______________________

Name of client: ____ Date of Birth_____________

The purpose of this exchange or disclosure of information is:

To improve assessment and treatment planning, share information relevant to treatment, and, when appropriate, coordinate treatment services. If necessary, please specify other purposes below.

____

I understand that I may revoke this release at any time, except to the extent that the practice has taken action in the reliance of the consent. Such revocation must be in writing and submitted in person, by US mail or email. The consent is valid for **one year** following the date of issuance unless revoked in writing prior to such date. Please be advised this authorization does not protect the information from being disclosed by the recipient.

Signature of Client ____ Date___________________

Signature of Parent/Guardian _____________________________________ Date___________________
(Be advised this authorization will be revoked on the child's 18th birthday)

This form will be kept in the client's file and the signatory will receive a copy for their records.

RecoveryResource
COUNCIL
Providing hope, conquering addiction, healing families.

Clinical Counseling

Informed Consent

Counseling Relationship: During the time we work together, we will meet for 50-minute weekly sessions. Although our sessions may be very intimate psychologically, this is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me except in the case of an emergency when you may contact me by phone or VSee TeleMental Health (TMH). **All services are provided by appointment only. Please be on time to your appointments. These are our attendance policies: Rescheduling 24 hours in advance is allowed for no more than two consecutive sessions; a total of two "no shows" or "cancellations" are allowed; sessions are cancelled and count as absence if you arrive 15 minutes late or more; a discharge session is offered if three or more "no shows" or cancellations" occur. If you arrive for the session under the influence of an intoxicating substance, I will immediately cancel the session and ask you to arrange for a ride home or call a cab at your own expense. If you try to leave in your car under any type of influence putting yourself and others in danger, we will call the police.** Please do not invite me to social gatherings, offer me gifts, ask me to write references, or ask me to relate to you in any way other than in the professional context of our counseling sessions. Should we encounter one another in a public place (e.g. restaurant or store), I will protect your privacy by not approaching you, and will only speak to you if you first approach me. You will be best served if our sessions concentrate exclusively on your concerns.

Effects of Counseling: At any time, you may initiate discussion of possible positive or negative effects of entering, not entering, continuing or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/ or your understanding of yourself. Some of these changes may be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights: Some clients need only a few counseling sessions to achieve their goals while others may require months or even years of counseling. As a client, you are in control and may terminate the counseling relationship at any time unless you are court-ordered to be in counseling. I do ask that you participate in a termination session. You also have the right to refuse or negotiate modification of any of my suggestions. I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. If at any time, for any reason, you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas State Board of Professional Counselors, Social Workers, or Licensed Marriage and Family Therapy by calling 1-800-942-5540 or writing to Complaints Management and Investigations Section, P.O. Box 141369, Austin, TX 78714.

Referrals: Should you and/ or I believe that a referral is needed, I will provide some alternatives including programs and/ or professionals who may be able to assist you. You will be responsible for contacting and evaluating those referrals.

Records and Confidentiality: All of our communication becomes part of the clinical record, which you may see upon written request. Some limitations and exceptions do exist and could require an ethical duty to warn: 1) I determine that you are a danger to yourself or someone else; 2) you disclose abuse, neglect or exploitation of a child, elderly or disabled person; 3) you disclose sexual contact with another health professional; 4) I am

ordered by a court of law to disclose information; 5) you direct me to release your records; or 6) I am otherwise required by law to disclose information.
In the case of marriage or family counseling, I will keep confidential (within the limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic process.

TeleMental Health (TMH) Defined: TMH is the delivering of health care services at a distance via technology-assisted media. Included are a wide array of clinical services and forms of technology (e.g., video, internet, PC desktop system, telephone, etc.). The audio/video communication is securely transmitted and encrypted from point-to-point. Additionally, to be HIPAA compliant, a Business Associate Agreement (BAA) must be established between the TMH service provider and the health care service provider. The BAA formalizes the responsibility of the TMH service provider as responsible for keeping all patient information secure.

Limitations of TeleMental Health (TMH) Therapy Services: TMH has several advantages such as flexibility and convenience. However, it is an adjunct or alternative form of therapy which may involve disadvantages and limitations. There may be a service disruption (e.g., video or audio disconnects, video quality temporarily decreases, etc.). Such disruptions may impact the flow of communication due to limitations to include visual or auditory cues, facial expressions, tone of voice, etc. I will take every precaution to provide psychotherapy sessions that are environmentally private and technologically secure. You are responsible for identifying a quiet and private space for sessions. Please consider using a "do not disturb" sign or note on the door. A reliable internet connection is necessary to minimize disruptions.

Professional Credentials: Elaine F Garrison, MS, LPC, license #69635; Juana Garcia, MS, LMFT, license #202065; Amber Phillips, MS, LPC, license #77691; Michelle McQueen, MA, LPC, license #75375; Chelsi Najera, MA, LPC Intern, license # 80510 under the supervision of Russell Bartee, PhD, LPC-S, license # 11248; Michael Fowler, MMFT, LMFT-Associate, license # 203354, under the supervision of Susan Martinez, LMFT-S, license #201742; Natalie McCurley, BA; Laurie Mitchell, BA; Federico Mendez, MS; Casey Gutiérrez, MEd, LPC, license #74446.
The Enduring Families Program staff uses a collaborative team approach for the wellbeing of all participants in our program. The goal of the collaborative team is to help participants achieve improved individual and family functioning. In order to accomplish this goal, the staff working in the Enduring Families Program will work together through consultation and/or navigation to provide the best care possible.

By your signature below, you are indicating that you have read and understood this document, and any questions you have had about this statement have been answered to your satisfaction.

____

Client and/or Parent/Guardian Signature Date

____

Intake Counselor Signature Date

____

Primary Counselor Signature Date

CONSENT TO RELEASE INFORMATION TO THE RECOVERY RESOURCE COUNCIL (RRC) AND TEXAS HEALTH AND HUMAN SERVICES (HHSC) - TV+FA PROGRAM

RRC is the lead partner agency of the 2019 to 2021 Texas Veterans + Family Alliance Program (TV+FA) collaborative funded through Senate Bill 55 and managed through HHSC. This program provides free services to veterans and their families in North Texas. In order to provide services through this funding, each of the following partner agencies are asked to share client information with RRC and HHSC: S.T.E.P.S. With Horses, Denton County MHMR, MHMR of Tarrant County, The Art Station, The Artist Outreach, and RRC.

I hereby authorize the above agency I am receiving services through to release the following information to RRC and HHSC:

- All records for internal audit purposes conducted by RRC
- Eligibility documentation, assessments, and survey copies to be stored at RRC for audit purposes conducted by HHSC
- Deidentified assessments and surveys for the purposes of service evaluation and reporting to and by RRC and HHSC

I understand I may stop services and withdraw this consent at any time. My signature indicates that I have read and understand the above and that I give my consent to share the listed information with RRC and HHSC.

Client Signature: ____ Date: ______________________

Staff Signature: ____ Date: ______________________

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

I am required by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical health records and other Protected Health Information in our possession. This Notice is to inform you of the uses and disclosures of information that may be made by the practice; your individual rights; and the practice's legal duties with respect to confidential information.

Ways in which we may use and disclose your Protected Health Information:

We may use and disclose, at our discretion, your medical records for each of the following purposes only:

Treatment means providing, coordinating, or managing mental health care and related services. For example, use or disclosure by the health care provider in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in counseling.

Payment means activities such as obtaining payment for the mental healthcare services provided for you, either from your insurance or another third party payer. For example, we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.

Healthcare operations include the business aspects of running the practice. For example, to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your Protected Health Information to any person you identify as involved in your care or payment for your care.

We will use and disclose your Protected Health Information when required to by federal, state, or local law. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information to other persons or agencies- even if you do not consent. These situations include: (1) I determine you are a danger to yourself or someone else; (2) you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person; (3) I am ordered by a court of law to disclose information; (4) you direct me to release your records; (5) I am otherwise required by law to disclose information.

Please sign to indicate you understand our operational use of your information for treatment, payment, and healthcare operations as stated above.

Client and/or Parent/Guardian Signature ____
Date__________________

VETERAN FAMILY IDENTIFICATION FORM - TV+FA PROGRAM

RRC is the lead partner agency of the 2019 to 2021 Texas Veterans + Family Alliance Program (TV+FA) collaborative funded through Senate Bill 55 and managed through HHSC. This program provides free services to veterans and their family members in North Texas. In order to provide services to family members through this funding, each of the following partner agencies must have veterans identify their family members through the completion of this form: S.T.E.P.S. With Horses, Denton County MHMR, MHMR of Tarrant County, The Art Station, The Artist Outreach, and Recovery Resource Council.

I, ____, am a veteran residing in the state of Texas

who hereby identifies ____ as a family member.

Veteran Signature: ____________________________________ Date: ____________________

For official use only: _______________ _______________

CONSENT TO RELEASE & PROVIDE INFORMATION

Recovery Resource Council is collaborating with the Bob Woodruff Foundation to validate the quality and effectiveness of the Recovery Resource Council Veteran's Services Program. This is made possible through the work of Dr. Vicki Nejtek, Associate Professor at University of North Texas Health Science Center, and her team. With your consent, Dr. Nejtek's group will be reaching out to you at six and twelve months after your counseling ends to assess the quality of the program you received at Recovery Resource Council and how well it has helped you. You will be compensated for your participation with Dr. Nejtek.

The information you will be asked to provide includes verifying the data you provided during your initial intake and at every weekly session you received previously.

Examples of verifying the data you previously provided include:

- Name, home/mailing address, contact information (phone and/or email)
- Military experience
- Health status and medication use

Examples of information that Dr. Nejtek and her team will need to re-assess include:

- Posttraumatic Stress, Suicide risks, Depression, Anxiety, and Quality of Life

I hereby give consent to the staff of Recovery Resource Council to allow Dr. Nejtek access to my client chart for verification purposes and allow her or her team to contact me directly so that I can receive more information about participating in this quality re-assessment project.

I understand, I can also choose to contact Dr. Nejtek and her team directly at her office at the University of North Texas Health Science Center in Fort Worth at 817-735-7689 or 817-735-0133.

I understand that if I participate in this project and complete all of the re-assessments I will receive compensation. I understand that I may withdraw this consent at any time. I also understand all information I provide for this quality re-assessment program is entirely confidential.

My signature indicates that I have read and understand the above and that I give my consent to Enduring Families to allow Dr. Nejtek to contact me and to access my client information as indicated above.

Print Name: ____

Client Signature: __________________________________ Date: __________________

Client Phone #: ____

Client Email: ____

Witness Signature: _________________________________ Date: __________________

Baseline

For official use only: ______________ ______________

Name: PLEASE DO NOT WRITE YOUR NAME   Date: NO DATE NEEDED

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your………

	Very Poor	Poor	Fair	Good	Very Good
…..physical health?	1	2	3	4	5
…..mood?	1	2	3	4	5
…..work?	1	2	3	4	5
…..household activities?	1	2	3	4	5
…..social relationships?	1	2	3	4	5
…..family relationships?	1	2	3	4	5
…..leisure time activities?	1	2	3	4	5
…..ability to function in daily life?	1	2	3	4	5
…..sexual drive, interest and/or performance?*	1	2	3	4	5
…..economic status?	1	2	3	4	5
…..living/housing situation?*	1	2	3	4	5
…..ability to get around physically without feeling dizzy or unsteady or falling?*	1	2	3	4	5
…..your vision in terms of ability to do work or hobbies?*	1	2	3	4	5
…..overall sense of well being?	1	2	3	4	5
…..medication? (If not taking any, check here _____ and leave item blank.)	1	2	3	4	5
…..How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction.

BDI-2

Date:

Name: PLEASE DO NOT WRITE PERSONAL INFORMATION Marital Status: XXXXXXX Age: XXXXX Sex: XXXX

Occupation: XXXXXXXXXXXXXXXXXXXXXXXXXXX Education: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry any more than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

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_______ Subtotal Page 2

_______ Subtotal Page 1

_______ Total Score

NAME PLEASE DO NOT WRITE PERSONAL INFORMATION DATE XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	**MILDLY** It did not bother me much.	**MODERATELY** It was very unpleasant, but I could stand it.	**SEVERELY** I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

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