Craig Thornhill, LPC, LAC
PO Box 770147
Steamboat Springs, CO 80477
810 Lincoln Ave.
970-879-7637 x7 office / 970-871-6811 fax
cthornhillcounseling@gmail.com

CLIENT REGISTRATION FOR SERVICES

Thank you for seeking counseling services from this office. We sincerely appreciate your choice to seek services here. Please let us know if you have any questions regarding you or your family's counseling here.

Please answer the questions below for you or your child. Please leave blank any questions that you do not wish to provide answers to.

Please print your (client's) name below:

_____ **Date of Birth**_____

Email address_____ **is it ok to email appt information? Yes / No**

Please provide your physical address:

_____
_____
_____

Please provide your mailing address (if different than physical):

_____
_____
_____

Please provide a primary phone # _____**cell / landline / other**

Is it ok to leave a message at this number? Yes / No

Secondary Phone if applicable # _____**cell / landline / other**

Is it ok to leave messages at this number? Yes / No

Are you (client) an Armed Forces Veteran? Yes / No

What branch if so? _____

How did you hear about this office/who referred you?

_____
_____
_____

Client identified gender preference: Male / Female / Other _____

Client identified pronouns you would prefer I use?_____

What is the primary language spoken in the home? _____

What is your (client's) primary Race and Ethnicity?_____

What is the highest education level you (client) have obtained? _____

Do you (client) have any specific vocational or other technical training/certificates/skills? Yes / No

Explain below if so please:

_____
_____
_____

Please explain your current employment status?

_____
_____
_____

Please explain your current living arrangements?

_____
_____
_____

Number of children under 18 living in the home? _____

Do you have any identified disabilities, physical or other _____Yes _____No, if so what?

_____
_____
_____

If applicable, please list your insurance or EAP information below (Please note this does not guarantee acceptance and billing of your insurance). A copy of an insurance card must be provided as well.

_____
_____
_____

Please Identify an Emergency contact if possible. By doing so you allow this office to contact this person in the event of an emergency or safety concern only (please see Privacy Practices Policy for further rights and details regarding the limits of confidentiality and privileged communications):

Name/Contact Information for Emergency contact:

_____
_____
_____

Are you currently receiving any disability benefits _____Yes _____No, if so for what reason?

_____
_____
_____

What is your (client's) primary reason for seeking services?

_____
_____
_____
_____
_____

Are there any legal (Probation, Parole, Diversion, etc) or child welfare entities involved at this time? ____Yes ____ No

If so, for what reason?

_____
_____
_____
_____

Parent or legal guardian information if client is a minor (otherwise this section is N/A):

Parent/Guardian/Representative contact information if different than above:

_____
_____
_____

If the client is a minor, are there any current custody orders or arrangements I need to be aware of?

_____
_____
_____
_____

If the client is a minor, are they in school? ____Yes ____ No

If so, what grade? _____

Initial Below Please.

_____I attest the above information is correct.

I am seeking services for: (please circle one or more) ____Myself ____My Child ____My Family

_____

CLIENT'S SIGNATURE **DATE**

_____

CLIENT'S PRINTED NAME

IF CLIENT IS A MINOR, SEE BELOW:

_____

SIGNATURE OF PARENT/GUARDIAN/PERSONAL REPRESENTATIVE **DATE**

_____

GUARDIAN OR LEGAL REPRESENTATIVE'S PRINTED NAME

IF YOU ARE SIGNING AS LEGAL GUARDIAN OR REPRESENTATIVE, PLEASE EXPLAIN THE AUTHORITY YOU HAVE FOR THIS INDIVIDUAL. SUPPORTING DOCUMENTATION MAY BE REQUESTED TO VERIFY YOUR AUTHORITY (ie power of attorney, adoption orders, custody orders, etc).

_____
_____
_____
_____

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DISCLOSURE STATEMENT - 2026

DEGREES, CREDENTIALS, LICENSES

I am a Licensed Professional Counselor (#4480) and a Licensed Addiction Counselor (#949), authorized to practice psychotherapy in Colorado by the Department of Regulatory Agencies. I hold a Bachelor's degree in Psychology from Louisiana State University (1997) and a Master's degree in Counseling Psychology from The University of Colorado Denver, with an emphasis in family therapy (2004).

I have been practicing psychotherapy since 2004, as well as providing mental health clinical supervision since 2013. I have been practicing addiction counseling since 2012, and addiction clinical counseling supervision since 2016.

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions or complaints may be addressed to:

The Board of Licensed Professional Counselors Examiners
The Board of Licensed Addiction Counselors Examiners
1560 Broadway, Suite 1350
Denver, Colorado 80202
(303) 894-7800
www.dora.state.co.us/reg_investigations/file_complaint.htm

REGULATION OF PSYCHOTHERAPISTS AND ADDICTION COUNSELORS PURSUENT TO C.R.S. 12-43-214

1. A Registered Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

2. A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience. A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam. A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam. A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.

3. A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work. A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination in social work.

4. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.

5. A Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one year post-doctoral practice, and pass an exam in marriage and family therapy.

6. A Licensed professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in in professional counseling.

7. A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.

CLIENT RIGHTS AND OTHER IMPORTANT INFORMATION

1. You are entitled to receive information from me about the methods of therapy, the techniques used, the anticipated duration of therapy, and the fee structure.

2. You can seek a second opinion from another therapist or terminate therapy at any time in a professional relationship.

3. Sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

4. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, as well as other exceptions in Colorado pursuant to C.R.S. 12-43-218, and the NOTICE OF PRIVACY PRACTICES provided:

    a. Mental health and addiction counselors and professional are required to report child and/or elder abuse to law enforcement or child welfare authorities pursuant to C.R.S. 18-65-108.
    b. Persons who are deemed "imminent" risk to themselves due to mental illness or grave disability must be evaluated and may be reported to Law Enforcement or other appropriate professional/medical staff to ensure safety pursuant to C.R.S. 27-65-105. Mental Health and Addiction Counseling professionals are also mandatory reporters of imminent threats to harm others. Knowledge of a threat to harm another person, building or entity must be reported to Law Enforcement and the identified target of said threat.
    c. Records may have to be released in response to a court order from a judge.

5. If I have concerns related to a client's safety due to a mental health or substance related crisis, I may involve Law Enforcement/Emergency Medical Staff to conduct a welfare check to ensure no imminent risk exists to self or others, and to ensure a client does not need evaluation for grave disability pursuant to C.R.S. 27-65-105.

6. I do not engage in direct social media with clients due to HIPPA and privacy concerns.

7. My cell phone # 970-846-3441 is available for emergent needs. Texting is an easy way to schedule appointments, though I cannot guarantee 100% confidentiality through texting. There are times when I may not be in cell phone range, limiting my availability. By signing this disclosure, you understand that I cannot guarantee 24 hr availability. Should a mental health or substance related crisis emerge, and I am not available/do not respond to a crisis call within 5-10 minutes, please present to the nearest Emergency Department or contact Colorado Crisis Services at 844-493-8255, or 911.

8. Clients have the right to have copies of this document.

9. I legally cannot use telehealth to provide counseling outside of the state of Colorado.

10. Under C.R.S 14-10-123.8 parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information.

11. Persons 15 years of age or older may seek psychotherapy without consent from their parent or guardian. Persons of any age may seek substance specific therapy without parental or guardian consent.

12. ATTENDANCE - By signing this you understand that clients are expected to give me 24 hour notice if they are unable to attend a scheduled appointment (barring emergency or illness). I reserve the right to charge for my time if an appointment is canceled the day of, or missed without any communication. Appointments will be considered missed and subsequently canceled if a client shows up later than 15 minutes after the scheduled hour. If an initial (first evaluation) appointment is scheduled and missed without communication, no subsequent appointments will be scheduled and referrals will be giving to seek services elsewhere. If a person misses/no shows for 2 appointments without communicating, it is my policy to discharge them from my caseload (barring safety concerns). ALL CLIENTS MUST BE SOBER TO ATTEND SESSIONS.

13. I can provide a treatment summary to any client or parent who requests this. I do not however as a general practice release specific session notes. Releases of information must be signed by a client or legal guardian to provide a treatment summary to another entity or agency (ie Primary Care Physician, Probation Officer, etc).

14. I do not provide any child custody or divorce/separation recommendations. Other professionals may be enlisted or assigned by the court to provide this if it is needed. I may at times testify as an expert regarding other areas of treatment if requested and/or subpoenaed. This would only be within my scope of practice including mental health and addiction counseling. Testimony hourly fees and other related travel expenses would apply. Releases of information must be in place for HIPPA for mental health and 42CFR for substance related information or testimony to be given in court.

15. Regarding fees for services, my rates are as follows:

    a. I charge by the "therapy hour" (50 minutes session) for my services. My fee is $175.00 per therapy session/hour. Sliding fees can be arranged based on need.
    b. I am qualified to conduct substance/mental health specific evaluations and submit subsequent court reports upon request. This process involves a diagnostic evaluation, biopsychosocial assessment, screening and time devoted to writing reports, with treatment/appropriate level of care recommendations. Releases of information must be in place for information to be released to any party/entity. The cost is $400.00 for completion of the evaluation and report. Insurance carriers will not cover this. If you are scheduling an evaluation of this kind, by signing this, you also agree not to hold Craig Thornhill, LPC, LAC or Thornhill Counseling, LLC liable for any subsequent court orders related to your case.
    c. I am able to bill the following insurance providers: Anthem, Aetna, Cigna and United/Optum/UMR. A copy of a patient's insurance card will be needed to submit insurance claims. Submission of an insurance claim is no guarantee of payment by the insurance carrier. Some plans require up-front payments until a deductible is reached, while others may require a copay at the time of service. If a client's insurance denies any claims for services, by signing this, the client acknowledges they will be subsequently responsible for payment.
    d. If a client is here with an identified funding source for treatment such as REPS or the Department of Human Services, an active release of information must be signed and sustained for billing purposes with the referring/funding agency or party.
    e. I am able to accept credit cards for payment of services at this time (Visa, Mastercard, Discover, and American Express, as well as some Health Savings Account "HSA" cards).
    f. Checks can be made out to Thornhill Counseling, LLC.

g. If the above fees are not financially manageable for clients, please speak directly to Craig Thornhill about a possible fee adjustment. Any sliding fee adjustments would be based on a client's ability to pay on a case-by-case basis.
h. Fees are subject to change at yearly intervals (January 1st).
i. Receipts for all claims and financial transactions are kept in each client's file. Copies of any receipt can be given to clients upon request.
j. Fees for services, copays etc are due at the date of service. Unpaid balances must be settled prior to scheduling future appointments (barring potential safety risk assessment to self or others).
k. Surprise Billing Disclosure
    i. As of January 1, 2022, Colorado state law protects you from "surprise billing," or "balance billing."
    ii. What is surprise/balance billing? If you are seen by a health care provider that is not in your health insurance plan's provider network, referred to as "out-of-network," you may receive a bill for additional costs associated with that care, above what may be covered by insurance. Colorado law protects patients from any surprise or balance billing if they receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or you unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado.
l. By signing this you agree to allow Craig Thornhill, LPC, LAC to use your personal health information for billing/insurance/claim submission and recoupment purposes.

16. COVID19 related disclosure:
    a. Craig Thornhill, LPC, LAC / Thornhill Counseling, LLC will abide by and follow all public health orders and risk mitigation efforts in the office space at 810 Lincoln Ave, Suite 200, Steamboat Springs, CO 80487.
    b. By signing this the client, or client representative, acknowledges that there may be inherent risks associated with COVID-19 and any in-person/in-office contacts. Subsequently, they agree to voluntarily assume any risk of exposure or infection associated with COVID-19, and agree to not hold responsible Craig Thornhill, LPC, LAC/Thornhill Counseling, LLC for any infection or harm that may have resulted from in-person contacts at the office space identified above. They also agree not to hold Craig Thornhill, LPC, LAC/Thornhill Counseling, LLC responsible for any infection or harm due to infection from COVID-19 associated with contact from other persons or providers' clients who may also be in the same building common suite spaces.
    c. By signing this you agree to not attend any in person meetings if you are displaying any fever, sore throat, or other COVID-19 Centers for Disease Control identified symptoms. Craig Thornhill, LPC, LAC agrees not to charge any clients for sessions that were canceled due to this reason.

RECORDS MANAGEMENT

Mental health professionals are required to maintain records of the people they serve, 18 years of age and older, for a period of ten (10) years from the date of termination of services. Under Colorado law (C.R.S. 12-43-224), if you feel we have violated the law regarding maintenance of records for an individual 18 years of age and older, you must file your complaint or other notice with the Division of Professions and Occupations within seven (7) years after you discover or reasonably should have discovered the violation. All records will be maintained as required under Colorado law. Please be advised that records for an individual 18 years of age and older may not be maintained after the ten-year period. Other relevant information related to how records are managed are included in the NOTICE OF PRIVACY PRACTICES provided.

PLEASE KEEP ALL OF THE ABOVE PAGES FOR YOUR RECORDS:

ONLY RETURN THIS SIGNATURE PAGE PLEASE.

I HAVE READ THE DISCLOSURE STATEMENT FOR CRAIG THORNHILL, LPC, LAC. BY SIGNING BELOW I ACKNOWLEDGE I UNDERSTAND MY RIGHTS AS A CLIENT, OR AS THE CLIENT'S RESPONSIBLE PARTY, ENTERING SERVICES WITH CRAIG THORNHILL, LPC, LAC/THORNHILL COUNSELING.

_____

CLIENT'S SIGNATURE **DATE**

_____

CLIENT'S PRINTED NAME

IF CLIENT IS A MINOR (BELOW THE AGE OF 18), SEE BELOW:

_____

SIGNATURE OF PARENT/GUARDIAN/OR PERSONAL REPRESENTATIVE **DATE**

_____

GUARDIAN OR LEGAL REPRESENTATIVE'S PRINTED NAME

IF YOU ARE SIGNING AS LEGAL GAURDIAN OR REPRESENTATIVE, PLEASE EXPLAIN THE AUTHORITY YOU HAVE FOR THIS INDIVIDUAL. SUPPORTING DOCUMENTATION MAY BE REQUESTED TO VERIFY YOUR AUTHORITY (ie power of attorney, adoption orders, custody orders, etc).

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPPA)

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal law that is designed to protect the privacy of patient information, provide for electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. A piece of this law known as the HIPPA Privacy Rule creates federal standards for the use and disclosure of Protected Health Information (PHI) by health organizations. One of the requirements of the Privacy Rule is that we give you a **NOTICE OF PRIVACY PRACTICES**, which describes your rights and protections regarding your health care records.

There are instances in which we may be permitted or required to use and disclose health and treatment information about you. You should be aware that you have certain rights regarding the use and disclosure of health and treatment information.

HOW I MAY USE OR DISCLOSE YOUR HEALTH AND TREATMENT INFORMATION ABOUT YOU

We use and disclose health and treatment information about you for the following reasons:

For Treatment: We may use or disclose PHI with those involved in your care for the purpose of providing, coordinating, or managing your health care and related services. This may include consultation with clinical supervisors or other treatment team members. Other disclosures would only occur with your authorization.

For Payment: We may use and disclose health and treatment information (PHI) about you so that we may bill for the services you receive and collect from appropriate payers or their designated representatives. Only the minimum amount of PHI would be provided in collection services for lack of payment needed for the purposes of collection.

For Health Care Operations: We may use and disclose health and treatment information about you for the purposes of supporting our business included but not limited to case management, quality assessment, employee review activities or licensing related activities.

Your Authorization: We must by law provide disclosures of your PHI upon your request. This may be done through written authorization to disclose your PHI to any other entity for any purpose. Authorizations may also be revoked at any time. Without your written authorization, we cannot use or disclose your PHI for any reason other than described in this notice.

Individuals Involved in Your Care: We may release health or treatment information about you to a family member actively involved in your care with your written authorization, or as allowed by Colorado law (CRS 27-65-121 and 27-65-122).

Verbal Permission: We may provide PHI to a requested entity with your verbal permission until such time as a written authorization can be obtained.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Research: Under certain limited circumstances, we may use and disclose health or treatment information about you for research purposes, if you consent to such research.

Appointment Reminders: We may use and disclose information to contact and remind you that you have an appointment.

Health-Related Information or Resources: We may use and disclose information to contact you in order to tell you about other treatment-related options that may be of interest to you, such as support groups or online self-help resources.

Substance Abuse Health Information: The confidentiality of records related to the diagnosis, treatment, referral for treatment, or prevention of alcohol or drug abuse is protected by federal law (42 USC 290dd-3, 42 USC 290ee-3, and 42 CFR part 2).

HIV Information: All medical information regarding HIV is kept strictly confidential and is released only in accordance with the requirements of state law (C.R.S. 25-4-1405[2013]).

Rights of Minors: All provisions of the Privacy Notice apply to parents, legal guardians, or other persons authorized to act on a minor's behalf, with certain exceptions.

Federal and state laws allow or require we disclose health or treatment information about you, without your written authorization, in certain special circumstances, including:

Public Health Risks (Health and Safety for You and/or Others): We may disclose health information about you for public health activities, when necessary, to prevent a serious threat to your or others' health and safety.

Health Oversight Activities: We may disclose health information about you to a health oversight agency for activities authorized by law, such as audits, investigations, inspections or licensure.

Lawsuits, Legal Actions, and Disputes: If you are involved in a lawsuit or legal action, we may be permitted or required to disclose health information about you in response to a court or administrative order or from a subpoena.

Law Enforcement: We may disclose health information about you if asked to do so by a law enforcement official for various reasons.

Coroners, Medical Examiners, and Funeral Directors: We may disclose information to a coroner or medical examiner.

National Security and Intelligence Activities: We may disclose health information about you in national security activities authorized by law.

As Required By Law: We will disclose health information about you when required to do so by federal, state or local law.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care, upon written request. Your request to inspect and copy your information may be denied in certain limited circumstances.

Right to Amend: If you feel that any health information we have about you is incorrect or incomplete, you may ask us to amend the information. You must provide a reason supporting your request. We may deny your request for various reasons.

Right to an Accounting of Disclosures: You have the right to request an accounting or list of disclosures of health information made about you.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you, however, we are not required to comply with your request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at a certain telephone number or address. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have the right to receive a written copy of this Notice.

Other Uses: Other uses and disclosures of health information not covered by this Notice or the laws that apply to mental health and substance abuse providers will only be made after you have given your prior written authorization. If you provide us with such a written authorization, you may revoke it, in writing, at any time, and we will no longer use or disclose information for the reasons covered in your prior authorization. However, when you revoke an authorization, we are unable to take back disclosures made in accordance with the authorization while it was in effect.

Assistance and Complaints
If you wish to have more information about our privacy practices or have any questions or concerns, please contact us at the contact information provided in the end of this document.

If you have concerns we may have violated any of your rights regarding PHI, or your disagree with a decision we have made about access to your health information or in response to a request you made to amend or restrict the use of your PHI or requests to have us communicate by alternative means or locations, you may complain to us at the identified contact information below, or to The Secretary of Health and Human Services at 200 Independence Ave, Washington DC, 20201, or by calling 202-619-0257. We will not retaliate in any way against you for making a complaint.

Effective date of this privacy notice is January 29, 2019.

Contact Information:
Craig Thornhill, LPC, LAC
PO Box 770147
Steamboat Springs, CO 80477
810 Lincoln Ave.
970-879-7637 office / 970-871-7637 fax
cthornhillcounseling@gmail.com

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ONLY RETURN THIS SIGNATURE PAGE.

I HAVE READ THE PRIVACY POLICIES FOR CRAIG THORNHILL, LPC, LAC. BY SIGNING BELOW I ACKNOWLEDGE I UNDERSTAND MY RIGHTS AS A CLIENT, OR AS THE CLIENT'S RESPONSIBLE PARTY, ENTERING SERVICES WITH CRAIG THORNHILL, LPC, LAC/THORNHILL COUNSELING.

_____

CLIENT'S SIGNATURE **DATE**

_____

CLIENT'S PRINTED NAME

IF CLIENT IS A MINOR (BELOW THE AGE OF 18), SEE BELOW:

_____

SIGNATURE OF PARENT/GUARDIAN/PERSONAL REPRESENTATIVE **DATE**

_____

GUARDIAN OR LEGAL REPRESENTATIVE'S PRINTED NAME

IF YOU ARE SIGNING AS A LEGAL GAURDIAN OR REPRESENTATIVE, PLEASE EXPLAIN THE AUTHORITY YOU HAVE FOR THIS INDIVIDUAL. SUPPORTING DOUCMENTATION MAY BE REQUESTED TO VERIFY YOUR AUTHORITY (ie power of attorney, custody orders, adoption orders, etc).

_____

_____

_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy*?					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family in trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	○	○
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ○ No problem ○ Minor problem ○ Moderate problem ○ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL; et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.