Jocelyn A. Lee, Ph.D.
Licensed Psychologist Florida PY8089
2653 SW 87th Drive, Suite A
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PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship entered by therapist and client with the goal of bringing about change for the client. Each of us, in these roles, has certain rights and responsibilities. I believe that it is very important to define our respective rights and responsibilities so that we can form a relationship that creates a safe and supportive foundation for making the changes that you want to make.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific exceptions outlined below, you have the right to the absolute confidentiality of your therapy. I cannot and will not tell anyone else of the things that you have told me, or even that you are in therapy with me. To release any information about you, I would need your written permission. You may ask me to share information about you with anyone you choose and you may revoke this permission at any time. Even when I have your written consent to release information, I will still protect your privacy and use my best judgment in sharing only information relevant to that person or that request. There are times that I may consult with professional colleagues to gain greater insight about my work with you. When I do this, I will not share your name or any other information that might identify you.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you are abusing or neglecting a child or a disabled or elderly adult, or if you give me information about someone else who is, I am required by law to report this to the Department of Health and Rehabilitative Services.

2. If I have good reason to believe that you are intending to harm another person, I am legally allowed to take actions that I deem appropriate to protect/warn that person (i.e., call the police, inform the victim).

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and inform those whom I believe could be of assistance to you (i.e., a family member, Alachua County Crisis Center). I will explore all other options with you before doing this.

4. If you are involved in a lawsuit or legal complaint and you bring up the question of your mental health, it is very likely that your attorney or opposing attorney will want access to your records. I will not release them without your written consent or unless I am issued a court order to do so. Please let me know if you are in this kind of situation so that we can discuss how to best maintain your privacy.

5. Please see attached HIPAA statement regarding use of your protected health information.

II. Record-keeping

I keep written records that include any forms that you complete for me, brief summaries of each of our sessions, and any other documents that are relevant to your treatment. While the physical record belongs to me, the content of the record belongs to you, and you may ask at any time about the content of your record. I keep them in a secure location in my office. I am required by law to keep these records for 7 years after our last

contact. They will be destroyed after 7 years.

If a third party, such as an insurance company, is paying for part or all of your therapy, it is likely that I will be required to give you a diagnosis. The diagnoses that I will use come from a book called the DSM-IV. I will share this information with you at your request, and I will be glad to talk with you about the implications of diagnosis.

III. Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I have done something and am willing to explore other alternatives that might work better for you. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

Therapy does have potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful, and I will do what I can to help you minimize risks and maximize positive outcomes.

If I am not, in my judgment, able to help you, either because of the kind of problem you have or because my training and skills are not sufficient, my ethics require that I inform you of this fact and refer you to another therapist who can meet your needs. I would continue to meet with you until you had established a relationship with a new therapist, and I would assist you in finding this person.

Unless we have arranged otherwise, I am generally not available outside of office hours. If you are experiencing extreme distress and are unable to reach me through the office, you may call the Alachua County Crisis Center at 352-264-6789. The Crisis Center has people available 24 hours a day and is an excellent supportive resource.

Your Responsibilities as a Therapy Client

I. You are responsible for playing an active part in your therapy. You will participate in setting the objectives and goals of your treatment and in each stage of the therapy process.

II. You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours notice, you must pay your session fee before or at our next regularly scheduled meeting. Missed sessions cannot be billed to insurance, so you will be responsible for these payments.

III. You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. Please see attached financial agreement for my fee schedule.

IV. If you have insurance, you are responsible for providing the information needed to submit your bill. You must pay your deductible, if this applies, and any co-payment. You must arrange for any pre-authorizations necessary. If an insurance check is mailed to you, you are responsible for paying that amount at the time of our next appointment.

V. If you are having a hard time paying for therapy, please discuss it with me. I have a percentage of slots available on a sliding scale, and if one of those is open, I would make it available. Or, we may meet less frequently. If your financial circumstances improve, please let me know so that I could make that sliding scale slot available to someone else.

VI. If you are unhappy with what is happening in therapy, I hope you will talk about it with me so that I can respond to your concerns. I will take such criticism seriously. If you believe that I have behaved unethically, you can complain about my behavior to either the Ethics Committee of the American Psychological Association, 750 1st Street NE, Washington DC 20002-4242, or the Florida Agency for Health Care Administration, Consumer Services Unit (complaint forms are available at www.doh.state.fl.us/mqa/ or by calling 850-414-7209).

Client Consent to Therapy

I have read this statement and have had the chance to ask any questions that I needed to, and I understand it. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Jocelyn A. Lee, Ph.D. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Dr. Lee.

Signed:_____ Date:_____

Therapist signature:_____

Notice of Privacy Practices

For the Independent Practice of Jocelyn A. Lee, Ph.D.

Privacy and confidentiality have always been important to each of the practitioners of this office. Privacy is regulated by federal and state government, as well as by professional organizations. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) updates privacy regulations for the increasing use of computers in health care and sets a minimum national standard for privacy of records. HIPAA requires everyone to receive a privacy notice, like this, but will change many of the familiar practices because these are mandated by stricter federal and state laws.

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your treatment provider may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent to this document. To help clarify these legal terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you and must be protected.
- 'Treatment, Payment and Health Care Operations"
  - Treatment means to provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be to consult with another health care provider, such as your family physician or another mental health provider. Under most circumstances uses of PHI for treatment purposes will first be explained and discussed with you, so that your concerns and preferences can be taken into consideration.
  - Payment means obtaining reimbursement for your healthcare. Common examples of disclosing PHI for payment are disclosure of your PHI to your health insurer to obtain reimbursement for your health care or to determine your eligibility or coverage. Most insurers want to know your diagnosis and the type of treatment you are receiving before they will pay for the treatment.
  - Health Care Operations are activities that relate to the performance and operation of a practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination. If you prefer not to be reminded of your appointments by mail or telephone, please tell your provider or the office staff.
- "Use" applies only to activities within this office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of this office such as releasing, transferring or providing access to information about you to other parties

Your treatment provider will use or disclose the least amount of information necessary to accomplish the goal of the use or disclosure.

II. Uses and Disclosures That Require Your Authorization

Your treatment provider may use or disclose PHI for purposes other than for treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your treatment provider is asked for information for purposes outside of treatment, payment, and health care operations, your authorization is necessary to release this information. If your treatment provider keeps psychotherapy notes, these are kept separately from the rest of your record and are given a greater degree of protection than your PHI. "Psychotherapy notes" are notes made about conversations occurring during a private, group, joint, or family counseling session.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization after your treatment provider has already acted on it or if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

III. Emergencies

Please make your preferences regarding emergency notifications known to your treatment provider.

IV. Uses and Disclosures with Neither Consent nor Authorization

Your treatment provider may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: Any information or suspicion that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, by law must be reported to the Florida Department of Children and Families.

- Adult and Domestic Abuse: Any information or suspicion that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, by law, must be immediately reported to the Florida Abuse Hotline (1-800-962-2873).

- Health Oversight: If a complaint is filed against your treatment provider with the Florida Department of Health, the Department has the legal authority to subpoena confidential mental health information relevant to that complaint. Your treatment provider could be asked to release information to governmental agencies that check on whether privacy laws are being obeyed.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and will not be released without a written authorization from you or your legal representative, or a court order, or a subpoena of which you have been properly notified and you have failed to inform your treatment provider that you are opposing the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety: If you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, your treatment provider may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities. Your treatment provider will talk to you in situations when public health authorities encourage or require confidential reporting of dangerous or defective products, as well as of diseases that can be easily spread between people. Law enforcement officials have the right to request and receive protected health information when they are investigating a crime, a criminal, or a missing person. If you disclose information about illegal activity during a psychotherapy or counseling session, or in the course of treatment for this sort of behavior, we may not disclose that information to law enforcement officials.

- Worker's Compensation: If you file a worker's compensation claim, your treatment provider must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

V. Patient's Rights and Provider's Duties

Patient's Rights:

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, your treatment provider is not required to agree to a restriction you request. You will be notified, in writing, if your requested restriction or other privacy request cannot be accommodated, and why not.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are receiving treatment. Upon your request, your bills can be sent to another address.)

- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in your treatment provider's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, your treatment provider will discuss with you the details of the request process. In the rare event that your treatment provider has a strong reason to object to your access, an alternative solution will be sought.

- Right to Amend - You have the right to request an amendment of your PHI for as long as the PHI is maintained in the record. Your treatment provider may deny your request. If your record cannot be amended, you may write a statement of disagreement that will be maintained in your record. On your request, your treatment provider will discuss with you the details of the amendment process.

- Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI regarding you. This accounting does not include uses and disclosures of information for the purposes of treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures that fulfill an authorization signed by you; relevant uses or disclosures made to family or friends who are involved in your care or in paying for your care; or uses or disclosures needed to notify family or friends of your location or condition. On your request, your treatment provider will discuss with you the details of the accounting process.

- Right to a Paper Copy - You have the right to a paper copy of the notice, even if you have agreed to receive the notice electronically.

Provider's Duties:

- Your treatment provider is required by law to maintain the privacy of PHI and to provide this notice of her legal duties and privacy practices with respect to PHI.
- Your treatment provider reserves the right to change the privacy policies and practices described in this notice. Unless you are notified, in person or by mail, of such changes, the terms currently in effect will prevail.
- If your treatment provider does revise any policies or procedures, you will be notified in writing, in person or by mail, at the most recent preferred address that you have provided to the office staff.

VI. Complaints

If you are concerned that your treatment provider has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact your treatment provider at Haile Market Therapy and Behavioral Medicine, 2653-A SW 87th Drive, Gainesville, FL 32608 or (352) 331-0020. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. We promise that we will not in any way limit your care or take any actions against if you file a complaint.

VII. Effective Date, Restrictions, and Changes to this Privacy Policy

This notice will go into effect on July 15, 2003. In the future, the terms of this notice may need to be changed, creating new notice provisions effective for all PHI currently maintained. If a change is made, it will be posted in the waiting room and you will be provided a copy of the revised notice at your request.

FINANCIAL AGREEMENT

Dr. Lee's Initial Diagnostic Interview	$175.00
Dr. Lee's 45-minute psychotherapy session	$150.00
Dr. Lee's 25 minute psychotherapy session	$ 75.00

PLEASE NOTE:

Time for phone calls to coordinate care with your other providers will need to occur as part of your therapy session time (prior to the start, during or at the end of your session). If during your treatment, you need written documentation from me, this will need to occur during your session. Alternatively, additional activities that you'd prefer or that need to occur outside of the session will be billed at the rate of $150/hr. **Insurance does not cover these costs.**

PLAN A: Cash payments of fees

1.) If I file my own insurance or do not have insurance that covers psychotherapy, I will pay the full fee to Dr. Lee on the day that services are rendered.

2.) I AGREE TO PAY THE FULL FEE FOR MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE. Payments must be made before or at the time of the next appointment.

3.) If I do not honor this financial agreement and develop an outstanding balance, I will pay the charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive the right to confidentiality for purpose of collection of the said fee. Any reasonable attorney fees and costs incurred by Dr. Lee for the collection of the past due account shall be my obligation as well.

PLAN B: Cash plus insurance payment of fees

I authorize the release of medical records and diagnostic information necessary to process this claim. I also authorize any payment of medical benefits to the above referenced provider for services rendered. However, it must be fully understood that the contract is between me and my insurance company and I am fully responsible for any amount not paid by my insurance.

1.) **I will submit to the office my co-payment on THE DAY OF MY SESSION.** Dr. Lee will file my insurance and any insurance payments received are to be deducted from the balance of my account.

2.) The office does not guarantee that my insurance company will pay. They will make every attempt at the beginning of my health care to receive verification of my policy and what it covers. However, if for some reason, my insurance claim is denied, or payments are requested to be refunded, I am responsible for the full amount of my bill.

3.) The office will not enter into a dispute with my insurance company regarding my claim. This is my responsibility and obligation.

4.) If my mental health insurance benefits are exhausted within a calendar year, I will be responsible for paying Dr. Lee her full fee until my benefits renew at the beginning of the next year.

5.) I AGREE TO PAY THE FULL FEE FOR ALL MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE**.** Payments must be paid before or at the time of the next appointment.

6.) If I do not honor this financial agreement and develop an outstanding balance, I will pay the charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive the right to confidentiality for purpose of collection of the said feel. Any reasonable attorney fees and costs incurred by Dr. Lee for the collection of the past due account shall be my obligation as well.

I understand and agree with all of the above office policies.

I will pay today by: (circle one) CASH CHECK CREDIT CARD

_____ Plan A or B _____

Signature Date

Jocelyn A. Lee, Ph.D.
Licensed Psychologist
Florida License PY8089

_____ _____
Last Name First Name Middle Initial Birthdate

_____
Street Address Apt. #

_____
City State Zip Code
Okay to send correspondence to this address? Y N

Phone Numbers:	Okay to call?		Okay to leave message?	
Home: _____	Y	N	Y	N
Work: _____	Y	N	Y	N
Cell: _____	Y	N	Y	N

Gender: _____

Race: □ Caucasian □ African Descent □ Native American
□ Asian/Pacific Islander □ Multiracial _____
□ Hispanic/Latino/a □ Other_____

Are there other ways that you identify yourself? (i.e., religious affiliation, sexual orientation, cultural identity, ability, etc.) _____
_____

Referred by:_____

CLIENT INTERVIEW

Please list the reasons/concerns that brought you here today.

_____

_____

_____

Completion of the following information will provide a thorough background in better understanding your concerns.

EDUCATIONAL/OCCUPATIONAL HISTORY

What is the highest level of education you achieved? (i.e. GED, high school diploma, BS, PHD) _____

From what institution (i.e. school, university) did you receive your highest degree?
_____

Are you currently employed? (circle one) YES NO

If yes, please describe your position and work _____

_____

If yes, how satisfied are you with your current employment?_____

Please indicate your history of previous employment

Positions ***starting with most recent**	**Month and Year**
	From: To:
	From: To:
	From: To:

Did you have any significant academic, behavioral or social difficulties growing up?

(circle one) YES NO

*If yes, please describe*_____

_____

_____

FAMILY HISTORY

The following is a checklist of characteristics or conditions that may run in families. Please put an X in the column if any of your family member(s) have or have had each characteristic or condition. If more than one brother or sister has or has had one of these characteristics or conditions, put an X for each one in the appropriate column (for example, if there were two brothers who had trouble with learning how to read, you would put two X's next to that item under the column "Brother(s)."). The "Others" column (for family members such as cousins, aunts, uncles, grandparents) should be used in the same way.

FAMILY HISTORY	Mother	Father	Brother(s)	Sister(s)	Others (specify)
Hyperactive/Attention problems					
Learning difficulties (reading/writing/math)					
Held back in school (retained in a grade)					
Speech problems					
Behavior problems					
Mental Retardation					
An honor student					

Legal problems due to conduct					
Depression or manic depression					
Drug or alcohol problems					
Tics, movement disorders					
Obsessive Compulsive Disorder					
School avoidance, phobias, panic attacks					
Eating Disorder					
Chronic or significant health problems					

Father: Name: _____Marital Status: Single/Married/Divorced/Widowed/Remarried

Father's present age _____ School level/Occupation_____

Mother: Name: _____Marital Status: Single/Married/Divorced/Widowed/Remarried

Mother's present age _____School level/ Occupation_____

Siblings: please circle brother or sister

Brother/Sister's Name: _____Present age _____School level/Occupation_____

Brother/Sister's Name: _____Present age _____School level/Occupation_____

Spouse/Partner: Name: _____Age _____School level/Occupation_____

Length of Relationship _____ circle one: married/lifetime partner living together dating

Children:

Additional family members (including adult children or close, extended family):

Name: _____Present age _____ School level/Occupation_____

Name: _____Present age _____ School level/Occupation_____

List everyone with whom you currently live.

_____

NOTE: If you do not live with your family of origin (i.e. parents, brother, sister, adult children), please describe your current relationships with them: _____

_____

MEDICAL HISTORY

Please rate your overall health (excellent, good, fair, poor)_____

Please list any history of chronic illness, hospitalizations, accidents/injuries/head injuries, loss of consciousness (date and nature of each)_____
_____
_____

Please list any regular medications: _____

If you take prescription medications, who is your prescribing physician? _____

Please describe your habits:

Do you use nicotine? _____ If so, how much (#cig./pack per day)_____
Do you use alcohol? _____ If so, how much (#drinks per day/week/month)_____
Do you drink caffeine (tea, coffee, cola)? _____ If so, how much (#8oz. cups/day)_____
Do you use illicit substances? _____ If so, what, how much, and how often_____
_____

PSYCHOSOCIAL HISTORY

How would you describe your relationships with other people at school/work, at social gatherings, in the neighborhood, etc? (i.e. close, pleasant, awkward, distant, tense):_____
How many close friends do you have and how often do you socialize with friends?_____

_____

Have you experienced any recent events you would consider especially stressful (i.e. health problems, job changes, moving, relationship difficulties, etc.).? (circle one) YES NO

*If yes, please describe*_____

_____

Have you ever experienced any of the following? Please circle any that apply.

Emotional abuse by a partner Physical abuse by a partner Sexual Assault

Emotional abuse as a child Physical abuse as a child Sexual Molestation as a child Incest

Have you ever experienced any events you would consider *traumatic or life endangering* (i.e. tornado, fire, car accident, etc.).? (circle one) YES NO

*If yes, please describe*_____

_____

Describe your *general* mood over the last few months. (Any ongoing difficulty with crying spells, seeming sad, anxious, unhappy or depressed?)

_____

Do you have any of the following sleep problems:

	NO	YES	If yes, please indicate duration and nature of problem including ***how often (____times/night, ____times/week).***
Can't fall asleep			
Wake up in the middle of the night			Usual time(s) of arousal:
Wake up too early in the morning (When: am)			
Restless sleeper (move around excessively during sleep)			
Very hard to wake up			
Nightmares			
Snore			
Fall asleep or get drowsy at school/work			

Describe your energy level. _____ Describe your appetite. _____

Has your appetite changed recently? Have you gained or lost a significant amount of weight recently?

_____

How satisfied are you with your weight and appearance? (Use back of page if necessary)_____

_____

Have you had feelings of hopelessness in the last few months? (circle one) YES NO

Have you had any thoughts about harming yourself or others? (circle one) YES NO

*If yes to either above, pleaseexplain*_____

Have you had any experience with prolonged (a day or more) periods of intense energy, which may include a significant decrease in sleep, feeling much more talkative or restless than usual, starting many projects at once?

(circle one) YES NO

Have you had any experience with prolonged (a day or more) periods in which you engage in more risk-taking behavior (i.e. hypersexed, spend large amounts of money) than is typical? Or feel extremely grand, powerful?

(circle one) YES NO

*If yes to either above, please explain*_____

Have you been troubled by seeing or hear things you know are not real? (circle one) YES NO

If yes, please explain _____

Have you had episodes of significant anxiety or worries? (circle one) YES NO

Have any had any significant difficulties with fears or phobias? (circle one) YES NO

If yes to either above, please explain _____

_____

Have you had any legal difficulties (i.e. arrests, probation, etc.)? (circle one) YES NO

*If yes, please describe*_____

Do you now or have you ever engaged in any self-harming behaviors? (circle one) YES NO

*If yes, please describe nature and frequency*_____

_____

Have you ever participated in individual, family or group counseling? (circle one) YES NO

If yes to either, when, with whom, and what was the outcome of this? _____

_____

What do you consider to be your strengths?_____

_____

Do you have any religious or spiritual beliefs or practices? If so, please describe _____

_____

Please list any strong interests/hobbies (i.e. what do you like to do for fun?) _____

_____

Is there anything else you think is important that I should know about you? _____

_____

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐
f. Headaches	☐	☐	☐
g. Chest pain	☐	☐	☐
h. Dizziness	☐	☐	☐
i. Fainting spells	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐
k. Shortness of breath	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. Questions about anxiety.		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question #5.			
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. Think about your last bad anxiety attack.		NO	YES
a.	Were you short of breath?	☐	☐
b.	Did your heart race, pound, or skip?	☐	☐
c.	Did you have chest pain or pressure?	☐	☐
d.	Did you sweat?	☐	☐
e.	Did you feel as if you were choking?	☐	☐
f.	Did you have hot flashes or chills?	☐	☐
g.	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h.	Did you feel dizzy, unsteady, or faint?	☐	☐
i.	Did you have tingling or numbness in parts of your body?...	☐	☐
j.	Did you tremble or shake?	☐	☐
k.	Were you afraid you were dying?	☐	☐

5. Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐
If you checked "Not at all", go to question #6.				
b.	Feeling restless so that it is hard to sit still.	☐	☐	☐
c.	Getting tired very easily.	☐	☐	☐
d.	Muscle tension, aches, or soreness.	☐	☐	☐
e.	Trouble falling asleep or staying asleep.	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐
g.	Becoming easily annoyed or irritable.	☐	☐	☐

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

	NO	YES
6. Questions about eating.		
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.		
c. Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

	NO	YES
7. In the last 3 months have you often done any of the following in order to avoid gaining weight?		
a. Made yourself vomit?	☐	☐
b. Took more than twice the recommended dose of laxatives?	☐	☐
c. Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

	NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

	NO	YES
9. Do you ever drink alcohol (including beer or wine)?	☐	☐
If you checked "NO" go to question #11.		

	NO	YES
10. Have any of the following happened to you more than once in the last 6 months?		
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c. You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d. You had a problem getting along with other people while you were drinking.	☐	☐
e. You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, 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
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.

	NO	YES
6. Questions about eating.		
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.		
c. Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

	NO	YES
7. In the last 3 months have you often done any of the following in order to avoid gaining weight?		
a. Made yourself vomit?	☐	☐
b. Took more than twice the recommended dose of laxatives?	☐	☐
c. Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

	NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

	NO	YES
9. Do you ever drink alcohol (including beer or wine)?	☐	☐
If you checked "NO" go to question #11.		

	NO	YES
10. Have any of the following happened to you more than once in the last 6 months?		
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c. You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d. You had a problem getting along with other people while you were drinking.	☐	☐
e. You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, 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
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.

Jocelyn A. Lee, Ph.D, LLC
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Please be kind enough to provide the following information. It would be greatly appreciated. Thank you.

How did you find out about my services?

- ❑ Referral from _____

  May I have your permission to thank them? Yes No

- ❑ Health insurance provider listing
- ❑ Brochure (From where? _____)
- ❑ Postcard (From where? _____)
- ❑ Business card (From where? _____)
- ❑ Other (Please specify) _____