

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name	First Name	Date of Birth: (mm/dd/yy)
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Subscriber ID	Authorization #	
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Clinician Last Name	First Name	Today's Date: (mm/dd/yy)
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Clinician ID/Tax ID	Clinician Phone	State
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Visit #: <input type="radio"/> 1 or 2 <input type="radio"/> 3 to 5 <input type="radio"/> Other		

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	<i>Not at All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>A Lot</i>
1. Nervousness or shakiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling sad or blue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Feeling hopeless about the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Feeling everything is an effort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Feeling no interest in things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Your heart pounding or racing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Trouble sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Feeling fearful or afraid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Difficulty at home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Difficulty socially	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Difficulty at work or school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much do you agree with the following?	<i>Strongly Agree</i>	<i>Agree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>
12. I feel good about myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I can deal with my problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I am able to accomplish the things I want	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I have friends or family that I can count on for help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. In the past week, approximately how many drinks of alcohol did you have?				Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
18. Please indicate if you have a serious or chronic medical condition:
☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Back Pain or Other Chronic Pain ☐ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ☐ None ☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? Days
(answer only if employed)
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? Days
(answer only if employed)
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ☐ Yes ☐ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

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

Name: _____ Age: _____ Sex: ☐ Male ☐ Female Date: _____

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

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past TWO (2) WEEKS , how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN , that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	



AUTHORIZATION FOR RELEASE AND ACQUISITION OF CONFIDENTIAL INFORMATION

I authorize Access Living to acquire and/or release the following information concerning:

Client Name:	Date of Birth:	Parent/Guardian Name: (if applicable)		
Address:		City:	State:	Zip:

I understand and authorize use of this information as it pertains to the assessment, diagnosis, and treatment of a psychiatric or behavioral condition through services offered by Access Living. This includes the following source or contact deemed necessary by the Access Living representative that will increase the quality of services.

I understand that this information may include material protected under federal regulations governing the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that information disclosed by Access Living pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

I understand that signing this release is voluntary and that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, unless the purpose is solely to obtain and disclose information for a third party, such as an employer.

I understand that I may revoke this release at any time, in writing, except to the extent that Access Living has already relied on it in making a disclosure. My written revocation will become effective when Access Living receives it. If I wish to revoke this release, I must submit a written request to Access Living.

This information may be ☐ acquired and/or ☐ released to/from the following:

Organization:	Individual:		
Address:	City:	State:	Zip:
Phone:	Fax:		

Date(s) of Service:

☐ All visits between the date _____ and the expiration date of this form.

☐ EXCEPTION: I do not give permission to release (please specify): _____

This authorization will expire one (1) year from date signed or until revoked by the authorized signer.

I acknowledge that I have the legal authority to authorize disclosure of protected health information about:

☐ Myself ☐ My Child ☐ My Ward (please describe): _____

I have read this authorization and I acknowledge an understanding of the purpose of the release of information. I am signing this authorization of my own free will. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

_____ Client/Guardian Name	_____ Client/Guardian Signature	_____ Date
	_____ Minor Signature (If 14 years or older)	_____ Date