

Atlanta Center for Eating Disorders
Patient Registration Information

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone# Home (____) _____ Work (____) _____ Cell (____) _____

May we leave you a message at home? _____ at work? _____ on cell? _____

Date of birth: _____ - _____ - _____ Age: _____ SS# _____ Gender: (F) (M)

Employed () Unemployed () Full-time Student () Part-time Student ()

Referred to ACE by? _____

May we thank this person for referring you? Yes No Phone# _____

If patient is under 25 years of age, please provide information for reaching each parent.

Mother's Name: _____ Cell phone: _____ Evening phone: _____

Father's Name: _____ Cell phone: _____ Evening phone: _____

Responsible Party Self Parent* Spouse Other

Name: _____ SS# _____ D.O.B. _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____

Insurance Information:

Primary Insurance: _____ Phone: _____

Insured's Name: _____ SS# _____ DOB: _____

ID# _____ Group# _____

Assignment of Benefits, Financial Agreement and Consent to Communicate with Financially Responsible Party

I hereby give lifetime authorization for payment of insurance benefits to be made directly to the Atlanta Center for Eating Disorders and any assisting practitioners, for services rendered at the Atlanta Center for Eating Disorders. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event that I default on payment of my bill, I agree to pay all costs of payment collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that this may include information from my chart. I further agree that a photocopy of this agreement shall be as valid as the original. I further authorize the Atlanta Center for Eating Disorders to communicate with the Financially Responsible Party named above regarding any billing issues.

Date: _____ Patient Signature: _____

Date: _____ Responsible Party Signature: _____

* - If divorce/custody decree states that both parents are financially responsible, please have both parents fill out separate forms and sign next to Responsible Party Signature.



4536 Barclay Drive, Suite A
458-8711
Atlanta, GA 30338

Phone: (770)

Fax: (770) 458-8640

Dear Client,

Welcome to the Atlanta Center for Eating Disorders. You are probably reading this because you have scheduled an assessment with us. We offer many different levels of care and the time you take to carefully fill out the following questionnaires will aid us in determining what level of care to recommend to you. You will also be asked to read and sign several pages of information and consents. We apologize that they are so lengthy. Some of these forms are required by the federal or state government and some have been written by us to help you understand ACE's own operating policies. We hope these forms will help you feel informed about treatment at ACE. After completing the paper work, a psychologist will meet with you to give you feedback about the results of the questionnaires and make recommendations about treatment. If you decide to participate in the program, you will also be given a Patient Handbook that describes the program and groups in more detail.

Your confidentiality and privacy is very important to ACE staff. The "Georgia Notice Form" attached, is based on the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). Health professionals are required to give you a copy of the Georgia Notice form and to get a signature from you that you were informed about the new law.

This form may be somewhat confusing but basically it is to let you know that any identifying information about you is "protected." The law states that psychotherapists are allowed to relate protected information about you only for very specific reasons and ACE always tries to operate on the "minimum disclosure necessary" rule. We will only relate information about you for the purposes of coordinating your treatment with our team, other professionals who you are seeing and for the purposes of collecting payments (see section I "notice"). If we need to relate information about you for any other purposes, we will do so only if you give us separate written authorization (see section II of "notice") or when required by law to do so (see section III). Finally, if a participant is under 18, the parent or guardian may obtain access to your PHI. For these participants, the issues of privacy should be discussed in individual and family sessions.

The other consents you will be asked to sign prior to beginning your treatment include information about billing procedures, emergency procedures and program policies.

We hope that you will ask us any questions you have about these forms and that your experience at ACE will be a rewarding one.

Sincerely,

ACE Staff

Atlanta Center for Eating Disorders Patient Emergency Medical Treatment Form

It is important to us that your health and safety is maintained at all times you or your child or loved one is here at ACE. Should a medical emergency occur during treatment at ACE, and in order to help you, your child or loved one access appropriate emergency medical services, please complete the information below so that there is no delay in responding to an emergency. **This form is a required part of your clinical paperwork and allows us to remain compliant with CARF policies.**

Date: _____ **Patient's Full/LegalName:** _____

Date of Birth: _____ **SS or License/ID #:** _____

Home Address: _____

Home Phone: _____ **Cell Phone:** _____

Significant medical problems AND HOW STAFF SHOULD REACT (eg. in case of seizure, use of Epi Pen or other responses to allergic reactions, etc):

Name, address and phone number(s) of physician(s) to be called in the event of an emergency

Name(s) and type of physician: _____

Address: _____

Phone number: _____

Other information about contacting this physician: _____

Name, address and telephone number of a relative or other person to notify:

Name(s) and relationship: _____

Phone numbers to call in order of preference: _____

Address: _____

Insurance Information:

Medical Insurance Company: _____

Policy number: _____ Group number: _____

Please provide any information ACE staff or medical professionals would need to know in the event of an emergency:

Medication allergies: _____

Current medications (prescription and over the counter, including names, strength, how and why they are taken):

Hospital preference, if any: _____

Please note any other pertinent information on the back side of this form.

Atlanta Center for Eating Disorders
4536 Barclay Drive, Suite A, Atlanta, GA 30338
(770) 458-8711 fax (770) 458-8640

Consent for Release of Information

Patient's Full Name: _____ Date of birth: _____

To the Patient: We at ACE are very conscientious about maintaining patient confidentiality while coordinating your care with others. **Please list any physicians, psychiatrists, or mental health therapists that you have seen in the last two years.** Please also list any family members with whom you think we may need to be in contact.

Professionals Seen	City	State	Phone Number	Reason

Family Members	City	State	Phone Number	Relationship

PURPOSE FOR CONSENT: To assist the ACE clinical staff in the evaluation and/or treatment of the patient's presenting concerns, to be informed of or to coordinate treatment with other health care or mental health professionals, and to facilitate continuity of care during discharge planning.

SPECIFIC INFORMATION TO BE RELEASED OR RECEIVED: The information exchanged with other health care or mental health professionals could include the following: results of psychological testing, results of medical examination or testing, diagnoses, names of other mental health care or health care providers, treatment plans, recommendations for current treatment, statement of progress in treatment, prognosis, discharge summary, and discharge recommendations.

I hereby request and/or consent for the clinical staff at ACE to release and obtain the above information regarding my dependent, or myself. I understand that this information may include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as regarding mental health treatment, mental retardation, privileged communications, communicable or infectious diseases, alcohol/drug abuse, AIDS (acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus). I also understand that I may cancel this consent at any time in writing. However, the revocation will not be effective to the extent that ACE has taken action in reliance on the consent. Unless I specify otherwise, this authorization is in effect for the duration of my treatment at ACE and it automatically expires six months after my termination of services.

The following are clinicians I have seen in the past two years or family members whom I do not give my consent for you to contact. (Please note that ACE may deny treatment in some cases when not given permission to contact other clinicians who have been or are involved in your care.)

Name Seen/Relationship	City	State	Phone Number	Reason

_____ Patient Signature	_____ Date	_____ Witness	_____ Date
_____ Parent/Guardian Signature	_____ Date	_____ Relationship to Patient	

Atlanta Center for Eating Disorders
4536 Barclay Drive, Suite A
Atlanta, GA 30338

Billing Procedures

- You will be asked to pay for your first visit at the time of your appointment. If you are admitted to the ACE program, we may submit claims for you after the first visit.
- We file insurance to your primary insurance company as a courtesy to you. If you have a secondary insurance company, it will be your responsibility to file with them. You are responsible for your bill regardless of the amount that insurance pays and you are ultimately responsible for following up with your insurance company if ACE has difficulty collecting payments. You also may choose to file your own claims. You will be expected to make payment on any deductibles or copayments at the time services are rendered.
- Some insurance companies only reimburse certain procedures or providers (i.e., may not pay for nutrition counseling or unkept appointments). If we know of limitations set by your insurance company, we will not submit claims for these particular program components. Nevertheless, you will be responsible for these charges. If your account has not been paid for more than 60 days and a payment plan has not been agreed on, ACE has the option of using legal means to secure payment.

Attendance:

- You will be given a schedule of your program which will include the time and type of session. It is very important that you attend all of your scheduled meetings. Interruptions in your treatment may slow your progress. Additionally, it is important to other group members that all scheduled members attend in order to establish trust and safety.
- You will be charged for all groups on your schedule.
- If you cannot attend, contact your individual therapist or case manager to discuss a planned absence. You will not be charged if you and your individual therapist or case manager, decide that the absence is of therapeutic benefit.
- Give a note to your individual therapist, case manager or the front office regarding the date of absence (to be posted).
- *Missed sessions with less than 24 hours notice will be **billed** as a late cancellation or unkept appointment.* Insurance companies will not pay for unkept appointments, therefore you are responsible for the fees. We will send you a statement at the time of a missed appointment. Payment is expected for missed appointments in addition to any other payment arrangements. No scholarship or patient courtesy discounts will be given for missed appointments. However, charges for an absence may be reversed if you and your case manager decide that the absence was an unforeseeable emergency.
- If, at any time, you believe that it is time to reduce or rearrange your program schedule, meet with your case manager/individual therapist to discuss your wishes. The changes will then be brought to the treatment team for consideration.

I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event that I default on payment of my bill, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that this may include information from my chart. I further agree that a photocopy of this agreement shall be as valid as the original. I give ACE my consent to release public health information requested by my insurance company for payment

Patient Signature

Date

Witness

Date

Financially Responsible Party

Date

Relationship to Patient

Atlanta Center for Eating Disorders

4536 Barclay Drive, Suite A
 Atlanta, GA 30338
 (770) 458-8711 fax (770) 458-8640

In Case of Emergency

ACE is not a medical facility. Therefore, we only admit participants that are physically safe. For this reason, we ask that you see a physician for blood work (Biochemical Profile and CBC) and that you consent to the following policy. During treatment, some patients have suicidal, self-harm or homicidal thoughts. These generally pass within hours or days if discussed in sessions. You may call ACE (770-458-8711) at any time during working hours and leave a message for your primary therapist who will make every effort to call you back before the end of the day. If you have an emergency after hours (5:30 pm - 9:30 am) or on the weekend, you may leave a message with our Answering Service (770-928-5051) for Dr. Buchanan or Dr. Kilmer.

Please read the following contract, which is required of all individuals being treated on an outpatient basis at the Atlanta Center for Eating Disorders:

- 1. I promise to talk with my individual therapist if I should have any thoughts of harming myself or someone else. I understand that for some individuals, these thoughts may be a natural part of the therapy process and are likely to pass if I talk about them.*

- 2. I understand that the ultimate responsibility for my health and therapy is my own. Therefore, I agree to give my therapist **24 hours to respond to my emergency call** before acting on any harmful impulses to myself or someone else. In the interim, I may phone a hotline for support or go to an emergency room if unable to keep myself safe.*

- 3. I understand that if I break this contract, it may result in ACE asking me to leave the program.*

I have read and understand the emergency policies and promise to abide by them.

Signature of Patient	Date	Witness	Date
Parent/Guardian Signature	Date	Relationship	

Emergency Mental Health Numbers

DeKalb	404-892-4646
Cobb	770-422-0202
Fulton	404-730-1600
Gwinnett	770-985-2494

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Procedure for Discontinuing Groups

It is very important to other group members that you do not stop coming to a group abruptly. We recommend the following procedure:

1. Make at least a one month commitment to any group that you begin. This increases group comfort and feelings of trust and helps you make a fully informed decision.
2. Mention to the group at least one week in advance, if not earlier, that you are planning to discontinue the group. Talk with the group about how you have arrived at your decision (i.e., “my eating is improved and I am reducing my schedule,” or “I have decided to discontinue this particular group for the following reason...”).
3. If your reason for discontinuing a group is not due to improvement, but to some problem you are having in the group, you will be asked to share your problem with the group, then the team will be able to support your decision to discontinue. This will certainly be beneficial to you in improving assertiveness and may improve the group as a whole. It will also prevent misunderstanding, which may be worked through with appropriate communication. If the problem cannot be solved, then you may bring up discontinuing the group. Therefore, this would involve two sessions; one to problem solve and, if ineffective, the second to wrap up and say good-bye.

These procedures are important to increase group safety and help the group adjust to a change in group structure, to help you learn how to have closure on relationships (since people come and go throughout your life), and to help you improve your assertiveness and problem-solving skills. Additionally, endings can stir up feeling of loss for other members, and these are important to work through.

Procedure for Discontinuing the Program

Following discontinuation of individual groups, you will be asked to fill out some questionnaires before leaving the program. These allow you to evaluate and give us feedback on the program. Your feedback is very important and can help strengthen the program. You will also be asked to take three short assessments so that we can identify improvements you have made in the areas of eating disorder symptoms, depression, and anxiety. Your case manager will give these to you before your last week. These assessments are the same ones you filled out in your initial assessment. If you would like, you can ask your therapist to go over these assessments with you and compare your results before and after treatment at ACE.

I understand and agree to the above policies.

Patient Signature	Date	Witness	Date
Parent/Guardian Signature	Date	Relationship to Patient	

Atlanta Center for Eating Disorders Medical History

Name: _____ Date of Birth: _____

Date of last physical exam: _____

Please use a checkmark to indicate whether or not you have had medical problems in any of the following areas. Also, please indicate if the condition is currently active or present.

Do you have a history of:	Yes	No	Current
Heart disease	_____	_____	_____
High blood pressure	_____	_____	_____
Abnormal EKG	_____	_____	_____
Pulmonary (lung)	_____	_____	_____
Tuberculosis	_____	_____	_____
Positive TB test	_____	_____	_____
Hepatitis/liver disease	_____	_____	_____
Ulcer	_____	_____	_____
Hernia	_____	_____	_____
Gall bladder problems	_____	_____	_____
Kidney/bladder disease	_____	_____	_____
Sexually transmitted disease	_____	_____	_____
Chronic infections	_____	_____	_____
HIV positive	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid disease	_____	_____	_____
Arthritis	_____	_____	_____
Back problems	_____	_____	_____
Blood disorders	_____	_____	_____
Cancer	_____	_____	_____
Disease of the colon	_____	_____	_____
Frequent headaches	_____	_____	_____
Disease of testes/ovaries	_____	_____	_____
Seizures	_____	_____	_____
Hearing problems	_____	_____	_____

Past surgery (describe): _____

History of Drug/Alcohol abuse: _____ Yes _____ No
Treatment: _____

History of psychiatric disorder: _____ Yes _____ No
Describe: _____

Treatment _____

Reviewed by Intake Clinician: _____ Date: _____

Nutrition Information Form

Name: _____ Phone: _____

Date: _____

1. Have you seen a Dietitian or Nutritionist before? _____ YES _____ NO

2. Do you still see this person? _____ YES _____ NO

Name: _____ Location: _____

3. If YES, do you still plan to continue with this person? _____ YES _____ NO

4. Would you give permission for us to contact this person? _____ YES _____ NO

If YES, please provide (if available) a phone number: _____

5. Are you currently experiencing any of the following nutrition related problems:

- | | |
|---|-------------------------|
| _____ Recent weight loss/gain (change of 3-5 pounds in two weeks or less) | |
| _____ Loss of appetite | _____ Hair loss |
| _____ Diarrhea/Constipation | _____ Skipping a Period |
| _____ Extreme Fatigue | _____ Bruising Easily |

6. Have you had a history of any of the above? _____ YES _____ NO

7. Have you had recent blood work done (within the past 3 months)? _____ YES _____ NO

8. Have you been struggling with putting your own menu together? _____ YES _____ NO

9. Have you been avoiding shopping for yourself? _____ YES _____ NO

10. Have you been avoiding dining out experiences? _____ YES _____ NO

11. Do you think you could benefit from a dietitian with any of the above?
 _____ YES _____ NO

12. Are you interested in an individual nutrition consultation? _____ YES _____ NO

13. Are you interested in receiving education in the ongoing nutrition therapy group?
 _____ YES _____ NO

14. What are the best days for you to schedule individual appointments?

**Atlanta Center for Eating Disorders
Initial Information**

Name: _____ Date: _____

In your own words, please briefly explain why you are seeking treatment at this time.

If you are here primarily because someone else has encouraged you to be here, please briefly state what you think their concerns and goals are for you.

Give a brief history of your problems: first symptoms, severity, periods of relief.

Do you have any other symptoms or related problems? (anxiety, depression, obsessions, compulsions, relationship problems, etc.)

Have you had any previous therapy or treatment? Describe briefly, including what was most and least helpful.

Please describe your relationship with the following people (past and present):

Mother:

Past: _____

Present: _____

Father:

Past: _____

Present: _____

Sister(s):

Past: _____

Present: _____

Brother(s):

Past: _____

Present: _____

Is there any family history of emotional problems, addictions, or major physical problems? Please describe:

Have you experienced any traumatic events, past or present? (deaths, accidents, loss, abuse).

With whom do you live? _____
How are your relationships with the persons living with you? _____

On a scale of 1-10, how would you rate the current quality of your life? (circle #)

10 9 8 7 6 5 4 3 2 1 0
excellent very good good Fair not so good poor miserable

Please list the number and names of any children you have had or raised.

How would you describe the quality of the relationships with these children?

What is your marital history and how would you describe the quality of this (these) relationship(s).

Describe your leisure time (what you do with free time, hobbies, how much time spent in leisure)

How would you describe your sexual preference? _____

Are you experiencing any problems in this area? _____

Are you experiencing any occupational difficulties? _____

What is your current eating pattern?

Good Day _____

Bad Day _____

Do you have a spiritual/religious background? _____

What is your current involvement? _____

Do you want to use your spiritual/religious faith as part of your recovery process?

Cultural Background: (race, ethnicity, family traditions) _____

Are there any cultural practices linked to your racial/ethnic background that are important to you and that might impact your treatment/recovery?

Please describe the goals you hope to achieve through treatment (stopping symptoms, learning skills, decreasing perfectionism, etc.).

Do you already have preferences related to treatment (level of care, days available, types of groups, etc)?

Please indicate what you see as strengths or abilities that you have which may help you in your recovery process (personality traits, motivation, spirituality, friends and family support, social skills, work skills, talents or hobbies, etc)

Adult Psychosocial/Social History

Instructions: Answer the following questions as they apply to you. On some questions no answers will apply so do not mark anything. Circle the right answers. Some questions will have more than one answer, so circle all that apply. Put a check mark by any answers you want to discuss.

Name: _____ Date: _____

Occupation: _____

1. Are you presently employed?
 1. No
 2. Yes
2. How long have you been working at this job?
 1. Less than 6 months
 2. 6-12 months
 3. 1-3 years
 4. 3-5 years
 5. 5-10 years
 6. 10-15 years
 7. 15-20 years
 8. More than 20 years
 9. Does not apply
3. How many hours per week do you work?
 1. Less than 10
 2. 10-20 hours
 3. 20-30 hours
 4. 30-45 hours
 5. More than 45 hours
 6. Does not apply
4. In general, how do you enjoy your work?
 1. Enjoyable
 2. Neutral
 3. Unenjoyable
 4. Does not apply
5. Have you ever been fired?
 1. No
 2. Yes
 3. Does not apply
6. Have you ever been laid off?
 1. No
 2. Yes
 3. Does not apply
7. What is the longest period of time you held one job?
 1. Less than 1 year
 2. 1-3 years
 3. 3-5 years
 4. 5-10 years
 5. More than 10 years
 6. Does not apply
8. Since starting full-time work, what is your longest non-work period?
 1. Less than 1 year
 2. 1-3 years
 3. 3-5 years
 4. 5-10 years
 5. More than 10 years
 6. Does not apply
9. Do you have any problems at work?
 1. No
 2. Yes
 3. Does not apply
10. What kinds of work have you performed in the past? (answer all that apply)
 1. Homemaker
 2. Professional
 3. Business Owner
 4. Skilled Craftsperson
 5. Office Worker
 6. Salesperson
 7. Skilled Laborer
 8. Unskilled Laborer
 9. Government Service
 10. Personal Service
 11. Executive
 12. Other
 13. Does not apply/have never worked
11. Currently, how much money does the household earn that you now live in?
 1. Less than \$25,000
 2. \$25,000-\$33,000
 3. \$33,000-\$40,000
 4. \$40,000-\$55,000
 5. \$55,000-\$75,000
 6. \$75,000-\$90,000
 7. \$90,000-\$125,000
 8. \$125,000-\$200,000
 9. \$200,000-\$300,000
 10. More than \$300,000
12. Have you had any major changes in income during the past 2 years?
 1. No
 2. Decreased significantly
 3. Increased significantly
13. What is your family's primary source of income?
 1. My earnings
 2. My partner's earnings
 3. Relatives
 4. Disability payments
 5. Unemployment
 6. Welfare
 7. Investments
 8. Other
14. Is providing enough income for your family a big stress in your life?
 1. No
 2. Yes
15. Who primarily raised you?
 1. Natural parents
 2. Father only
 3. Mother only
 4. Father/Stepmother
 5. Mother/Stepfather
 6. Adoptive parents
 7. Foster parents
 8. Institutional caretakers
 9. Aunt and/or Uncle
 10. Brother and/or Sister
 11. Maternal Grandparent(s)
 12. Paternal Grandparent(s)
 13. Other
16. How would you characterize your childhood? (answer all that apply)
 1. Happy
 2. Frightening
 3. Unhappy
 4. Dull
 5. Hard to remember
 6. Secure
 7. Painful
 8. Regimented
17. Which descriptor(s) characterize your mother/maternal caretaker? (answer all that apply)
 1. Warm
 2. Distant
 3. Uncaring
 4. Strict
 5. Unpleasant
 6. Rejecting
 7. Overprotective
 8. Abusive
 9. Faultfinding
 10. Understanding
 11. Perfect
 12. Affectionate
 13. Domineering
18. Which descriptor(s) characterize your father/paternal caretaker? (answer all that apply)
 1. Warm
 2. Distant
 3. Uncaring
 4. Strict
 5. Unpleasant
 6. Rejecting
 7. Overprotective
 8. Abusive
 9. Faultfinding
 10. Understanding
 11. Perfect
 12. Affectionate
 13. Domineering

19. How would you describe your parents'/parent substitutes' relationship? (answer all that apply)

- | | |
|---------------------|----------------------------|
| 1. Close | 8. Reserved |
| 2. Cold | 9. Distant |
| 3. Ideal | 10. Happy |
| 4. Violent | 11. Domineering/submissive |
| 5. Indifferent | 12. Loving |
| 6. Full of conflict | 13. Hostile |
| 7. Hot and cold | |

20. How many siblings do you have?

- | | |
|----------|--------------------|
| 1. One | 6. Six |
| 2. Two | 7. Seven |
| 3. Three | 8. More than seven |
| 4. Four | 9. None |
| 5. Five | |

21. Which descriptors characterize you as a child? (answer all that apply)

- | | |
|------------------|--------------------|
| 1. Outgoing | 10. Nervous |
| 2. Shy | 11. Rebellious |
| 3. Active | 12. Serious |
| 4. Aggressive | 13. Stubborn |
| 5. Awkward | 14. Unhappy |
| 6. Happy | 15. Calm |
| 7. Friendly | 16. Temperamental |
| 8. Emotional | 17. Self-Confident |
| 9. Irresponsible | |

22. What was your order of birth?

1. Oldest
2. Middle
3. Youngest
4. Only child

23. What were problems for you as a child (to age 12)? (answer all that apply)

1. None
2. Getting along with mother
3. Getting along with father
4. Getting along with siblings
5. Getting along with peers
6. Bed-wetting
7. Nightmares
8. Excessive fears or worries
9. Academics
10. Physical/medical problems
11. Nerves
12. Felt I was a burden to my parents
13. Overweight
14. Underweight
15. Having my feelings hurt
16. Fear of failure

24. What did your parents/parent caretakers argue about? (answer all that apply)

1. Money
2. Discipline of children
3. Relatives interfering
4. Drinking
5. Sex
6. Jealousy
7. Not taking care of the home
8. Not being a good provider
9. Never argued

25. What was your father's/paternal caretaker's occupation?

- | | |
|----------------------|------------------------|
| 1. Homemaker | 9. Unemployed |
| 2. Professional | 10. Disabled |
| 3. Owner of business | 11. Government service |
| 4. Skilled craftsman | 12. Personal service |
| 5. Office worker | 13. Military service |
| 6. Salesperson | 14. Executive |
| 7. Skilled Laborer | 15. Other |
| 8. Unskilled laborer | 16. Does not apply |

26. What was your mother's/maternal caretaker's occupation?

- | | |
|----------------------|------------------------|
| 1. Homemaker | 9. Unemployed |
| 2. Professional | 10. Disabled |
| 3. Owner of business | 11. Government service |
| 4. Skilled craftsman | 12. Personal service |
| 5. Office worker | 13. Military service |
| 6. Salesperson | 14. Executive |
| 7. Skilled Laborer | 15. Other |
| 8. Unskilled laborer | 16. Does not apply |

27. How would you describe your mother's/maternal caretaker's method of discipline?

- | | |
|------------------|-----------------|
| 1. Strict | 4. Lenient |
| 2. Fairly strict | 5. Inconsistent |
| 3. Fair | |

28. How would you describe your father's/paternal caretaker's method of discipline?

- | | |
|------------------|-----------------|
| 1. Strict | 4. Lenient |
| 2. Fairly strict | 5. Inconsistent |
| 3. Fair | |

29. What fears did you have as a child (to age 12)? (answer all that apply)

1. No significant fears
2. Death
3. Might fall
4. Might be seriously injured or become ill
5. Strangers
6. Might be laughed at
7. Might be abandoned/lose my parents
8. Animals
9. Other children
10. Other

30. How would you characterize your sexual experiences?

1. Pleasant
2. Neutral
3. Unpleasant

31. How far did you go in school?

1. Completed less than 6 grades
2. Completed elementary school
3. Completed junior high (9th grade)
4. Attended high school but did not receive a diploma
5. Received a GED
6. Graduated high school
7. Vocational or business training school beyond high school
8. Attended college but did not graduate
9. Graduated college (4-year degree)
10. Completed college coursework at the graduate level
11. Earned a Master's degree
12. Earned a Doctoral degree

32. How would you rate your intellectual ability?

- | | |
|------------------|--------------------|
| 1. Below average | 3. Above average |
| 2. Average | 4. Superior/gifted |

33. Were you ever held back in school?

1. No
2. Yes

34. In general, what grades did you make in school?

- | | |
|-----------------------|---------------------|
| 1. Mostly A's | 3. Mostly C's |
| 2. Mostly B's and A's | 4. Many D's and F's |

35. Did you ever get in trouble while in school?

1. No
2. Occasionally
3. Often

36. Did you have any problems learning to read?

1. No
2. Yes

37. Did you have any problems learning math?

1. No
2. Yes

38. Did your peers ridicule, tease or make fun of you more than other kids?
 1. No
 2. Yes
39. Rate your family's economic status during childhood and adolescence.
 1. Poverty level
 2. Working class
 3. Middle class
 4. Upper middle class
 5. Wealthy
40. Who provided the main source of income for your family?
 1. Mother
 2. Father
 3. A relative
 4. Social Service (Welfare, Unemployment, Disability)
 5. A friend of the family
 6. Other
41. Did your parents/parental caretakers agree on how money should be spent?
 1. Agreed most of the time
 2. Disagreed
 3. Disagreed frequently
42. Did your family experience any financial problems?
 1. No
 2. Occasionally
 3. Often
43. Which of the following substances have you used? (answer all that apply)
 1. None
 2. Cocaine
 3. Barbiturates
 4. Amphetamines/Methamphetamine
 5. Hallucinogens
 6. Opiates
 7. Quaaludes
 8. Heroin
 9. Marijuana
 10. Tranquilizers without a prescription
 11. Pain pills without a prescription
 12. PCP
 13. Other
44. Have you ever felt there was a time you drank too much alcohol?
 1. No
 2. Yes, on one occasion
 3. Yes, on several occasions
 4. Yes, on more than several occasions
45. On the average, how often do you drink alcohol?
 1. Never
 2. Once or twice a year
 3. Once or twice a month
 4. Once a week
 5. A couple times a week
 6. Daily
46. How would you describe your illegal drug usage?
 1. Have never used drugs
 2. Do not currently use drugs
 3. Once or twice a year
 4. Once or twice a month
 5. Once a week
 6. A couple times a week
 7. Daily
47. Have you ever been involved in a drug or alcohol treatment program?
 1. No
 2. Yes
48. Did your parents have a problem with drug/alcohol abuse when you were a child?
 1. No
 2. Mother only
 3. Father only
 4. Both parents did
 5. The person who raised me did
49. Do you smoke cigarettes?
 1. No, never have
 2. No, I quit smoking
 3. Yes, a pack a week or less
 4. Yes, approximately a half a pack a day
 5. Yes, a pack a day
 6. Yes, more than a pack a day
50. Have any family members ever experienced mental illness? (answer all that apply)
 1. No
 2. I have
 3. Mother
 4. Father
 5. Sibling(s) (brothers/sisters)
 6. Grandparents
 7. Outside the immediate family (aunts, uncles, etc.)
51. Did you have any bad illnesses as a child (eg. hospitalizations)?
 1. No
 2. Yes
52. Have you had any significant accidents in the past 3 years?
 1. No
 2. Yes
53. Rate your general level of health.
 1. Excellent
 2. Good
 3. Fair
 4. Poor
 5. Extremely poor
55. Are you currently under the care of a physician?
 1. No
 2. Yes
56. What medications are you currently taking? (answer all that apply)
 1. None
 2. Pain pills
 3. Anitbiotics
 4. Anit-inflammatory pills
 5. Anti-convulsant pills
 6. Heart pills
 7. High blood pressure pills
 8. Tranquilizers
 9. Anti-depressants
 10. Vitamins
 11. Insulin
 12. Allergy pills
 13. Stomach pills
 14. Other
57. What is your marital status?
 1. Single
 2. Single, but involved in an intimate relationship
 3. Married
 4. Separated
 5. Divorced
 6. Widowed
58. Have you ever been divorced?
 1. No
 2. Yes
59. How long have you been with your current partner?
 1. Does not apply
 2. Less than 1 year
 3. 1 year
 4. 2 years
 5. 3 years
 6. 3-5 years
 7. 5-10 years
 8. 10-15 years
 9. 15-20 years
 10. 20-25 years
 11. 25-30 years
 12. More than 30 years

60. How many children do you have?
 1. One
 2. Two
 3. Three
 4. Four
 5. Five
 6. More than 5
 7. None
61. How would you describe your partner? (answer all that apply)
 1. Does not apply 11. Perfect
 2. Warm 12. Indifferent
 3. Unhappy 13. Argumentative
 4. Distant 14. Boring
 5. Uncaring 15. Stimulating
 6. Unpleasant 16. Unforgiving
 7. Enjoyable 17. Tense
 8. Abusive 18. Affectionate
 9. Faultfinding
 10. Understanding
62. Are you having problems with your child(ren's) behavior?
 1. Does not apply
 2. No
 3. Yes
63. Is the frequency of sex a problem?
 1. No
 2. Yes
64. What are your living arrangements? (answer all that apply)
 1. Living with relatives in their home
 2. Living with friends in their home
 3. Renting a home
 4. Renting an apartment
 5. Buying a home
 6. Own my own home
 7. Boarding
 8. Living in a dorm
 9. Other
65. Whom do you live with?
 1. Alone
 2. With a roommate
 3. With more than one roommate
 4. With family member(s)
66. How often do you and your partner argue?
 1. Does not apply 5. Once a week
 2. Never 6. Several times a week
 3. Rarely 7. Daily
 4. Once a month 8. Several times a day
67. Has your relationship ever been threatened by an affair?
 1. Does not apply
 2. No
 3. Yes, my affair
 4. Yes, my partner's affair
68. What interests do you and your partner share? (answer all that apply)
 1. Does not apply 11. Socializing with friends
 2. None 12. Television
 3. Children 13. Religious activities
 4. Work-related 14. Club activities
 5. Sports 15. Talking
 6. Hobbies or crafts 16. Games
 7. Movies 17. Camping
 8. Theatre 18. Hunting/fishing
 9. Music 19. Other
 10. Politics
69. How well do you feel your partner fulfills his/her role with you?
 1. Does not apply 4. Poorly
 2. Very well 5. Very poorly
 3. Fairly well
70. Do you eat a balanced diet?
 1. No 2. Yes
71. Do you participate in a regular exercise program?
 1. No
 2. Yes
72. How would you characterize your size?
 1. Very thin 4. A little overweight
 2. Thin 5. Overweight
 3. About average 6. Very overweight
73. Which of the following have you experienced in the past two years?
 (answer all that apply)
 1. Marital reconciliation
 2. Jail term
 3. Retirement
 4. Fired at work
 5. Change in health of family member
 6. Marital separation
 7. Divorce
 8. Death of spouse/partner
 9. Pregnancy
 10. More or less arguments with partner
 11. None
74. Which of the following have you experienced in the past two years?
 (answer all that apply)
 1. Death of a close friend
 2. Marriage
 3. Death of a close family member
 4. Change in financial state
 5. Personal injury or illness
 6. Change to different line of work
 7. Business readjustment
 8. Gain of a new family member
 9. Sex difficulties
75. How would you rate your ability to cope with life?
 1. Very good 3. Fair
 2. Good 4. Poor
76. How would you describe yourself? (answer all that apply)
 1. Quiet 11. Stubborn
 2. Outgoing 12. Easygoing
 3. Talkative 13. Friendly
 4. Shy 14. Smart
 5. Active 15. Impatient
 6. Aggressive 16. Responsible
 7. Temperamental 17. Rebellious
 8. Self-confident 18. Serious
 9. Wild 19. Unassertive
 10. Carefree
77. How would you describe your mental state? (answer all that apply)
 1. Tense 11. Regretful
 2. Depressed 12. Irritable
 3. Forgetful 13. Calm
 4. Sad 14. Scared
 5. Worried 15. Hyperactive
 6. Fearful 16. Nervous
 7. Angry 17. Happy
 8. Unenthusiastic 18. Distrustful
 9. Confused 19. None of the above
 10. Disappointed 20. Other
78. Have you ever had legal problems? (answer all that apply)
 1. No 3. Arrested
 2. Civil (eg. divorce) 4. Convicted
79. What is the primary problem bothering you? (One answer)
 1. Marriage 8. Physical (ill / tired)
 2. Family 9. Alcohol
 3. Loneliness 10. Drugs
 4. Moodiness 11. Sex
 5. Depression 12. Money
 6. Anxiety 13. Work
 7. Self-confidence 14. Other

80. How long ago did you begin to be troubled by this problem?

1. Within the past month
2. Between 1 and 6 months ago
3. Between 6 and 12 months ago
4. Between 1 and 2 years ago
5. Between 2 and 5 years ago
6. Between 5 and 10 years ago
7. More than 10 years ago
8. All my life
9. Does not apply

81. Rate the degree to which this problem has affected your life.

- | | |
|------------------|-------------------|
| 1. Very little | 4. A good deal |
| 2. A little | 5. A great deal |
| 3. A fair amount | 6. Does not apply |

82. How often do your experience this problem?

1. Many times a day
2. Several times a day
3. Daily
4. Several times a week
5. Once a week
6. Several times a month
7. Monthly
8. Several times a year
9. Less than once a year
10. Does not apply

83. Please describe your sleep within the past month. (Circle all that apply)

1. Trouble falling asleep
2. Trouble staying asleep/interrupted sleep
3. Difficulty waking up
4. Nightmares
5. Must use sleeping medication to help sleep
6. Excessively fatigued
7. Sleep schedule is off (ex. stay up at night, sleep during day)

84. What other kinds of problems are bothering you? (answer all that apply)

- | | |
|---------------------------|--------------------|
| 1. Marriage | 9. Alcohol |
| 2. Family | 10. Drugs |
| 3. Loneliness | 11. Sex |
| 4. Moodiness | 12. Money |
| 5. Depression | 13. Work |
| 6. Anxiety | 14. Other |
| 7. Self-confidence | 15. Does not apply |
| 8. Physical (ill / tired) | |

85. Have you ever served in the military?

1. No
2. Yes

86. Which branch did you serve in?

1. Does not apply
2. Air Force
3. Army
4. Coast Guard
5. Marines
6. Navy

87. How long did you serve?

1. Does not apply
2. Less than 3 months
3. Less than 1 year
4. 1 to 2 years
5. 2 to 4 years
6. 4 to 6 years
7. 6 to 10 years
8. 10 to 15 years
9. More than 15 years

88. What kinds of problems did you experience in the military? (answer all that apply)

1. Does not apply
2. None
3. Getting used to following rules and regulations
4. Taking orders
5. Nerves
6. Began using drugs
7. Began using alcohol to excess
8. Was reprimanded by my superiors for my conduct
9. Had to perform special duty because of my conduct
10. Did time in the stockade/brig
11. Was court marshaled
12. Went AWOL
13. Other

89. Were you stationed in a combat zone?

1. Does not apply
2. No
3. Yes, for less than 3 months
4. Yes, for 3 to 6 months
5. Yes, for 1 to 2 years
6. Yes, for 2 to 3 years
7. Yes, for 3 to 4 years
8. Yes, for longer than 4 years

90. What was the highest rank you attained?

1. Does not apply
2. Enlisted person
3. Noncommissioned Officer
4. Officer

91. What were the terms of your discharge?

1. Does not apply
2. Still on active duty
3. Honorably discharged due to mental problems
4. Honorably discharged due to medical problems
5. Honorably discharged
6. Dishonorably discharged

92. Did you ever see a psychologist or psychiatrist while in the military?

1. Does not apply
2. No
3. Yes, physical
4. Yes, mental/emotional
5. Yes, physical and mental/emotional

93. Do you have a service-connected disability?

1. Does not apply
2. No
3. Yes, physical
4. Yes, mental/emotional
5. Yes, physical and mental/emotional

94. What is your race?

1. African American/Black
2. Asian
3. Caucasian/White
4. Latin
5. Mexican American
6. Mixed Race
7. Native American
8. Other

Thank you.

(8/09)