Name: _____ Date: _____

Address: _____ City/Zip: _____

DOB: _____ Age: _____ Gender: ☐ M ☐ F

Social Security Number: _____ Race: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Parent /Guardian Name: _____ DOB: _____

Relationship to client _____ Gender: ☐ M ☐ F

Other Parent /Guardian Name: _____ DOB: _____

Relationship to client _____ Gender: ☐ M ☐ F

Home Phone: _____ Permission to contact/confirm at this #: ☐ Yes ☐ No

Cell Phone: _____ Permission to contact/confirm at this #: ☐ Yes ☐ No

Client school and grade (if applicable): _____ Medical Dr _____

Previous Mental Health Provider and diagnosis (if known): _____

Currently on probation ☐ Yes ☐ No If yes, Name of P.O. _____

Are there pets in your home? ☐ Yes ☐ No If yes what kind? _____

Who referred you to Cadence Care Network? _____

What agency does the referral source work for? _____

What is your current reason for seeking services at Cadence Care Network? _____

_____

_____

Financial Information:

in household: _____ Household monthly income: _____

Medicaid MMIS # (if applicable): _____

Additional Insurance Name: _____

Guarantor (Policy Holder): _____

Guarantor DOB & SS# _____

Acknowledgment of Receipt of
Cadence Care Network Handouts

I have reviewed the following Cadence Care Network Handouts and received a copy upon my request. By signing this acknowledgement statement, I hereby confirm that I have read the documents and understand the contents, and have asked my assessment therapist any questions that I have about these documents.

	Initial	
☐	_____	Clients Rights Policy/Client Grievance
☐	_____	Client Care Philosophy
☐	_____	Attendance Policy
☐	_____	Partner Solutions Release
☐	_____	Notice of Privacy Practices Booklet
☐	_____	Trumbull County Privacy Notice (pertains only to Trumbull County Residents)

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/ Guardian Date

_____ _____

Signature of Staff Reviewing Handouts Date

Consent for Mental Health Services
and Publicly Funded Services Disclosure Notice

Client Name: _____ DOB: _____

I hereby authorize Cadence Care Network to provide routine evaluation and treatment services as may be deemed necessary or advisable for the diagnosis and/or care of the above-named individual.

I acknowledge that the risks and benefits of each proposed treatment, of alternative treatment and of no treatment have been explained to me. I have also been advised of my right to refuse or withdraw consent for treatment and that the implications and potential consequences of refusing or withdrawing consent have been/will be fully explained.

This consent applies to treatment services for any and all of the services identified in which the client may be enrolled or to which they may be transferred.

I also acknowledge that to receive alcohol, drug addiction and mental health services paid for by public funds, I must provide information to the appropriate Board of Mental Health so they can:

- enroll this client in the County Behavioral Healthcare Program,
- determine if the client is eligible for publicly funded services, and
- pay the provider for services for this client through the MACSIS (Multi Agency Community Services Information System) computer system, or any future replacements to MACSIS, which connects the Board to the Ohio Department of Mental Health and Addiction Services, and the Ohio Department of Human Services.

I agree that I am responsible for payment for services provided to my dependents or me by Cadence Care Network. I request that payment of authorized benefits be made to Cadence Care Network for mental health services furnished by Cadence Care Network. I authorize release to the indicated insurance carrier or Medicaid any medical information about me needed to determine these payments for related services. I will be fully responsible for payment for any claims my insurance or Medicaid denies and agree to pay the balance to Cadence Care Network. Cadence Care Network will notify me of any services not covered by my insurance or Medicaid or changes to coverage. Cadence Care Network will not discontinue services to any individual in a critical situation until appropriate arrangements can be made for continuation of services. If the client is not covered by Medicaid or Insurance, Cadence Care Network may allow for “out of pocket” payment using a sliding scale fee.

All information will be kept confidential. Name identifying information will be used only to pay for services provided to this client. Demographic information will be kept without the youth’s name attached, and reported to the State departments and Ohio Health Care Data center. This information will not be available to any other sources or used for other purposes. Billing information will only be kept for ten years after the client has received services, and only demographic information will be kept after that time.

Please note: In accordance with section 5122.04 of the revised code, mental health services, except for the use of medication, may be provided to minors 14 years of age or older for not more than 6 sessions or thirty days, whichever occurs first without a consent for treatment form signed by the minor’s parent or guardian.

A copy of my signature shall be the functional equivalent of the original. I consent to treatment and have received this information:

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Printed Name of Member (client receiving services) Client Signature

I have read and explained this information to the above named individual:

_____ _____
Agency Staff Member Signature Date

SmartCareMCO Residency Verification Form

The purpose of this form is to clarify which PartnerSolutions board is responsible for adjudicating claims for behavioral health services provided to the client being enrolled in SmartCareMCO. The form should be completed at the time the client first presents for treatment/services at the submitting agency and whenever a change in the client's residency occurs. The form should be presented to the appropriate PartnerSolutions board enrollment contact when:

1.) The county of the submitting agency does not match the legal county of residence of the client as noted on the enrollment form.

2.) The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client.

3.) The minor's physical address as noted on the enrollment form does not match the legal custodian's address.

4.) The board staff person responsible for processing the enrollment requests the form, such as in cases when a client needs to be transferred from one PartnerSolutions board's coverage plan to another's in SmartCareMCO.

A client or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Instructions: Fill out only the "Adult" section and the associated signature and date fields if the client is a legal adult or emancipated minor. Fill out only the "Minor" section and the associated signature and date fields if the client is a legal minor. If the form is completed by hand rather than electronically, please print legibly.

Adult

Client Name

Enter the client's street address, city, state, and ZIP for residency determination purposes.

Address 1

Address 2

City

State

ZIP

County of Residence

Minor

Indicate if minor is in legal custody of the following:

◯ Parent ◯ CSB ◯ DYS ◯ Court ◯ Other (specify):

Client Name

Legal Custodian Name

If legal custodian is Parent, enter the Parent's street address, city, state, and ZIP if different from the client's physical address on the enrollment form.

Address 1

Address 2

City

State

ZIP

County of Residence

Signatures

Signatures must be handwritten rather than electronically signed.

Client Signature (if Legal Adult or Emancipated Minor)

Date

Legal Custodian Signature (if Legal Minor)

Date

* For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

Verification of Guardianship

I, _____, attest that I am the legal guardian of
Printed Name

_____.
Printed Name of Client

Please indicate Relationship to Client _____

_____ _____

Guardian Signature Date

_____ _____

Cadence Care Network Staff / Witness Signature Date

RELEASE OF INFORMATION FOR
PARTNERSOLUTIONS HEALTH INFORMATICS CONSORTIUM (PSHIC)

I, _____ *authorize* _____
Name of Client ***Agency Name***

and the other members of the PartnerSolutions Health Informatics Consortium, ***as listed on the back of this form****, to communicate with and disclose to one another the following information about me:*

_____ *My name, contact information and other personal identifying information*
_____ *My status as a services recipient*
_____ *Initial and subsequent evaluations of my service needs*
_____ *Medications and allergies*
_____ *My treatment history, including mental health and alcohol/drug services*
_____ *Discharge plans and outcomes*
_____ *Enrollment, eligibility and payment information*

The purposes of this exchange of information is to enable the members of PSHIC to better evaluate my need for services, to enable the coordination of services provided to me, to allow for billing and payment of those services and to enhance the care that I receive. All disclosures will be limited to the information necessary to fulfill these purposes.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), CFR Parts 160 & 164, and cannot be re-disclosed to a third party without my written authorization unless permitted by the regulations. I also understand that my mental health treatment records are protected by HIPAA but if the recipient of my information is not subject to HIPAA, they may no longer be protected by state or federal law and therefore subject to re-disclosure by a third party.

I understand that I may revoke this authorization at any time, except to the extent that the entity(ies) authorization to make the disclosure has taken action in reliance on it, and that in any event this authorization expires automatically when I am no longer receiving services from any member of PSHIC and no longer have an active case record.

I understand that I may refuse to sign this authorization, if it is for purposes other than alcohol and/or drug treatment and payment for that treatment, and that my refusal to sign it for other purposes will not otherwise affect my ability to obtain treatment, my eligibility for benefits, or the payment provided for those services. I understand that refusing to sign this form does not prohibit disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

_____ _____ _____
Signature of Client/Legal Representative ***Date*** ***Client Date of Birth***

_____
Printed Name and Authority of Person Signing on Behalf of Client (if applicable)

NOTICE TO RECIPIENTS OF ALCOHOL AND/OR DRUG TREATMENT INFORMATION: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

MEMBERS OF THE PARTNERSOLUTIONS HEALTH INFORMATICS CONSORTIUM

ASHTABULA COUNTY:

- **Ashtabula County Mental Health and Recovery Services Board -** 4817 State Road, Suite 203, Ashtabula, Ohio 44004
- **Lake Area Recovery Center-** 2801 C Court, Ashtabula, Ohio 44004

JEFFERSON COUNTY:

- **Jefferson Behavioral Health System -** 1 Ross Park Blvd - Suite 201 Steubenville, Ohio 43952

MONTGOMERY COUNTY:

- **ADAMHS Board for Montgomery County -** 409 E. Monument Avenue, Suite 102, Dayton, Ohio 45402
- **Addiction Services -** 1 Elizabeth Place SE 3rd Floor, Dayton, Ohio 45417
- **Nova Behavioral Health, Inc. -** 732 Beckman Street, Dayton, Ohio 45410
- **PLACES Inc. -** 11 West Monument Ave, 7th Floor, Dayton, Ohio 45402
- **Project Cure, Inc. -** 200 Daruma Parkway, Moraine, Ohio 45439

PORTAGE COUNTY:

- **Mental Health & Recovery Board of Portage County -** 155 E. Main Street, PO Box 743, Kent, Ohio 44240
- **Children's Advantage -** 520 North Chestnut Street, Ravenna, Ohio 44266
- **Townhall II -** 155 N Water St, Kent, Ohio 44240

STARK COUNTY:

- **Stark County Mental Health & Addiction Recovery -** 121 Cleveland Avenue SW, Canton, Ohio 44702
- **Child and Adolescent Behavioral Health -** 919 Second Street NE, Canton, Ohio 44704
- **CommQuest Services, Inc. -** 625 Cleveland Avenue NW, Canton, Ohio 44702
- **Crisis Intervention and Recovery Center, Inc. -** 832 McKinley Avenue NW, Canton, Ohio 44703
- **Domestic Violence Project, Inc. -** PO Box 9459, Canton, Ohio 44711
- **Stark County TASC -** 624 Market Ave North, Canton, Ohio 44710

TRUMBULL:

- **Trumbull County Mental Health and Recovery Board -** 4076 Youngstown Road SE, Suite 201, Warren, Ohio 44484
- **Cadence Care Network -** 165 E. Park Avenue, Niles, Ohio 44446

WAYNE/HOLMES COUNTIES:

- **Mental Health & Recovery Board of Wayne & Holmes Counties -** 1985 Eagle Pass Drive, Wooster, Ohio 44691
- **Anazao Community Partners -** 2587 Back Orrville Road, Wooster, Ohio 44691

Payment and Billing Policy

We are committed to providing you with quality and affordable health care. Please read below, ask us any questions you may have, and sign in the space provided. A copy will be provided to you **upon request**.

1. **Insurance.** We participate in most insurance plans. **Please contact your insurance company with any questions you may have regarding your coverage**.

2. **Co-payments and deductibles.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Proof of insurance.** We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 30 days, the balance will automatically be billed to you.

5. **Nonpayment**. If your account has been sent up to two billing statements without payment, you will receive a phone call from our billing department stating you have an overdue balance. We will give you the option to make your payment in full or set up a monthly payment plan. If you choose not to pay in full or set up a payment plan you will receive a 10-day letter stating you have 10 days to pay your outstanding balance. You will also be given the names of other local agencies to seek medical care. If payment is not received within 10 business days we will refer your account to a collection agency and you or your child will be immediately discharged.

6. **Uninsured patients.** This agency serves all patients regardless of ability to pay. Discounts for essential services are offered based on family size and income. For more information, ask the front desk about our sliding scale fee schedule.

7. **Usual Customary Charge.**
   Mental Health Assessment: $150.00
   Psychotherapy (Individual, Family, or Crisis): $72.41-$190.00
   Group Psychotherapy: $29.20
   Community Psychiatric Supportive Treatment Group: $35.96/hour
   Intensive Home-Based Treatment: $133.04/hour
   Therapeutic Behavioral Services: $107.80-$154.40/hour
   Therapeutic Behavioral Services Group: $26.96-$29.48/hour
   Community Psychiatric Supportive Treatment: $78.16/hour

8. **Discharge from the agency**: **We have the right to discharge a client for consistent missed, no show or late appointments; delayed or no payment to an account; an account in collections and/or noncompliance.**

Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

I have read, understand, and agree to make the appropriate co-payment prior to services rendered. In the case that my insurance coverage is inadequate or inactive at the time of service, I understand that I am personally responsible for any balance due as a result of services I have received.

_____	_____	_____
Client name	**Signature of patient or guardian**	**Date**

Client Name: _____ MRN: _____ Date: _____

Client Age at time of questionnaire: _____

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…Swear at you, insult you, put you down, or humiliate you? **Or** Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…Push, grab, slap, or throw something at you? **Or Ever** hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…Touch or fondle you or have you touch their body in a sexual way? **Or** Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 _____

4. Did you **often or very often** feel that … No one in your family loved you or thought you were important or special? **Or** Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced? Yes No If yes enter 1 _____

7. Was your mother or stepmother: **Often or very often** pushed, grabbed, slapped, or had something thrown at her? **Or Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **Or Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 _____

10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

The Centers for Disease Control and Prevention (CDC) hosts the official website for information about the ACE Study, including the original ACE Study questionnaires and articles resulting from the Study. In 2007, responding to popular demand for a condensed version of the original questionnaires, Dr. Anda created an ACE Score Calculator 10-qacecalc.pdf which allows individuals to calculate their own ACE Scores, based on the original scoring criteria of the ACE Study. To use this survey, add up all of the YES responses. The sum is the ACE Score. The ACE Score can range from "0", meaning no exposure to the ten categories of child abuse and trauma investigated by the Study, to "10", meaning exposure to all ten categories. The Study found the higher the ACE Score, the greater the risk of experiencing poor physical and mental health, and negative social consequences later in life. NOTE: Sometimes people take exception to the phrasing of questions 3, 6, and 7, arguing that sexual assault by anyone of any age is traumatic, that the death of a parent should be included, and that both males and females can be victims of domestic violence. If, when taking the survey, you prefer to modify the questions to allow for these factors, feel free to do so. Cadence Care Network is gathering this information to help better inform your mental health treatment.

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales

P

Parent Rating – Short Form

Child's Name: _____ Date: _____ Child's Grade: ____ ID#: _____ Completed by Agency

Child's Date of Birth: _____ Child's Sex: ❑ Male ❑ Female Child's Race: _____

Form Completed By: ❑ Mother ❑ Father ❑ Step-mother ❑ Step-father ❑ Other: _____

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your relationship with your child right now?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How capable of dealing with your child's problems do you feel right now?
    1. Extremely capable
    2. Moderately capable
    3. Somewhat capable
    4. Somewhat incapable
    5. Moderately incapable
    6. Extremely incapable
3. How much stress or pressure is in your life right now?
    1. Very little
    2. Some
    3. Quite a bit
    4. A moderate amount
    5. A great deal
    6. Unbearable amounts
4. How optimistic are you about your child's future right now?
    1. The future looks very bright
    2. The future looks somewhat bright
    3. The future looks OK
    4. The future looks both good and bad
    5. The future looks bad
    6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. To what degree have you been included in the treatment planning process for your child?
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all

Total: _____

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

 January 2000 (Parent-2)

(Add ratings together) Total _____

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales

Y

Youth Rating – Short Form (Ages 12-18)

Name: _____ Date: _____ Grade: _____ ID#: _____
Completed by Agency

Date of Birth: _____ Sex: ❑ Male ❑ Female Race: _____

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	**Not at All**	**Once or Twice**	**Several Times**	**Often**	**Most of the Time**	**All of the Time**
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your life right now?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How energetic and healthy do you feel right now?
    1. Extremely healthy
    2. Moderately healthy
    3. Somewhat healthy
    4. Somewhat unhealthy
    5. Moderately unhealthy
    6. Extremely unhealthy
3. How much stress or pressure is in your life right now?
    1. Very little stress
    2. Some stress
    3. Quite a bit of stress
    4. A moderate amount of stress
    5. A great deal of stress
    6. Unbearable amounts of stress
4. How optimistic are you about the future?
    1. The future looks very bright
    2. The future looks somewhat bright
    3. The future looks OK
    4. The future looks both good and bad
    5. The future looks bad
    6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How much are you included in deciding your treatment?
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
3. Mental health workers involved in my case listen to me and know what I want.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
4. I have a lot of say about what happens in my treatment.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all

Total: _____

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	**Extreme Troubles**	**Quite a Few Troubles**	**Some Troubles**	**OK**	**Doing Very Well**
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____