Beloit Health System
COUNSELING CARE CENTER
INITIAL INTAKE ASSESSMENT

Name_____ Medical Record Number _____

Therapist _____ Today's Date (Intake) _____

Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Gender: ☐ Male ☐ Female ☐ _____

Present Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabitating

☐ Civil Union ☐ Domestic Partnership ☐ Unmarried Partner ☐ Other _____

Length of current marriage/relationship: _____

Assessment of current relationship if applicable: ☐ Poor ☐ Fair ☐ Good

How many times have you been married? _____

How would you describe your cultural identity? ☐ African American ☐ Caucasian/White ☐ Asian American

☐ Native American ☐ Hispanic ☐ Biracial _____ ☐ Other _____

Referred by: ☐ Self ☐ Dr. _____ ☐ Other _____

Briefly describe the problem for which you are seeking to have counseling for? _____

_____

What would you like to see happen as a result of counseling? _____

_____

Which of the following concerns do you have?

Suicidal Thoughts &/or Attempts	☐	Self Injury Behaviors	☐
Homicidal Thoughts &/or Behaviors	☐	Troubling Thoughts/Urges/Habits	☐
Anger outbursts/ Aggressive behaviors	☐	Poor Academic Performance	☐
Learning difficulties	☐	Parenting Issues	☐
Attention and concentration difficulties	☐	Physical Health/Pain	☐
Hyperactivity	☐	Traumatic Experience/s	☐
Anxiety/ Nervousness	☐	Fears	☐
Victim of Abuse/Neglect	☐	Low Self-Esteem	☐
Fatigue/Low Energy	☐	Mood Swings	☐
Depression/sadness	☐	Social Isolation	☐
Feeling Hopeless/Worthless	☐	Unstable/Excited moods	☐
Obsessive thinking/behaviors	☐	Hallucinations/Delusions	☐
Motor Coordination	☐	Repetitive Behaviors/ Movements	☐
Relationship problems	☐	Alcohol/drug Use	☐
Seizures	☐	Eating habits/nutrition/problems	☐
Grief/Loss Issues	☐	Medication Problems	☐
Nightmares/ Night Terrors	☐	Problems with Hearing/Vision	☐
Problems Falling Asleep	☐	Problems Staying asleep	☐
Other _____	☐		

Please rate how intense the issues are, that bring you/your child to the Counseling Care Center today.

0 1 2 3 4 5 6 7 8 9 10

Not At All Overwhelming

MARITAL AND FAMILY INFORMATION

Please list all members in your present household:

Name	Relationship	Age	Employment/School Status

Please describe any problems or concerns about family issues/conflicts (i.e., emotional, behavioral, legal, alcohol or drug use, etc.) _____

_____

Please describe strengths and/or supports in your family or friends _____

_____

FAMILY OF ORIGIN

How would you describe your family life growing up? _____

_____

Please describe any significant childhood/adolescent or young adult issues that are still affecting you today: _____

_____

Did you have any of the following problems growing up?

☐ Physical developmental problem – please describe _____

☐ Learning difficulty/disability – please describe _____

☐ Emotional/Behavioral problems/disability – please describe _____

EDUCATION / VOCATION

Please check all those that apply to you:

☐ Housing concerns ☐ Limited social supports ☐ Financial concerns ☐ Other _____

What are your strengths? _____

What personal qualities would others say you have? _____

What is your highest level of education completed?

☐ Grade School ☐ GED

☐ High School – highest grade completed ____ ☐ Some College ☐ Associate's Degree

☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

What was your emphasis of study? _____

Did you serve in the military? ☐ Yes ☐ No Branch: _____ Rank _____

Dates of Service _____ Where _____

Please describe your experience _____

What is your present employment status? ☐ Full Time ☐ Part Time ☐ Disability

☐ Homemaker ☐ Retired ☐ Unemployed

Where do/did you work (most recent job)? _____ What is/was your job title? _____

How would you describe your job experiences? _____

LEISURE ACTIVITES

Please list any of your current interest, hobbies, community or recreational activities: _____

_____

Has there been a change in your involvement in these activities lately? ☐ No ☐ Yes

☐ Increase ☐ Decrease ☐ Gave Up

LEGAL STATUS

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past: _____

_____

PSYCHIATRIC INFORMATION

Please list previous **OUTPATIENT** mental health/counseling or alcohol/drug/addiction services:

Dates of Mental Health/Addiction Treatment	Hospital/Clinic	Diagnosis	Age	Type of Treatment (Mental health or addiction)

Please list previous **INPATIENT** mental health services or alcohol/drug/addiction inpatient treatment:

Dates of Mental Health/Addiction Treatment	Hospital/Clinic	Diagnosis	Age	Type of Treatment (Mental health or addiction)

Please describe any mental health concerns in your family _____

_____

MEDICAL INFORMATION

Who is your current physician(s)? _____

When was your most recent physical exam? _____

Please list any allergies including food, pollens and medications _____

Please list any current medications/over the counter medications/vitamins/natural remedies _____

_____

CURRENT medical health concerns _____

What is your current pain level?

0 1 2 3 4 5 6 7 8 9 10

None Unbearable

Where is the pain located in your body? _____

PAST medical health concerns _____

Is there a history of any of the following in you or your family?

- ☐ Tuberculosis
- ☐ Thyroid Problems
- ☐ Stroke
- ☐ Cirrhosis
- ☐ High Blood Pressure
- ☐ Alzheimer's disease/dementia
- ☐ Birth Defects
- ☐ Cognitive Disabilities
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Ulcers/Colitis
- ☐ Emotional Problems
- ☐ Heart Disease
- ☐ Fibromyalgia
- ☐ Huntington's Disease
- ☐ Cancer Type_____
- ☐ Auto-Immune Disease- Lupus
- ☐ Behavior Problems
- ☐ Obesity
- ☐ Asthma
- ☐ Parkinson's Disease
- ☐ Other: Please Describe: _____

SUBSTANCE USE/ABUSE HISTORY

Has anyone expressed concern about your use of alcohol or drug use? ☐ Yes ☐ No

Are you concerned about your use of alcohol or drug use? ☐ Yes ☐ No If Yes:

Has your tolerance increased over time? Please explain _____

Have you experienced work problems related to use? Please explain _____

Relationship problems related to use? Please explain _____

How often do you drink to intoxication per month? Please explain _____

Do you experience cravings and/or withdrawal symptoms? Please explain _____

Family history of use? Please describe _____

_____

RELIGION/SPIRITUALITY

Do you consider yourself a spiritual/religious person? ☐ Believe in God ☐ Believe in a Higher Power

☐ Non-believer ☐ Unsure ☐ Other _____

Do you feel this has an impact on your therapy? ☐ No ☐ Yes, Please explain _____

Please describe any thoughts, feelings, plans or attempts you are experiencing/have experienced to hurt yourself, kill yourself or hurt others: _____

_____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

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

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Patient's Name _____ DOB: _____

MRN: _____

Beloit Health System
COUNSELING CARE CENTER
SERVICE AGREEMENT AND INFORMED CONSENT

The Counseling Care Center of Beloit Memorial Hospital is a certified clinic by Wisconsin statute (DHS 35 & HFS 75.13), and is able to receive mandated benefits from Wisconsin-based insurance companies. Our staff consists of licensed psychiatrists, psychologists, nurses, social workers and counselors. Staff psychiatrists and psychologists provide clinical supervision for each client. Initial assessments generally last 50 to 120 minutes while psychotherapy sessions consist of 25 to 50 minute visits. Other individual and group sessions typically last from 15 minutes to 2 hours, as scheduled. A fee schedule has been provided and discussed with you and is available on request.

CONSENT FOR TREATMENT: Your signature authorizes the staff of Beloit Health System's Counseling Care Center to provide mental health services to the identified client, understanding that you will be responsible for payment of all charges incurred in the course of such services.

TELEMEDICINE SERVICES: Your signature authorizes the staff of Beloit Health System's Counseling Care Center to provide mental health services, including psychiatric care, psychiatric medication management, and counseling/psychotherapy telemedicine services via phone or internet (video) to the identified client. Your signature also confirms that you have been fully informed about and understand the following:

The nature of the treatment, the risks and benefits, and the available treatment options, including:

1. In-person treatment at the physical location of Counseling Care Center
2. Telemedicine services via the internet or by phone

Your signature also confirms that:

- You have had the opportunity to have all questions answered to your satisfaction.
- Your consent has been given voluntarily.
- You are legally competent and have the authority to provide consent for treatment.
- You are responsible for payment and verifying insurance.
- You are responsible for securing a private location during telemedicine services.
- You are responsible for providing your practitioner with your physical location and emergency information at the beginning of each telemedicine session.
- You understand if you are experiencing a psychiatric/medical emergency your provider will contact emergency services.
- You are responsible for your own internet access and equipment in order to receive telemedicine services.
- You have the right to withdraw your consent for this treatment at any time.
- Withdrawing consent for this treatment will not prejudice your continued treatment relationship.

GUARDIAN CONSENT FOR TREATMENT: Minor's guardian(s), or guardians of adults termed not competent, will complete all consents and agreements for treatment. Guardians or approved caregivers (i.e., foster parent given rights by the state, step-parents with guardian permission, approved nurses' aide) will be present for all appointments. You agree to respect the confidentiality of communication between your child (or ward) and his/her therapist.

AGREEMENT FOR ATTENDING, RESCHEDULING AND CANCELING APPOINTMENTS: In order to provide prompt mental health services to you and to our other clients, we need your cooperation in being on time and attending all scheduled appointments. Our staff will also make every effort to be on time, but because of emergencies, there may be short delays. If a significant delay is anticipated, you will be informed.

In order to avoid being charged for a missed appointment, if you know that you will need to change or cancel a scheduled appointment, you must do so at least ***one business day prior to the day of your scheduled appointment, during normal business hours.*** "Business days" are Monday through Friday, excluding holidays.

If an emergency arises, we still ask that you call our clinic to inform us that you cannot attend your appointment. You will not need to provide any explanation in such a circumstance. Because of client demand for services, if there are more than three instances in any six month period in which:

a) you miss or fail to appear for any scheduled appointments and/or
b) you do not give advance notice for cancellations (as defined above)

Then all of your treatment in the Counseling Care Center will be closed for six months, allowing new patients access to services. By signing below, I confirm that I have read and understand the importance of the above agreement, and I understand that my failure to comply will result in termination of all of my services in the Counseling Care Center.

PAYMENT FOR SERVICES: The billing department of Beloit Memorial Hospital will cooperate with you in filing for reimbursement with your third party payer. By signing below, you give consent for release of information, including photocopies of your record as requested, which may be necessary to obtain reimbursement. However, the hospital does not accept responsibility for collection of your claim or for negotiating a settlement on a disputed claim. **I understand that it is my responsibility to contact my insurance company regarding coverage limits at the Counseling Care Center and its providers. I further understand that any fee not covered by insurance will be made my responsibility unless prior financial arrangements have been made with the hospital's billing department.**

CONFIDENTIALITY POLICY: The Counseling Care Center places a high value on the confidentiality of the information our patients share with us. We understand that this information is often highly sensitive. This policy has been prepared to clarify our legal and ethical responsibilities, in reference to federal law 42 CFR, Part 2 S.51.30, and Ch. 51 of the Wisconsin Statutes as well as HSS Regulation 61.23 of state law, under the licensing statutes DHS 35 and HFS 75.13

If there is a need to share your records with someone not employed by the Counseling Care Center (for example, your physician, family members, or another agency) you will be asked to sign a form authorizing a transfer of the information. Only if you provide a written, informed consent will information about your history and treatment be shared with others. If oral communication is to occur between your provider and another person, this will occur with similar consent. You can revoke your permission at any time.

EXCEPTIONS TO CONFIDENTIALITY:

There are several important instances where confidential information may be released to others, without your consent. These include the following:

First, if we have reason to suspect abuse or neglect of a child or elderly person, we are obligated by law to report this to an appropriate state or county social service agency. This law is designed to protect the vulnerable from harm and our obligation to report suspected abuse or neglect is clear. Social Service agencies may/may not choose to investigate the report.

Second, if you are involved in a litigation of any kind criminal or civil, (including a pending divorce), and inform the Court of the services you received from us, the Court may subpoena the records.

Third, if you threaten to harm either yourself or someone else and our staff believes your threat is serious, they are obligated under Wisconsin law to take actions necessary to protect you and/or others from serious harm. This may include our staff having to divulge confidential information to police or others in order to assure your and other's safety. Such confidential information would be divulged only under unusual circumstances where someone's life or physical safety appeared to be in significant imminent danger.

Fourth, if you have been referred to this agency by a Court (Court Order), you can assume that the Court expects to receive formal updates regarding your treatment. You should discuss with us exactly what kind of information would be included in the report *before* you disclose any kind of confidential material.

ELECTRONIC MEDICAL RECORDS: With a focus on comprehensive care and quality communication, since 3/18/13, all services completed by the Counseling Care Center are documented, stored, and billing services completed, through a united Beloit Health System medical record. Access to Counseling Care Center records by employees of Beloit Health System or its affiliated must follow system policy and procedures. Some examples of access may include releasing records with your permission, or a medical physician/nurse prescriber may review your medications and care for consideration of ongoing medical care. Efforts to maintain your privacy are consistent with HIPAA and Chapters 35 & 75 of the Wisconsin Administration Codes.

CONFIDENTIALITY AND PATIENT RIGHTS: You have received and have had explained to you the Counseling Care Center's description of its confidentiality policy and patient rights for being treated in the Counseling Care Center.

I agree to participate in services for the Counseling Care Center, in accord with my service agreement. Customary fees have been discussed with me, and I know I may request a copy of the fee schedule. I have also received a copy of the Counseling Care Center's confidentiality statement. I understand the terms of the above and assign insurance benefits by my signature. I may receive a copy of this document. This consent shall remain in effect for 12 months from the date signed unless otherwise revoked in writing.

_____ _____

Patient Signature Date In the Presence of Date

_____

Parent/Guardian/Power of Attorney Date

Beloit Health System
COUNSELING CARE CENTER
DESCRIPTION OF PATIENT RIGHTS

The following is a brief summary of your rights as a patient treated in the Counseling Care Center. Please feel free to ask questions about your rights at any time during meetings with your treatment providers or other Counseling Care Center staff.

1. You have the right to be informed of your treatment plan including:
   a. Possible outcomes and side effects of treatment recommended in the treatment plan.
   b. Treatment recommendations and benefits of the treatment recommendations.
   c. Approximate duration and desired outcome of recommendations in the treatment plan.
   d. The rights of the patient receiving outpatient mental health services, including the patient's rights and responsibilities in the development and implementation of an individual treatment plan.
   e. The outpatient mental health services that will be offered under the treatment plan.
   f. The nature of care, procedures and treatment that you will receive;
   g. Potential treatment risks, including potential adverse affects of medication;
   h. Treatment alternatives.
   i. The time period for which you will provide informed consent for treatment, which is one year unless otherwise specified;
   j. The right to withdraw your informed consent at any time, in writing.
   k. Under what circumstances you may be involuntarily discharged from care, and resulting referral needs.

2. You have the right to treatment in the least restrictive setting available, consistent with your and others' safety and your health and well-being.
3. You have the right to receive prompt and adequate treatment.
4. You have the right to refuse medication, unless ordered by a court.
5. You have the right to request a second opinion of a consultant, at your expense (or as covered by your public or private insurance), if you do not agree with any/all of your treatment plan.
6. You have the right to review your treatment records with your treatment provider(s).
7. You have the right to confidential treatment except as otherwise provided by law.
8. You or your guardian may inspect or receive a copy of your treatment records and challenge any inaccuracies. Records will be copied without a due delay only upon your written request.
9. You have a right to know the fees you will be expected to pay for services.
10. You have a right to be informed of means to obtain emergency mental health services during periods outside the normal operating hours of the clinic.
11. You have the right to file a grievance concerning any aspect of your treatment, and to have your grievance investigated.
12. You have the right to be provided assistance in exercising your rights if you request it.

I understand these rights and have been offered a copy of this document. I understand that I may contact or Laura Neece, Director of the Counseling Care Center at 364-5686 for patient grievance or advocacy needs.

_____ _____

Patient Signature Date Parent/Guardian Signature Date

BELOIT HEALTH SYSTEM, INC.
PREAUTHORIZATION AND CONSENT TO TREAT MINORS ENROLLED WITH THE SCHOOL DISTRICT OF BELOIT

PURPOSE

This form may be used to allow minors who are School District of Beloit students to receive health care services from Beloit Health Services, Inc. ("BHS") at the Beloit School Clinic, located at Beloit Memorial High School, or other BHS locations. For some families, we understand that it may be more convenient to have prior authorization in place that allows health care services to be delivered to minors if a parent or legal guardian cannot be present to provide consent. If you would like to have such a preauthorization in place, please review and complete the following form authorizing health care services for your minor child in advance.

PREAUTHORIZATION AND CONSENT TO TREAT

I have the legal right to preauthorize BHS and its personnel to deliver health care services to the below named minor child enrolled in the School District of Beloit. Services provided may include, but are not limited to: medical evaluation, physical exam, x-rays, lab work, immunizations, sports physicals, reproductive health care, mental health services, and alcohol and drug abuse services (collectively, "Health Care").

I request and authorize BHS and its personnel to deliver Health Care to the below named minor child as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Name: _____ Date of Birth: _____

I acknowledge that state law allows minors to consent to and obtain certain Health Care without parental consent. In those situations, I acknowledge that the above named minor child may still be able to obtain certain Health Care from BHS without my authorization and that BHS will comply with all applicable laws regarding consent requirements.

I understand that the provision of Health Care is not an exact science and I acknowledge that no guarantees have been made to me as to the results of Health Care received from BHS.

FOLLOW-UP RESPONSIBILITY

I understand that BHS may provide instructions to follow at home and that it is my responsibility to arrange follow-up care and to follow through on any instructions provided. I understand that I should contact BHS if I have questions about any necessary follow-up care or instructions.

MISSED APPOINTMENTS

I understand that missed appointments impact the ability of BHS to provide quick access to patients. I agree to notify BHS 24 to 48 hours in advance of a cancellation or for rescheduling.

RELEASE OF INFORMATION FOR BILLING PURPOSES

I agree that BHS will release to and receive from my insurers, other payers or other persons as necessary for billing and related purposes, at reasonable times and in accordance with current policies and procedures, any information which may be needed for the purpose of billing, collection or payment of claims for services provided. This information may include the minor child's identity, medical and psychological evaluations, diagnosis, prognosis and treatment for physical and/or emotional illness, developmental disabilities, treatment of alcohol or drug abuse, progress notes, and all other information contained in health care records to the extent that such records are needed for billing or collection of benefits due from any payer. I understand that I have the right, upon request, to inspect and receive a copy of all such records being disclosed.

BELOIT HEALTH SYSTEM, INC.
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, I acknowledge that I received a copy of BHS' Notice of Privacy Practices ("NPP") which:

- Explains how BHS uses and discloses health information;
- Outlines my privacy rights with regard to my protected health information;
- Details BHS' obligations to me concerning use and disclosure of protected health information; and
- Provides a contact for additional information on BHS' privacy policies.

_____ _____

Patient/Legal Guardian signature Date

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Beloit Health System

INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

PATIENT INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____ DATE OF BIRTH ___/___/___

STREET ADDRESS _____ CITY, STATE, ZIP _____ PHONE NUMBER _____

I HEREBY AUTHORIZE AND REQUEST:

Counseling Care Center _____ TO RELEASE TO BLA Office Staff
ORGANIZATION/INDIVIDUAL

1969 W. Hart Road _____ TO RECEIVE FROM 1033 Woodward Ave.
STREET ADDRESS

Beloit, WI 53511 _____ TO RELEASE TO AND RECEIVE FROM Beloit WI 53511
CITY, STATE ZIP

Phone: 608-364-5686 (608) 361-4300
PHONE FAX

Fax: 608-363-5756

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: _____ Mental Health _____ HIV Status _____ Alcohol and/or Drug Abuse

Specific Information Requested:

_____ Psychosocial History
_____ Physical Examination
_____ Treatment Plan
_____ Physician's Orders
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Psychiatric Treatment Notes
_____ Psychotherapy Treatment Notes
_____ AODA Assessment
_____ AODA Treatment Notes
_____ Appt./Confirmation/Referral
_____ Discharge Summary
_____ School Records
_____ Lab Data
_____ Other _____

Service dates to be released: From _____ to _____

Purpose for need of disclosure: (please check all that apply)

_____ Further Medical Care
_____ Claims Resolution
_____ Coordinating Care for Dependent/Spouse
_____ Other: Release Records past date of Signature
_____ Other: Release Verbal information past date of Signature.
_____ Insurance

I understand that I have the right to copy and inspect the information that is to be released. I further understand that the records contain information regarding the patient's medical condition and treatment and possibly could include information pertaining to drug and/or alcohol usage and/or mental health status and/or AIDS or HIV related illness.

It is further understood that I have the right to withdraw this authorization at any time. I understand that if I withdraw this authorization I must do so in writing. I understand that the withdrawal will not apply to information that has already been released in response to this authorization, and that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise withdrawn, this authorization will expire on the following day or event: _____. If I fail to specify an expiration date, this authorization will expire in six months.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal confidentiality rules.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I may experience consequences for not signing this authorization if referred from a mandatory agency (i.e., employer, courts).

I understand that I have the right to have a copy of this signed consent.

_____ _____
Signature of Patient (Includes minors 14 years of age and over) Date Signed

_____ _____
Signature of Parent/Guardian/Personal Representative (Relationship) Date Signed

_____ _____
Signature of Witness Date Signed

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

	YES	NO
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***		

- ☐ Low Risk
- ☐ Moderate Risk
- ■ High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu