Price Counseling Center
2920 Marietta Hwy, Ste 132
Canton, GA 30114
770-479-5501

Mental Health Evaluation

Please respond completely and accurately to the following items so that we might be better able to serve you. If an item does not apply to you, please place "N/A" in the space. Thank you for your time and cooperation. WELCOME TO OUR PRACTICE!

CLIENT'S NAME:_____ DATE: _____
(Last) (First) (Middle)

How would you like to receive your evaluation (circle one): **MAIL** **EMAIL** **PICK UP**

Address:_____Email: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: _____ Current Age: _____

Marital Status: _____How long?_____ Race: _____

Client's Nearest Relative (in case of emergency):

Name: _____ Relation:_____

Address: _____

Home Phone: _____ Work Phone: _____

Please list the names **and ages** of any children or other persons residing in client's household:

_____

Probation Officer: _____ Phone No. _____

Address: _____ Email: _____

Attorney: _____ Phone No: _____

Address: _____ Email: _____

Has any of your family ever experienced any of the above items to the point that professional attention was sought?
Yes_____ No _____ If yes, please explain: _____

_____

Have you ever received counseling or psychotherapy before? Yes _____ No _____
If yes, where? _____
For what reason? _____
Do you feel like you benefitted from this experience? Yes _____ No _____
Name of Counselor/Therapist/Psychiatrist seen previously: _____

THE PRICE COUNSELING CENTER

Grace Riley Price, L.C.S.W.

Release of Information

Patient Name: _____ DOB:_____

I authorize Price Counseling Center to communicate/release information to the following person/organization.

Organization Name: _____

And/Or Persons' name: _____

Address:_____

Phone: _____ Email: _____

I understand that my health information is protected by 42CFR Part ⅔ and HIPAA 45 CFR. I release the Price Counseling Center from any and all liabilities, responsibilities, damages, and claims which may arise from the release of information authorized above. I acknowledge that this consent is good for 12 months and can be revoked at any time by informing the Price Counseling Center in writing. I understand that revoking the release of information does not rescind any information that might have already been transmitted.

Patient's Signature: _____ Date: _____

Patient's Representative _____ Date: _____
(if Patient is under 18)

2920 MARIETTA HWY STE 132 CANTON, GA 30114 770-479-5501 FAX 770-479-5502

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

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

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

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

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

PTSD Symptom Scale (PSS)

Name _____ Date _____ (Side One)

Below is a list of traumatic events or situations. Please mark YES if you have experienced or witnessed the following events or mark NO if you have not had that experience.

1. Serious accident, fire or explosion	☐ Yes ☐ No
2. Natural disaster (tornado, flood, hurricane, major earthquake)	☐ Yes ☐ No
3. Non-sexual assault by someone you know (physically attacked/injured)	☐ Yes ☐ No
4. Non-sexual assault by a stranger	☐ Yes ☐ No
5. Sexual assault by a family member or someone you know	☐ Yes ☐ No
6. Sexual assault by a stranger	☐ Yes ☐ No
7. Military combat or a war zone	☐ Yes ☐ No
8. Sexual contact before you were age 18 with someone who was 5 or more years older than you	☐ Yes ☐ No
9. Imprisonment	☐ Yes ☐ No
10. Torture	☐ Yes ☐ No
11. Life-threatening illness	☐ Yes ☐ No
12. Other traumatic event	☐ Yes ☐ No
13. If "other traumatic event" is checked YES above; please write what the event was	_____
14. Of the question to which you answered YES, which was the worst (Please list the question #)	_____
15. Which of the above incidences is the reason for which you are currently seeking treatment? (Please list the question #)	_____

If you answered **NO** to all of the above questions, **STOP**
If you answered **YES** to any of the above questions, please complete the rest of the form

Please check YES or NO regarding the event listed in question 15.

Were you physically injured?	☐ Yes ☐ No
Was someone else physically injured?	☐ Yes ☐ No
Did you think your life was in danger?	☐ Yes ☐ No
Did you think someone else's life was in danger?	☐ Yes ☐ No
Did you feel helpless?	☐ Yes ☐ No
Did you feel terrified?	☐ Yes ☐ No

Please complete both sides of this document if you answered YES to any of the first series of questions (1-14).

PTSD Symptom Scale (PSS)

(Side 2)

Below is a list of problems that people sometimes have after experiencing a traumatic event. Please rate on a scale from 0-3 how much or how often these following things have occurred to you in the last two weeks:

0 Not at all
1 Once per week or less/ a little bit/ one in a while
2 2 to 4 times per week/ somewhat/ half the time
3 3 to 5 or more times per week/ very much/ almost always

1.	Having upsetting thought or images about the traumatic event that come into your head when you did not want them to	0	1	2	3
2.	Having bad dreams or nightmares about the traumatic event	0	1	2	3
3.	Reliving the traumatic event (acting as if it were happening again)	0	1	2	3
4.	Feeling emotionally upset when you are reminded of the traumatic event	0	1	2	3
5.	Experiencing physical reactions when reminded of the traumatic event (sweating, increased heart rate)	0	1	2	3
6.	Trying not to think or talk about the traumatic event	0	1	2	3
7.	Trying to avoid activities or people that remind you of the traumatic event	0	1	2	3
8.	Not being able to remember an important part of the traumatic event	0	1	2	3
9.	Having much less interest or participating much less often in important activities	0	1	2	3
10.	Feeling distant or cut off from the people around you	0	1	2	3
11.	Feeling emotionally numb (unable to cry or have loving feelings)	0	1	2	3
12.	Feeling as if your future hopes or plans will not come true	0	1	2	3
13.	Having trouble falling or staying asleep	0	1	2	3
14.	Feeling irritable or having fits of anger	0	1	2	3
15.	Having trouble concentrating	0	1	2	3
16.	Being overly alert	0	1	2	3
17.	Being jumpy or easily startled	0	1	2	3

Please mark YES or NO if the problems above interfered with the following:

1.	Work	☐ Yes ☐ No	6.	Family relationships	☐ Yes ☐ No
2.	Household duties	☐ Yes ☐ No	7.	Sex life	☐ Yes ☐ No
3.	Friendships	☐ Yes ☐ No	8.	General life satisfaction	☐ Yes ☐ No
4.	Fun/leisure activities	☐ Yes ☐ No	9.	Overall functioning	☐ Yes ☐ No
5.	Schoolwork	☐ Yes ☐ No			

Mental Health Screening Form-III

Name: _____ Date: _____

1	Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?	YES	NO
2	Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?	YES	NO
3	Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	YES	NO
4	Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	YES	NO
5	Have you ever heard voices no one else could hear or seen objects or things which others could not see?	YES	NO
6a	Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?	YES	NO
6b	Did you ever attempt to kill yourself?	YES	NO
7	Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?	YES	NO
8	Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?	YES	NO
9	Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?	YES	NO
10	Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?	YES	NO
11	Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	YES	NO
12	Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?	YES	NO
13	Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?	YES	NO
14	Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?	YES	NO
15	Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.	YES	NO
16	Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?	YES	NO
17	Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?	YES	NO

Total Score: ___ (each yes = 1 point)
Important: The Total Score is not a measure of severity and is not intended for use in individual evaluations. For more information about the Total Score, see the sixth paragraph of the "Guidelines" on the preceding page.

The original instructions for the use of the MHSF-III as a screening device for individuals seeking admission to a substance abuse treatment program are as follows:

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation. This is why each question begins: "Have you ever..."

Confidentiality/Behavior in Session

Our relationship with you is confidential in that we will not release information about your status, affiliation with us, condition, etc., without your consent - EXCEPT: we must breach confidentiality in the following instances:
1) As required by Georgia Law (e.g., court subpoena, if you pose a danger to yourself or others or if child abuse is determined or suspected), and/or
2) In the event the services of a collection agency are required, the following information may be released: your name, address, phone number, social security number and balance due.
3) In the case of an emergency cancellation by a therapist, the office secretary (or under unusual circumstances - an associate at Price Counseling Center) may notify you of the cancellation. The person calling will have access only to your name and phone number(s).
4) For the mutual benefit of the client and therapist, please be advised that the associates at Price Counseling Center conduct clinical staffings, during which your case may be discussed. Such group supervision is a common practice in the mental health community and is not intended in any way to breach confidentiality. Only clinical issues are discussed and names of clients are used only in very extenuating circumstances. If you are concerned about the possibility of your case being discussed in clinical staff meetings, please talk to your individual therapist.

I understand that I am being referred to an introductory evaluation/treatment as part of my probation or legal situation. This program does not claim to treat underlying psychological problems or severe depression. If I have other issues, it is my responsibility to speak to my therapist about them and an additional program will be outlined for me.

_____ _____

Client's Signature Date

Appointments/Cancellations

Our appointments are generally 30-50 minutes. It is not our policy to "double book" appointments so our time is exclusively committed to your appointment. When an appointment is missed, own schedule is seriously disrupted as I am unable to make this time available to other clients. For this reason we require that you give me 24 hours notice of your intent to cancel or reschedule an appointment. **If you cancel an appointment without 24 hours notice, or if you miss an appointment, you will be charged for the session.** These charges are not covered by insurance and are due at the next scheduled appointment, or within two weeks of the cancellation. My signature below indicates that I have read and understand the information regarding appointments and cancellations. If you elect to pay by credit card, if the credit card is not in your name, we reserve the right to communicate with the owner of the credit card for matters of finance only.

_____ _____

Client's Signature Date