The Steven A. Cohen Military Family Clinic at Metrocare

Client/Guardian Name: _____ Date: _____

***CLINIC INFORMATION AND ORIENTATION***

***Welcome!***

Welcome to the Steven A. Cohen Military Family Clinic at Metrocare. We are glad you are here and honored that you have chosen to seek care with us. Please review the information below and feel free to ask any questions.

***Hours:*** Monday – Thursday 9 a.m. to 8 p.m., Friday 8 a.m. to 1 p.m.
***Address***: 16160 Midway Road, Suite 218 Addison, TX 75001
***Phone:*** 469-680-3500 ***Email:*** MFC@MetrocareServices.org
***Social Media (Facebook, Twitter & Instagram):*** @CohenMetrocare

***About us*** **Initial _____**

We provide accessible and comprehensive mental health care to post-9/11 veterans, veterans' family members, and active-duty family members regardless of insurance. Services are available to any person who has served in the U.S. Armed Forces, including the National Guard and Reserves, regardless of role or discharge status. We use targeted, evidenced-based practices provided by trained and credentialed staff who are bound by professional ethical standards. Veterans and their family members can receive services individually and as a family unit at the same place with the same treatment team. We encourage family involvement and help connect families to community resources and services, as necessary. In addition to in-person, we utilize telehealth to provide services anywhere in Texas.

We are accredited by CARF International. If you have any feedback, you can contact CARF at feedback@carf.org or (866) 510-2273.

***About your care*** **Initial _____**

You are invited to be an active participant in the treatment-planning process. You and your therapist will formulate a treatment plan that incorporates evidence-based practices along with your individual strengths, needs, abilities, and preferences. Most of our clients are involved in therapy here for 3-4 months at a time. Therapy sessions are typically 50 minutes. Treatment may include individual, couples, family, or group therapy; case management services are also available. Current clients may be seen by a staff psychiatrist for medication evaluation and management.

Due to the time-limited nature of our clinic, we are unable to see clients for long-term, ongoing care. If you need longer-term care, we can assist in making referrals and helping you find the necessary care. Discharge from services will occur when you and your clinician agree that you have met most or all of your treatment goals or that your needs are better served elsewhere. As part of your transition, we will work together to identify the resources that best fit your needs moving forward.

We regularly ask clients to complete questionnaires for a variety of purposes, including to track symptoms, to assess progress in treatment, and to gain feedback on our functioning as a clinic so we can better serve our clients. We will ask you to complete these measures during treatment. Follow-up calls will be made at the following intervals: 1, 3, 6, & 12 months.

***Scheduling and after-hours information*** **Initial _____**

Please call our main line **(469) 680-3500** or email **MFC@metrocareservices.org** to schedule, cancel or reschedule appointments. After hours calls to the main line are routed to an answering service managed by trained veteran peers. For emergency/crisis situations, please call 911 or go to your local emergency room. You may also use the VA Veteran Crisis Line (1-800-273-8255).

Staff can be reached directly via email, though responses will be limited based on privacy laws.

***Late policy*** **Initial _____**

When possible, please notify us if you are running late. We will do our best to accommodate you. However, if you are late by 15 minutes or more, we may need to reschedule your appointment.

***Cancellation policy*** **Initial _____**

Please notify us at least 24 hours in advance if you need to cancel an appointment; if outside of clinic hours, call or e-mail and provide a reason for the cancellation. If you miss or cancel 3 scheduled appointments without advance notice, your treatment may be discontinued. Ensuring commitment to care allows us to best serve you, fellow veterans and family members.

***Can I bring the following items into the clinic?*** **Initial _____**

Illegal Drugs and Alcohol: The use, consumption, or possession of illegal drugs or alcohol is expressly prohibited. Services will not be provided to individuals who are under the influence of substances at the time of their appointment, and we will take appropriate measures in an attempt to ensure everyone's safety.

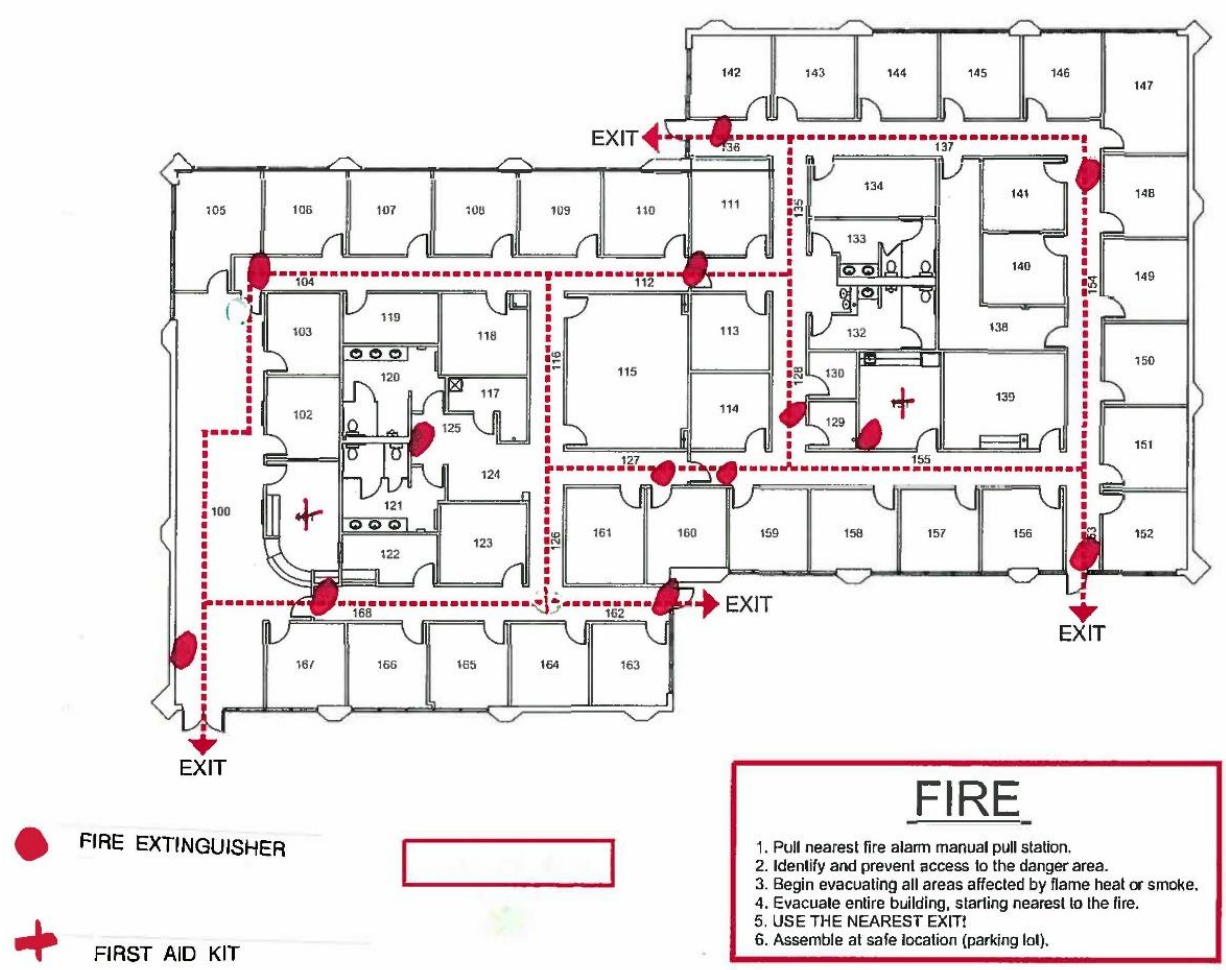
Legal Drugs (including OTC drugs, vitamins, herbs) and Prescription Medication: If you choose to bring other legal drugs or prescription medications on site, please adhere to the following guidelines: All items must be sealed, properly labelled (where appropriate), kept with you at all times, and not given or sold to any other individuals.

Weapons: Metrocare is classified as a governmental agency, which means that Texas Open Carry laws apply. We may not prohibit you from bringing firearms or knives under these laws; however, we ask that you be respectful of the therapeutic environment in deciding whether/how to bring any weapons on-site. For more information, please ask clinic staff.

Tobacco: All Metrocare locations are tobacco-free.

***What do I do in case of emergency while at the clinic?*** **Initial _____**

See map on next page for location of emergency exits, first aid kids, and fire extinguishers. Should you need to shelter-in-place, proceed to the conference room (115).


EXIT
EXIT
EXIT
EXIT
FIRE EXTINGUISHER
FIRST AID KIT
FIRE
1. Pull nearest fire alarm manual pull station.
2. Identify and prevent access to the danger area.
3. Begin evacuating all areas affected by flame heat or smoke.
4. Evacuate entire building, starting nearest to the fire.
5. USE THE NEAREST EXIT!
6. Assemble at safe location (parking lot).

***Thank you!***

The Steven A. Cohen Military Family Clinic at Metrocare

# Notice Regarding Your Right to File a Complaint

INDIVIDUAL RESPONSIBILITIES

**The Right to File a Complaint**

If you are unhappy or unsatisfied with any service or any staff member from Metrocare Services, you have the right to file a complaint.

If you feel that any of your rights have been violated, you may also file a complaint.

**Filing a Complaint with Metrocare:**

1. Contact Metrocare's Client Rights Protection Office directly at **(214) 743-1296** and speak with someone about your complaint; or

2. Submit your complaint in writing by mail to the following address:

   **Client Rights Protection Office**
   **Metrocare Services**
   **1345 River Bend Drive, Suite 200**
   **Dallas, Texas 75247**

3. Ask a staff member if you need help submitting your complaint by telephone or in writing to the Client Rights Protection Office on your behalf.

Please be prepared to provide the following information when filing a complaint:

- Your name, date of birth and phone number
- Name and date of birth of the individual who receives services from Metrocare if not same person
- Details of your complaint

Complaints may be submitted anonymously. However, without knowing your identity or additional information the Client Rights Protection Office may not be able to assist you further.

Complaints are assessed within 24 hours and prioritized in the order that it was received and based on the nature of the complaints.

**Review:**

Once your complaint is submitted, the Client Rights Protection Office will:

- Review your complaint,
- Contact you for further information as needed, and
- Notify you about the steps taken or that will be taken to address or resolve your complaint.

If you do not hear from anyone at Metrocare within 5 business days after submitting your complaint, please contact the Client Rights Protection Office at (214) 743-1296 for further assistance.

**Resolution:**

You should receive a call from the Client Rights Protection Office or another appointed person regarding an available resolution or the steps that will be taken in regards to resolving your complaint within 5 business days from the date the complaint was received.

Complaints are generally resolved within 14 business days of the initiation of a review.

**Appeals Process:**

If, after speaking with someone from the Client Rights Protection Office, your concern has not been satisfactorily resolved, you may contact the following to file a complaint:

- Regarding Mental Health Services:
  **Department of State Health Services ("DSHS") of Consumer Services and Rights Protection**
  **Phone: 1-800-252-8154**

- Regarding Intellectual and Developmental Disabilities Services:
  **Department of Aging & Disability Services ("DADS")**
  **Office of Consumer Services and Rights Protection**
  **Phone: 1-800-458-9858**

- Regarding Substance Abuse or Narcotic Treatment:
  **Substance Abuse Facility Investigations (MC 1979)**
  **Phone: 1-800-832-9623**

- Regarding any services you receive here as this is an ACHC accredited organization:
  **Accreditation Commission for Health Care, Inc. ("ACHC")**
  **Consumer Complaints Against ACHC Accredited Organizations**
  **Phone: Toll Free at 1-855-937-2242 or (919) 785-1214**

**By signing below, I acknowledge that I have received this *Notice Regarding My Right to File a Complaint* on this date.**

_____ _____
Signature of Individual/Legal Representative Date

_____
Printed Name of Individual

Reviewed by: _____
Staff Member Printed Name

| Name (First, Last): | RU: | DOB: | MRN: |
|---|---|---|---|

The Steven A. Cohen Military Family Clinic at Metrocare

# Consent for Services

I,_____, hereby acknowledge the following:

- **Consent to Evaluation and Assessment**. I consent for an evaluation and assessment to help determine my treatment/service needs. I understand the importance of providing detailed and accurate information during my evaluation.

- **Consent to Treatment/Services**. I consent for treatment/services to be provided to me. My clinician and I will develop a treatment plan based on my evaluation and stated goals. The treatment plan will be explained and agreed upon before proceeding with services. Any changes to the plan will be discussed as part of ongoing services. Options for available alternative treatments will also be reviewed. At any time, I can opt out of the treatment/services.

- **Contact for Research Study**. The Steven A. Cohen Military Family Clinic at Metrocare (Cohen Clinic) may partner with Cohen Veterans Network, Inc. ("CVN"), and its parent agency, Metrocare Services, to conduct research studies for the purposes of advancing the field of military behavioral healthcare and other behavioral healthcare. You are invited to volunteer for any Metrocare-approved research study for which you may qualify. Additionally, your participation serves to advance and expand the types of future treatment and services options for you and your peers. Please check the box below to indicate whether you would like to be contacted by Cohen Clinic to participate in Metrocare-approved research studies.

| | |
|---|---|
| ☐ **YES.** I want to be contacted by Cohen Clinic about participating in Metrocare-approved research studies. | ☐ **NO. I do not want** to be contacted by Cohen Clinic about participating in Metrocare-approved research studies. |

I understand that I may withdraw my consent to be contacted for research study by submitting my request to be withdrawn in writing. Cohen Clinic staff are available to assist me in the withdrawal of consent if needed. Alternatively, if I decide I want to be contacted for research study, I may contact the Cohen Clinic to notify them of my interest.

- **Authorization for Payment.** I ☐ do OR ☐ do not authorize the Cohen Clinic to bill my insurance company for all charges incurred in connection with my diagnosis, care, and treatment, and other eligible, covered services. I authorize and consent Cohen Clinic to use and disclose my health information to my insurance company as needed to obtain payment from my insurance company.

- **Notice of Privacy Practices**. I acknowledge that I have received the Notice of Privacy Practices which describes the ways in which the Cohen Clinic may use and disclose my health information for its treatment, payment, healthcare operations, and other prescribed and permitted uses and disclosures.

- **Telehealth.** I may be provided the opportunity to receive services through a HIPAA compliant two-way audio/video link. I understand the benefits of this are increased access to care and convenience. The possible risks are interruption/disconnection to the audio/video link, delay in treatment due to failure of equipment, need for internet connection that may fail, and the lack of access to all information that might be available in an in-person visit. If telehealth services are deemed inappropriate by my provider at any time, I will be offered a different follow-up plan. By consenting to telehealth, I approve email communication to receive links to measures as well as appointments.

- **Individual Rights and Responsibilities of Persons Served.** I acknowledge that I have received the Individual Rights and Responsibilities document that summarizes rights and responsibilities while I am undergoing services within the agency.

- **Notice Regarding Your Right to File a Complaint.** I acknowledge that I have received this notice which describes how to make a complaint to Metrocare and/or state agencies.

***Consent to text, email & video recording***

**Text Messages & Email**

I _____ consent to receive the following information from the Cohen Clinic by the method(s) indicated below *(check all that apply)*:

☐ Appointment reminders from the Cohen Clinic

☐ Other communications by the Cohen Clinic that do not fall under the impermissible categories below

I authorize and consent to the Cohen Clinic to *(check all that apply)*:

☐ Send **text message communications*** to me at: _____ cell phone carrier: _____

*I understand that if I reply to a text message, I may incur additional charges from my phone carrier

☐ Send **e-mail communications** to: _____

**I understand that it is my responsibility to provide the Cohen Clinic with my most current telephone number and e-mail address.**

The Cohen Clinic **does not permit** the use of text or e-mail communications for the following:

- Emergency or time-sensitive issues;
- Highly sensitive or confidential medical and/or personal information, including protected health information;
- A substitute for clinical services or encounters; and
- Requests for medical records or other documentation.

**I understand that by authorizing e-mail and text message communications that there are certain privacy and security risks involved with there being no guarantee that my text messages and/or e-mail are private and/or secure.** However, understanding these risks, I consent to receive e-mail and text message communications specifically for what I have authorized above and what is acceptable by the Cohen Clinic. **I can make changes or revoke my consent to receive future text message and/or e-mail communications as authorized above at any time by informing Cohen Clinic of my intent**.

**Audio/Video Recording**

I _____ ☐ consent to audio/video ☐ consent to audio-only (no video) ☐ do not consent to audio/videotaping for training and supervision purposes. The contents of these taped sessions are confidential and the information will not be shared outside the context of training and supervision. I understand that I can request that the video recorder be turned off at any time and that the tape or any portion thereof be erased. I may terminate this permission to videotape at any time. Recordings will be stored digitally and destroyed after they have served their purpose.

**Acknowledgment.** I have been given the opportunity to read and ask questions about the information contained in this form. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than to provide services to me. I understand that I may withdraw this consent for services by submitting my request in writing at any time.

_____ _____

Signature of Client or Legally Authorized Representative Date

_____

Printed Name of Client or Legally Authorized Representative

_____ _____

Signature of Cohen Clinic Staff Printed Name of Cohen Clinic Staff


The Steven A. Cohen Military Family Clinic at Metrocare

## Personal Information

Full Name: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Gender Identity: *(Circle one)*

Male Female Other/Non-conforming

Transgender, identifies as male Transgender, identifies as female

Sexual Orientation: *(Circle one)*

Bisexual Fluid Gay/Lesbian

Other Straight or Heterosexual Do Not Know Choose Not to Disclose

SSN: _____ DOB _____

Race/Ethnicity: *(Circle all that apply)*

American Indian/ Alaska Native | Asian/ South Asian | Black/ African American | Hispanic/ Latino

Native Hawaiian/ Pacific Islander | White/ Caucasian | Other: _____

## Emergency Contact Information

Full Name: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

## Military Background - Veteran as Identified Client

Military Branch: *(Circle all that apply)*

| | | |
|---|---|---|
| Air Force | Army | Coast Guard |
| Marine Corps | Navy | National Guard |
| Reserves | Currently Guard/ Reserve | Current Active Duty |

Military rank: _____

Military discharge status: Honorable ❑ General ❑ Other than honorable ❑

Are you currently receiving care at the VA? Yes ❑ No ❑ Don't know ❑

If YES, what type of service are you currently receiving from the VA? *(Check all that apply):*

- ❑ Primary health care
- ❑ Mental health evaluation
- ❑ Mental health treatment
- ❑ Prescription medication
- ❑ HUD/VASH
- ❑ Specialty care: _____
- ❑ Other: _____

Do you have a disability rating through the VA? Yes ❑ No ❑

If yes, please list condition(s) and percentage? _____

## Military Background – Family Member as Identified Client

Which family member served in the US Military? _____

Military discharge status: Honorable ❑ General ❑ Other than honorable ❑ Unknown ❑

Is s/he currently enrolled in the VA for health care? Yes ❑ No ❑ Unknown ❑

Do they have a disability rating through the VA? Yes ❑ No ❑

If yes, what is their percentage? _____

Are you currently serving as a caregiver for your veteran family member? Yes ❑ No ❑

## Personal Background Information

Marital Status: *(Circle one)*

Now married Divorced Separated Widowed

Never married Living with partner Other: _____

Highest level of education completed: *(Circle one)*

Less than high school High school Associates degree College degree

Post college degree Other: _____

Current employment status: *(Circle one)*

Full-time Part-time Unemployed Do not work

Other: _____

Current Employer: _____

What is your annual household income? $_____

How much of your annual household income comes from subsidies (e.g., disability benefits/ social security/ TANF/ other support)? $_____

How much of your annual household income comes from wages? $_____

Who currently resides in your home?

| Name | Age | Relationship to Patient |
|---|---|---|

Are there any firearms in your home? Yes ☐ No ☐

If yes, please provide more information (if they are locked, who has access, etc):

## Medical History

Do you have any chronic illnesses or current physical problems? Yes ❑ No ❑

If yes, please note any current health needs: _____

Do you smoke? Yes ❑ No ❑

Do you have any medication or other allergies? Yes ❑ No ❑

If yes, please list: _____

Are you taking any prescription or non-prescription medications, including those for mental health? (please include any supplements or homeopathy)
If yes, please list in table below Yes ❑ No ❑

Current pregnancy/ prenatal care? (if applicable) Yes ❑ No ❑

Do you have a primary care physician? Yes ❑ No ❑

If yes, please list name/phone: _____

Do you have an advanced directive? Yes ❑ No ❑

If no, do you want more information? Yes ❑ No ❑

**Current Medications:** *Attach additional pages if necessary*

| Medication | Dosage | Taken as Prescribed? | |
|---|---|---|---|
| | | Yes | No |
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |

Do you feel your medications are effective? ☐ **Yes** ☐ **No**

If no, please explain:

Are you concerned about any side effects or adverse reactions? ☐ **Yes** ☐ **No**

If yes, please explain:

**Past Medications: Please list any past medications and their efficacy** *Attach additional pages if necessary*

| Medication | Efficacy | |
|---|---|---|
| | Yes | No |
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |

**In the past two weeks, were there any changes to your medication?**

If YES, what were the changes? _____

## Pain Questionnaire

**In the past 3 months**, have you been experiencing pain that interferes with your normal activities on **more than half the days each month?** Yes ❑ No ❑

If yes, please rate your pain by circling the number that best describes your pain in the last 24 hours:

| 1 | | | | | | | | | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No pain | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | As bad as you can imagine |

How much has your pain interfered with your normal activities (including work outside and inside the house)?

| 1 | | | | | | | | | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No interference | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Complete interference |

Do you need additional help with your pain? Yes ❑ No ❑

## Health Questionnaire

Q-LES-Q-SF

Taking everything into consideration, **during the past week**, how satisfied have you been with your…

| | Very Poor | Poor | Fair | Good | Very Good |
|---|---|---|---|---|---|
| 1. physical health | 1 | 2 | 3 | 4 | 5 |
| 2. mood | 1 | 2 | 3 | 4 | 5 |
| 3. work | 1 | 2 | 3 | 4 | 5 |
| 4. household activities | 1 | 2 | 3 | 4 | 5 |
| 5. social relationships | 1 | 2 | 3 | 4 | 5 |
| 6. family relationships | 1 | 2 | 3 | 4 | 5 |
| 7. leisure time activities | 1 | 2 | 3 | 4 | 5 |
| 8. ability to function in daily life | 1 | 2 | 3 | 4 | 5 |
| 9. sexual drive, interest, and/or performance* | 1 | 2 | 3 | 4 | 5 |
| 10. economic status | 1 | 2 | 3 | 4 | 5 |
| 11. living/housing situation* | 1 | 2 | 3 | 4 | 5 |
| 12. ability to get around physically without feeling dizzy or unsteady or falling?* | 1 | 2 | 3 | 4 | 5 |
| 13. your vision in terms of ability to do work or hobbies?* | 1 | 2 | 3 | 4 | 5 |
| 14. overall sense of well being | 1 | 2 | 3 | 4 | 5 |
| 15. medication (if not taking any, check here ❑ and leave item blank) | 1 | 2 | 3 | 4 | 5 |
| 16. How would you rate your overall life satisfaction and contentment during the past week? | 1 | 2 | 3 | 4 | 5 |

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction. *(For example, if your satisfaction is poor for your housing situation, underline housing.)*

## Injury Questionnaire

DVBIC

The following questions are about any physical injuries you may have had at some point in your life.

1. Have you ever had an injury (or injuries) from any of the following? *(Check all that apply)*

   - ❑A Fragment
   - ❑B Bullet
   - ❑C Vehicular (car, motorcycle, bicycle, ATV, airplane, etc.)
   - ❑D Fall (on ice, from a horse, from a height, etc.)
   - ❑E Blast (IED, RPG, land mine, grenade, etc.)
   - ❑F Sports
   - ❑G Physical altercation (hit in the head, being shaken violently, being choked, etc)
   - ❑H Other (specify): _____
   - ❑I No injury

2. Did an injury result in any of the following? *(Check all that apply)*

   - ❑A Being dazed, confused, "seeing stars," "having your bell rung"
   - ❑B Not remembering the injury
   - ❑C Losing consciousness (knocked out) for less than a minute
   - ❑D Losing consciousness for 1 to 20 minutes
   - ❑E Losing consciousness for longer than 20 minutes
   - ❑F Having any symptoms of concussion afterward (such as headache, dizziness, irritability, etc.)
   - ❑G Head injury (head bleeding, skull injury)
   - ❑H None of the above

3. Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion? *(Check all that apply)*

   - ❑A Headaches
   - ❑B Ringing in the ears
   - ❑C Dizziness
   - ❑D Irritability
   - ❑E Memory problems
   - ❑G Sleep problems
   - ❑H Balance problems
   - ❑I Other: _____
   - ❑J None of the above

## Childhood Experiences Questionnaire

ACE

| **While you were growing up, during your first 18 years of life:** | **Yes** | **No** |
|---|---|---|
| 1. Did a parent or other adult in the household **often** …<br>Swear at you, insult you, put you down, or humiliate you?<br>**or**<br>Act in a way that made you afraid that you might be physically hurt? | | |
| 2. Did a parent or other adult in the household **often** …<br>Push, grab, slap, or throw something at you?<br>**or**<br>**Ever** hit you so hard that you had marks or were injured? | | |
| 3. Did an adult or person at least 5 years older than you **ever**…<br>Touch or fondle you or have you touch their body in a sexual way?<br>**or**<br>Try to or actually have oral, anal, or vaginal sex with you? | | |
| 4. Did you **often** feel that …<br>No one in your family loved you or thought you were important or special?<br>**or**<br>Your family didn't look out for each other, feel close to each other, or support each other? | | |
| 5. Did you **often** feel that …<br>You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?<br>**or**<br>Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? | | |
| 6. Were your parents **ever** separated or divorced? | | |
| 7. Was your mother or stepmother:<br>**Often** pushed, grabbed, slapped, or had something thrown at her?<br>**or**<br>**Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?<br>**or**<br>**Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife? | | |
| 8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? | | |
| 9. Was a household member depressed or mentally ill or did a household member attempt suicide? | | |
| 10. Did a household member go to prison? | | |

## Life Events Checklist

LEC

**Instructions:** Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

| Event | Happened to me | Witnessed it | Learned about it | Part of my job | Not sure | Doesn't apply |
|---|---|---|---|---|---|---|
| 1. Natural disaster (for example, flood, hurricane, tornado, earthquake) | | | | | | |
| 2. Fire or explosion | | | | | | |
| 3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash) | | | | | | |
| 4. Serious accident at work, home, or during recreational activity | | | | | | |
| 5. Exposure to toxic substance (for example, dangerous chemicals, radiation) | | | | | | |
| 6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up) | | | | | | |
| 7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb) | | | | | | |
| 8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm) | | | | | | |
| 9. Other unwanted or uncomfortable sexual experience | | | | | | |
| 10. Combat or exposure to a war-zone (in the military or as a civilian) | | | | | | |
| 11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war) | | | | | | |
| 12. Life-threatening illness or injury | | | | | | |
| 13. Severe human suffering | | | | | | |
| 14. Sudden violent death (for example, homicide, suicide) | | | | | | |
| 15. Sudden accidental death | | | | | | |
| 16. Serious injury, harm, or death you caused to someone else | | | | | | |
| 17. Any other very stressful event or experience | | | | | | |

## PLEASE COMPLETE ON WORST TRAUMA FROM PREVIOUS PAGE

PCL-5 Monthly **Conduct if PC-PTSD during screener indicated**

This questionnaire asks about problems you may have had in response to a very stressful experience.

**This could be any event that involved *actual or threatened death, serious injury, or sexual violence*.** It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend.

Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; or homicide or suicide.* If nothing like this has happened to you, just identify the most stressful event you have experienced.

Please briefly describe your *worst event*, that is, the event that bothers you the most currently. The worst event might be something that happened more than once, and you might have a hard time deciding which time was the worst. If so, you may want to consider all of the similar events together as the worst event.

| Briefly describe the event: |
|---|
| How long ago did it happen? |

| **In the past month, how much were you bothered by:** | **Not at all** | **A little bit** | **Moderately** | **Quite a bit** | **Extremely** |
|---|---|---|---|---|---|
| 1. Repeated, disturbing, and unwanted memories of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 2. Repeated, disturbing dreams of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*? | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling very upset when something reminded you of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*? | 0 | 1 | 2 | 3 | 4 |
| 6. Avoiding memories, thoughts, or feelings related to the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*? | 0 | 1 | 2 | 3 | 4 |

| **In the past month, how much were you bothered by:** | **Not at all** | **A little bit** | **Moderately** | **Quite a bit** | **Extremely** |
|---|---|---|---|---|---|
| 8. Trouble remembering important parts of the stressful experience *(for some reason besides a head injury or alcohol or drug use)*? | 0 | 1 | 2 | 3 | 4 |
| 9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*? | 0 | 1 | 2 | 3 | 4 |
| 10. Blaming yourself or someone else *(who didn't directly cause the event or actually harm you)* for the stressful experience or what happened after it? | 0 | 1 | 2 | 3 | 4 |
| 11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? | 0 | 1 | 2 | 3 | 4 |
| 12. Loss of interest in activities that you used to enjoy? | 0 | 1 | 2 | 3 | 4 |
| 13. Feeling distant or cut off from other people? | 0 | 1 | 2 | 3 | 4 |
| 14. Having trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*? | 0 | 1 | 2 | 3 | 4 |
| 15. Feeling irritable or angry or acting aggressively? | 0 | 1 | 2 | 3 | 4 |
| 16. Taking too many risks or doing things that could cause you harm? | 0 | 1 | 2 | 3 | 4 |
| 17. Being "super alert" or watchful or on guard? | 0 | 1 | 2 | 3 | 4 |
| 18. Feeling jumpy or easily startled? | 0 | 1 | 2 | 3 | 4 |
| 19. Having difficulty concentrating? | 0 | 1 | 2 | 3 | 4 |
| 20. Trouble falling or staying asleep? | 0 | 1 | 2 | 3 | 4 |

## Relationship Questionnaire

RDAS

Are you currently in a relationship? Yes ❑ No ❑ (If NO, do not complete the rest of this questionnaire.)

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

| | Always agree | Almost always agree | Occasionally agree | Frequently disagree | Almost always disagree | Always disagree |
|---|---|---|---|---|---|---|
| 1. Religious matters | 5 | 4 | 3 | 2 | 1 | 0 |
| 2. Demonstrations of affection | 5 | 4 | 3 | 2 | 1 | 0 |
| 3. Making major decisions | 5 | 4 | 3 | 2 | 1 | 0 |
| 4. Sex relations | 5 | 4 | 3 | 2 | 1 | 0 |
| 5. Conventionality (correct or proper behavior) | 5 | 4 | 3 | 2 | 1 | 0 |
| 6. Career decisions | 5 | 4 | 3 | 2 | 1 | 0 |

| | All of the time | Most of the time | More often than not | Occasionally | Rarely | Never |
|---|---|---|---|---|---|---|
| 7. How often do you discuss or have you considered divorce, separation, or terminating your relationship? | 0 | 1 | 2 | 3 | 4 | 5 |
| 8. How often do you and your partner quarrel? | 0 | 1 | 2 | 3 | 4 | 5 |
| 9. Do you ever regret that you married (or live together)? | 0 | 1 | 2 | 3 | 4 | 5 |
| 10. How often do you and your partner “get on each other’s nerves”? | 0 | 1 | 2 | 3 | 4 | 5 |

| | Every day | Almost every day | Occasionally | Rarely | Never |
|---|---|---|---|---|---|
| 11. Do you and your mate engage in outside interests together? | 4 | 3 | 2 | 1 | 0 |

How often would you say the following events occur between you and your mate?

| | Never | Less than once a month | Once or twice a month | Once or twice a week | Once a day | More often |
|---|---|---|---|---|---|---|
| 12. Have a stimulating exchange of ideas | 0 | 1 | 2 | 3 | 4 | 5 |
| 13. Work together on a project | 0 | 1 | 2 | 3 | 4 | 5 |
| 14. Calmly discuss something | 0 | 1 | 2 | 3 | 4 | 5 |

This resource assessment and complementary activity list is designed to ensure we are discussing all your potential needs and connecting you with resources and supports that may assist you.

Name:_____ DOB: _____

Are you interested in resources regarding any of the following:
(Please check all that apply)

☐ Basic Needs (food, clothing, shelter, toiletries)
☐ Financial Assistance (rent/utilities)
☐ Transportation Assistance (bus passes)
☐ Veteran Caregiver Support
☐ Support Groups (for Veteran and/or spouse)
☐ Legal Assistance
☐ Employment/Job Training
☐ Medical/Dental/Prescription assistance
☐ Services for Military Children
☐ Service Connection Disability Assistance
☐ Female Veteran Support
☐ Veteran Education Benefits
☐ Childcare Assistance
☐ Credit Repair/Budgeting
☐ LGBTQ
☐ Transitional Housing
☐ Substance Abuse Treatment Facilities
☐ Disability Benefits (SSI, VA)
☐ Health Insurance
☐ Immigration Services

**Complimentary Activities**

☐ Fishing/Hunting/Shooting Events
☐ Yoga/Meditation
☐ Volunteer Opportunities
☐ Hiking/Biking/Running Activities
☐ Art/Music Workshops
☐ Veteran Ranch Retreats/Horseback Riding

Have you accessed resources for any of the above issues in the past? □ Yes □ No
Would you like to communicate with our case manager to discuss checked items? □ Yes □ No

Other areas of concern: