Psychiatry High Risk Program  
Psychiatry Faculty Practice, Inc.  
719 Harrison St., 3rd Floor  
Syracuse, NY 13210  
315.464.3117 Phone  
315.464.3263 FAX

Program Summary

Thank you for considering Upstate’s Psychiatry High Risk Program, an innovative recovery-based suicide prevention program for youth and young adults ages 14 through 40 years, recognized by the national Suicide Prevention Resource Center as “a best practice” in suicide prevention. Common conditions of clients treated in our program include depression and anxiety, bipolar disorder, eating disorders, borderline personality disorder, PTSD, or addictive behaviors. Instead of treating repeated crises through support, advice, and symptom management in a chronic illness model, we address the underlying vulnerabilities of these conditions, so that our clients no longer feel stuck alone with overwhelming pain. Most clients describe treatment at our program as very different and more helpful than previous treatments with which they have participated.

The program is outpatient only; there is no residential or day hospital component. Treatments include evidence-based individual psychotherapy, along with medication management, family and group therapy as needed. Through addressing underlying neurocognitive and psychosocial vulnerabilities, we aim for transformative healing, building resilience for long-term recovery. Note that family therapy sessions are strongly encouraged for any teen or adult who is living with their parents.

In order for the program to be helpful to you, it is necessary to make the commitment to yourself to attend sessions on a regular basis, work towards health and recovery, actively participate in treatment, and enable open communication among all members of your care team, including your primary care provider. Your first 4 sessions are for consultation purposes to see if the program is a good fit for your needs; therefore, keep your current therapist and psychiatrist until you are formally admitted into the program. The first two of these sessions will involve a comprehensive psychiatric evaluation for treatment planning purposes. Please bring previous records to these sessions. We do not prescribe injectables or controlled medications in the program, except for younger teens. If you have questions, please call our Intake Coordinator Nichole at (315) 464-3117 or email her at GallaN@upstate.edu.

Please check the appropriate box:

☐ Yes  ☐ No  I have read the above summary and agree to the commitments outlined in the last paragraph
# Patient Information

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>SSN</th>
<th>Birth Date</th>
<th>Gender Assigned At Birth</th>
<th>Gender Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Home/Cell Phone</td>
<td>Alt. Phone</td>
<td>Marital Status</td>
</tr>
<tr>
<td>Email</td>
<td>Employer/School</td>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer’s Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Start Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next of Kin/Emergency Contact</td>
<td>Relationship</td>
<td>Phone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Primary Insurance Information

<table>
<thead>
<tr>
<th>Insurance Company and Address</th>
<th>Phone #</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/Member ID #</td>
<td>Group #</td>
<td></td>
</tr>
<tr>
<td>Policy Holder</td>
<td>Address (if different)</td>
<td>SSN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self</td>
</tr>
</tbody>
</table>

# Secondary Insurance Information

<table>
<thead>
<tr>
<th>Insurance Company and Address</th>
<th>Phone #</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/Member ID #</td>
<td>Group #</td>
<td></td>
</tr>
<tr>
<td>Policy Holder</td>
<td>Address (if different)</td>
<td>SSN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self</td>
</tr>
</tbody>
</table>

# Guarantor Information (Person responsible for payment): Self

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Parent (if minor)</th>
<th>Spouse</th>
<th>Other</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (if different from pt)</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Social Security #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home/Cell Phone</td>
<td>Work Phone</td>
<td>Employer/School</td>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer’s Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Start Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In order to best serve you, please complete all of the following:

How did you hear about the program (or who referred you)?

What would you most like help with?

Have you been diagnosed with mental health conditions? If so, which diagnoses have been given?

If you currently have a psychiatrist, therapist, or counselor, what are their names and organizations?

How old were you when you first saw a psychiatrist, therapist, or counselor, and for what reason?

Have you ever been admitted to a psychiatric hospital? If so, when was the most recent time?

Have you ever tried to harm yourself or commit suicide? If so, when was the most recent time and what was the attempt?

Have any family members ever been treated for mental disorders or addictions? If so, which ones and for what conditions? (include parents, siblings, children, aunts, uncles and grandparents)

With whom do you currently live, or are you homeless?

Have you ever been arrested, or have a current legal mandate?

Are you currently employed? If so, where and for how long?

Would you be willing to attend weekly in-person sessions, unless you live far away?  
Yes  No

If you live longer than 45 min drive away, would you be willing to attend in-person at least monthly and have access to internet connection, webcam/phone, and a private location at home?  
Yes  No

Are any of these active or pending services?

☐ Yes  ☐ No  SPOA, Health Home Assistance, or case management?

☐ Yes  ☐ No  Child Protective Services (CPS) open case?

☐ Yes  ☐ No  Medicaid Transportation assistance needed?

☐ Yes  ☐ No  EIP/504 or other accommodations for school or frequent meetings (1x monthly)?
Please list all medications that you are currently taking with dosages (include supplements and over-the-counter medications):

What medications have you taken previously for mental health?

Are you allergic to any medications? If so, please list the medication and the allergic reaction to it:

Have you seen a primary care provider within the past 6 months? If so, what is his/her name?

Have you had any major medical (non-psychiatric) illnesses or surgeries? (Please list below current and past medical problems)

What is your approximate HEIGHT ___________ WEIGHT ___________

How often do you have difficulties with... (check boxes)

<table>
<thead>
<tr>
<th></th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Does not apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain or palpitations?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach pain, nausea, diarrhea, or constipation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulties with urination or sexual functioning?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint or muscle aches?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness or headaches?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irregular periods? (women only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Double or blurry vision? (other than needing glasses)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with your ears, nose, mouth, or throat?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with your skin or hair?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other physical symptoms not mentioned above? (please describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please check the box for YES or NO for the following psychiatric symptoms:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you ever see things or hear things that other people don't see or hear?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ever have panic attacks?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel uncomfortable in crowded situations, such as malls or stores?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have scary memories or dreams of things that happened to you in the past?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had several days in a row of feeling so good that you hardly need any sleep, you are running from one thing to another, your thoughts are racing a mile a minute, and you get big ideas in your head?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Consent for Video Recordings For Clinical Care or Education Purposes

I hereby authorize the Psychiatry Faculty Practice Inc. to:

Take and use video or digital photographs/images of myself either for enhancing the quality of the clinical care provided to me or for use in medical teaching. I understand that these images may be used in various mediums and may be transmitted electronically.

By signing below, I waive any rights I may have in such photographs/images or recordings, as well as the privilege of inspecting or approving them for determining their final disposition. I hereby agree to release Upstate Medical University and Psychiatry Faculty Practice Inc. from any and all liability in connection such photographing, video recordings, etc. for which I am hereby giving my consent. In the event that I wish to revoke my permission granted herein, I understand that I must do so in writing that will be signed and dated by me.

Print Individual’s Name: ________________________________

Signature: ________________________________

Parent or Legal Guardian’s Signature: ________________________________

(Required for patients who are minors)

Date: ________________________________

*Note that the recordings are used for purposes of peer feedback from other therapists in the Psychiatry High Risk Program after particularly challenging sessions. This feedback is important for ensuring that we are delivering to you the highest possible care. We therefore strongly encourage patients in the program to sign consent for recording to maximize their chances of success.
Please describe a recent CONFLICT you had with another person in 5-10 sentences.
Safety Plan

A safety plan is a list of skills and supports that you create before a crisis so that you have it available at times when you are overwhelmed and less able to think clearly. Be sure to keep it in an easily accessible place and give copies to family and other supports so that they can help you to stay safe.

1. **Warning signs**
   *What are the signs that you are doing worse or in crisis? These can be thoughts, feelings, behaviors, or types of situations.*
   a. 
   b. 
   c. 
   d. 

2. **Activities and coping skills**
   *What can you do by yourself to take your mind off of the problem? Ex: walking/gym, Netflix, drawing, music, reading, deep breathing, meditation.*
   a. 
   b. 
   c. 
   d. 

3. **Social support**
   *Who can you turn to for emotional support, distraction, or fun?*

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. **Steps to make the environment safer**
   *Ex: limit access to weapons/meds/sharps, increase supervision, lockboxes*
   a. 
   b. 
   c. 
   d. 

5. **Crisis Resources**
   1. CONTACT in Onondaga County: 315-251-0600 or dial 211
   2. National Suicide Hotline: Dial 988 or TEXT HELLO to 741741

6. **In case of an emergency, please CALL 911 or take self to ER, as well as call your therapist ______________________ at _______________**
The section on page 5 is titled "C. Behavior (Positive):" and asks you to list the number below which indicates how often you used the following positive behaviors:

- 1. Choose to use positive activity in situations of...
- 2. Choose to use positive activity in situations of...
- 3. Choose to use positive activity in situations of...
- 4. Choose to use positive activity in situations of...
- 5. Choose to use positive activity in situations of...
- 6. Choose to use positive activity in situations of...
- 7. Choose to use positive activity in situations of...
- 8. Choose to use positive activity in situations of...

The section on page 6 is titled "A. Thoughts and Feelings:"

- 1. I am feeling overwhelmed or anxious about...
- 2. I am feeling overwhelmed or anxious about...
- 3. I am feeling overwhelmed or anxious about...
- 4. I am feeling overwhelmed or anxious about...
- 5. I am feeling overwhelmed or anxious about...
- 6. I am feeling overwhelmed or anxious about...
- 7. I am feeling overwhelmed or anxious about...
- 8. I am feeling overwhelmed or anxious about...

The section on page 7 is titled "B. Behavior (Negative):"

- 1. I have difficulty completing tasks because...
- 2. I have difficulty completing tasks because...
- 3. I have difficulty completing tasks because...
- 4. I have difficulty completing tasks because...
- 5. I have difficulty completing tasks because...
- 6. I have difficulty completing tasks because...
- 7. I have difficulty completing tasks because...
- 8. I have difficulty completing tasks because...

The section on page 8 is titled "D. Overall Progress:"

- 1. My overall progress has been...
- 2. My overall progress has been...
- 3. My overall progress has been...
- 4. My overall progress has been...
- 5. My overall progress has been...
- 6. My overall progress has been...
- 7. My overall progress has been...
- 8. My overall progress has been...

The section on page 9 is titled "E. Overall Score:"

- 1. My overall score is...
- 2. My overall score is...
- 3. My overall score is...
- 4. My overall score is...
- 5. My overall score is...
- 6. My overall score is...
- 7. My overall score is...
- 8. My overall score is...

The section on page 10 is titled "F. Overall Comments:"

- 1. I noticed that...
- 2. I noticed that...
- 3. I noticed that...
- 4. I noticed that...
- 5. I noticed that...
- 6. I noticed that...
- 7. I noticed that...
- 8. I noticed that...

The section on page 11 is titled "G. Overall Recommendations:"

- 1. I recommend...
- 2. I recommend...
- 3. I recommend...
- 4. I recommend...
- 5. I recommend...
- 6. I recommend...
- 7. I recommend...
- 8. I recommend...

The section on page 12 is titled "H. Overall Recommendation:"

- 1. I recommend...
- 2. I recommend...
- 3. I recommend...
- 4. I recommend...
- 5. I recommend...
- 6. I recommend...
- 7. I recommend...
- 8. I recommend...

The section on page 13 is titled "I. Overall Conclusion:"

- 1. My overall conclusion is...
- 2. My overall conclusion is...
- 3. My overall conclusion is...
- 4. My overall conclusion is...
- 5. My overall conclusion is...
- 6. My overall conclusion is...
- 7. My overall conclusion is...
- 8. My overall conclusion is...

The section on page 14 is titled "J. Overall Summary:"

- 1. My overall summary is...
- 2. My overall summary is...
- 3. My overall summary is...
- 4. My overall summary is...
- 5. My overall summary is...
- 6. My overall summary is...
- 7. My overall summary is...
- 8. My overall summary is...

The section on page 15 is titled "K. Overall Evaluation:"

- 1. My overall evaluation is...
- 2. My overall evaluation is...
- 3. My overall evaluation is...
- 4. My overall evaluation is...
- 5. My overall evaluation is...
- 6. My overall evaluation is...
- 7. My overall evaluation is...
- 8. My overall evaluation is...
PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ___________________________ DATE: ________________________

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems? (use a check mark to indicate your answer)</th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better of dead, or of hurting yourself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add columns: + + +

TOTAL:

Please check YES or NO for the past month:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has there been a time in the past month that you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>[ ]</td>
</tr>
<tr>
<td>2. In the past month, have you actually had any thoughts about killing yourself?</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
### Generalized Anxiety Disorder 7-item (GAD-7) scale

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all sure</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it’s hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add the score for each column

\[ \text{Total Score (add your column scores)} = \]

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?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

SHEEHAN DISABILITY SCALE

A BRIEF, PATIENT RATED, MEASURE OF DISABILITY AND IMPAIRMENT

Please mark ONE circle for each scale.

WORK* / SCHOOL

The symptoms have disrupted your work / school work:

Not at all  Mildly  Moderately  Markedly  Extremely
0 1 2 3 4 5 6 7 8 9 10

☐ I have not worked/studied at all during the past week for reasons unrelated to the disorder.
* Work includes paid, unpaid volunteer work or training

SOCIAL LIFE

The symptoms have disrupted your social life / leisure activities:

Not at all  Mildly  Moderately  Markedly  Extremely
0 1 2 3 4 5 6 7 8 9 10

FAMILY LIFE / HOME RESPONSIBILITIES

The symptoms have disrupted your family life / home responsibilities:

Not at all  Mildly  Moderately  Markedly  Extremely
0 1 2 3 4 5 6 7 8 9 10

DAYS LOST

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? ______

DAYS UNDERPRODUCTIVE

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? ______
Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently, and mark one box [✓] indicating how you feel.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all true for me</th>
<th>Somewhat true for me</th>
<th>Very true for me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>These days, the people in my life would be better off if I were gone</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>2</td>
<td>These days, the people in my life would be happier without me</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>3</td>
<td>These days, I think I am a burden on society</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>4</td>
<td>These days, I think my death would be a relief to the people in my life</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>5</td>
<td>These days, I think the people in my life wish they could be rid of me</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>6</td>
<td>These days, I think I make things worse for the people in my life</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>7</td>
<td>These days, other people care for me</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>8</td>
<td>These days, I feel like I belong</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>9</td>
<td>These days, I rarely interact with people who care about me</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>10</td>
<td>These days, I am fortunate to have many caring and supportive friends</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>11</td>
<td>These days, I feel disconnected from other people</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>12</td>
<td>These days, I often feel like an outsider in social gatherings</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>13</td>
<td>These days, I feel that there are people I can turn to in times of need</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>14</td>
<td>These days, I am close to other people</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>15</td>
<td>These days, I have at least one satisfying interaction every day</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>Statement</td>
<td>Almost Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------------</td>
<td>--------</td>
<td>-----------</td>
<td>-------</td>
</tr>
<tr>
<td>1  When I fail at something important to me, I become consumed by feelings of inadequacy.</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
</tr>
<tr>
<td>2  I try to be understanding and patient towards those aspects of my personality I don't like.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>3  When something painful happens, I try to take a balanced view of the situation.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>4  When I'm feeling down, I tend to feel like most other people are probably happier than I am.</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
</tr>
<tr>
<td>5  I try to see my failings as part of the human condition.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>6  When I'm going through a very hard time, I give myself the caring and tenderness I need.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>7  When something upsets me, I try to figure out what emotions I am experiencing.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>8  When I fail at something that's important to me, I tend to feel alone in my failure</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
</tr>
<tr>
<td>9  When I'm feeling down, I tend to obsess and fixate on everything that's wrong</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
</tr>
<tr>
<td>10 When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>11 I'm disapproving and judgmental about my own flaws and inadequacies.</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
</tr>
<tr>
<td>12 I'm intolerant and impatient towards those aspects of my personality I don't like.</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
</tr>
</tbody>
</table>
Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by circling the corresponding number. Give only one answer for each statement.

Circle 1 if you STRONGLY DISAGREE
Circle 2 if you MODERATELY DISAGREE
Circle 3 if you NEITHER DISAGREE NOR AGREE
Circle 4 if you MODERATELY AGREE
Circle 5 if you STRONGLY AGREE

1. I am often confused about what emotion I am feeling. | 1 2 3 4 5
2. I have physical sensations that even doctors don't understand. | 1 2 3 4 5
3. When I am upset, I don't know if I am sad, frightened, or angry. | 1 2 3 4 5
4. I am often puzzled by sensations in my body. | 1 2 3 4 5
5. I have feelings that I can't quite identify. | 1 2 3 4 5
6. I don't know what's going on inside me. | 1 2 3 4 5
7. I often don't know why I am angry. | 1 2 3 4 5
Adverse Childhood Experience (ACE) 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 …
   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 …
   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
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes  No  If yes enter 1  

4. Did you 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 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 pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over 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

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In the **PAST 30 DAYS**: *(for each item, please fill in the number of days)*

How many days did you spend in the emergency room or CPEP?

How many days did you spend on a psychiatric hospital ward?

How many days were you paid for working (employment) or were attending school?

How many days did you go on eating binges during which you ate so much that you felt uncomfortably full?

How many days did you force yourself to vomit, exercise excessively, use laxatives, or go on strict diets?

How many days did you try to harm yourself by cutting, overdose, puncturing, burning, or smothering?

How many days did you physically harm or threaten to harm another person?

How many days did you have 5 or more drinks containing alcohol (wine, beer, liquor, etc.)?

How many days did you use an illegal drug or use a prescription medication for nonmedical reasons? *(Please include marijuana and prescribed THC)*