COMMANDER
COUNSELING & WELLNESS

CLIENT INFORMATION

Name _____ Date of Birth _____/_____/_____

Email _____ Phone (_____)_____-_____

Gender _____ Ethnicity _____

Address _____

City and State_____ Zip Code _____

Parent/Guardian name (if under 18 years old): _____

Emergency Contact Name _____ Phone (_____)_____-_____

Who referred you here? _____

INSURANCE

Insurance Name _____ Member ID # _____

Insured Name _____ Insured DOB _____

BILLING & PAYMENT INFO

For non-Medicaid patients, we require you keep a credit, debit, or health card on file in case of a no-show in which we charge a $65 fee.

Card number: _____ Exp. Date: _____/_____

3-digit Security Number: _____ Zip Code: _____

Clients are now able to take advantage of easier pay options, with automatic payments. A credit card is stored in a HIPAA secured format and automatically processes copays and deductibles at the end of the day. This adds convenience of not having to pay at the time of the session, and the ability to pay online through the client portal.
I authorize Commander Counseling & Wellness (CCW) to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that CCW will charge my card for $65 as a late cancel or no show if I do not show up for the appointment.
I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Signature:_____Date:_____/_____/_____

Payment/copayments are due at the time of service. If you do not have your copayment you may be asked to reschedule your appointment. We accept cash, check, and credit/debit cards. Payment is determined by the following:

- Medicaid (Soonercare) insures you and the treatment are covered under the age of 18: No payment is due for services.
- You are insured by a Managed Care plan with which your provider is contracted, it is your responsibility to make sure that we are contracted with your particular plan. The amount due at the time of service will depend on the specifics of your plan. Co-pay and deductible are due at the time of service.
- If you are unable to provide insurance information at the time of the appointment you will be required to make payment in full or reschedule your appointment. You will be given an itemized receipt that you can file with your insurance company for reimbursement.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

RELEASE OF INFORMATION

I authorize Commander Counseling & Wellness (CCW) to furnish information to insurance carriers concerning my diagnosis and treatments and I hereby assign to the provider all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also authorize the release of all or part of the client's record, for incident of care to any person liable for any part of provider charges. I also acknowledge the responsible party is liable for payment in full for the services provided. I also understand the responsible party is liable for all attorneys' fees necessary in the collection of my delinquent amount. All appointments require 24-hour notice for cancellation. If 24-hour notice is not provided, the responsible party will be charged **$65** for the charge of the session. I also authorize my provider to consult with other CCW mental health care providers on an as needed basis.

Signature _____ Date _____/_____/_____

Relationship to Client if Minor _____

CONSENT FOR TREATMENT

I consent to medical treatment for myself or for the patient/client for whom I am the parent or legally authorized representative. I understand that Commander Counseling & Wellness will share patient/client health information according to federal and state law for treatment and operations. Further, I understand that the information discussed in the counseling setting is held confidential and will not be shared without written permission except under the following conditions:

1. The patient/client threatens suicide.
2. The patient/client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The patient/client reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The patient/client reports abuse of the elderly.
5. The patient/client reports sexual exploitation by a therapist.
6. The psychologist is required by court order to reveal privileged information.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies. Communication between the clinician and patient/client will otherwise be deemed confidential as stated under the laws of this state.

Having read and understood the above, I agree to these limits of confidentiality.

_____

Name of Patient Signature of Patient or Guardian Date

PSYCHOLOGIST-PATIENT SERVICES AGREEMENT

Welcome to Commander Counseling and Wellness. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy
Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement and can be found at CommanderCounselingandWellness.com, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a physician visit. Instead, it calls for very active effort on your part. In order for therapy to be most successful, you will have to work on issues discussed, both during our sessions and at home.
Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits.
Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

Sessions are typically 45-50 minutes, once per week at a time agreed on, although some sessions may be longer or more/less frequent. **Once an appointment hour is scheduled, you will be expected to pay the $65 no show fee unless you provide at least 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If it is possible, we will try to find another time to reschedule the appointment.

Our providers make every effort possible to schedule clients at the earliest possible opportunity. One business day prior to your appointment you will receive a text message reminder (if you have not opted out of this service). The text message will request that you reply to confirm, reschedule, or cancel your scheduled appointment. Should you need to reschedule or cancel, we ask that you notify us 24 hours prior to your appointment, as we have individuals on the cancellation list that would appreciate an earlier appointment. On the occasion that you miss an appointment, you will receive a notice of the "No Show." Should this occur a second and future times, you will be responsible for a $65 fee that cannot be billed to your insurance. This fee can be collected either by charging a card on file or if you choose not to have a card on file must be paid in office or over the phone prior to scheduling your next appointment. If you are more than 15 minutes late for your appointment, your provider may ask that you reschedule.

TELEHEALTH

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).

- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

EMAIL & TEXTING

Our office may only use email and texting only to schedule or modify appointments. Please do not email/text your provider any content related to your therapy sessions, as it is not secure or confidential. If you choose to communicate with us through email/texting, be aware that unencrypted emails may be intercepted and read by third parties. Also, all email/texts are retained in the logs of the internet and telephone service providers. While it is unlikely that someone will look at these logs, they are able to be read by the system administrator(s). Also, please be aware that any emails or texts received by your service provider and sent from your provider become a part of your client file. Note that University of Oklahoma emails are considered open records and can be requested by outside sources.

SOCIAL MEDIA POLICY

Our office does not accept friend or contact requests from current or former clients on any social networking site (i.e. Facebook, LinkedIn, Twitter, etc.). Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective policy. It may also blur the boundaries of a therapeutic relationship.

PROFESSIONAL FEES

Hourly fees range from $80-$150 for 45-50-minute individual psychotherapy sessions. In addition to weekly appointments, we may charge $150 per hour for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. We charge $150 per hour for preparation and $350 per hour for attendance at any legal proceeding; the latter is charged from the time we leave the office until we return.

CONTACTING US

Due to our work schedule, we are often not immediately available by telephone. While we are usually in the office between 9 AM and 5 PM, we will not answer the phone when we are with a patient. When we are unavailable, you may leave a message. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of times when you will be available. In emergencies or crises that you believe cannot wait for us to return your call, contact your family physician or go to the nearest emergency room and ask for the mental health professional on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only disclose information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that do not require your authorization, including the following:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that we may employ administrative staff to assist us with billing. These personnel need to have access to protected information in order to perform their duties. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without our permission.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. There are some other situations where we are permitted or can be required to disclose information without your consent or Authorization.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, we may disclose information relevant to that claim to the appropriate parties, including the Administrator of the Workers' Compensation Court. There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.
- If we have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that we report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation, the law requires that we report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, we may be required to provide additional information.
- If a patient communicates an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable victim and he/she has the apparent intent and ability to carry out the threat, or if a patient has a history of violence and we have reason to believe that there is a clear and imminent danger that the patient will attempt to kill or inflict serious bodily injury upon a reasonably identified person. We may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.
- If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and WE will limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. **EXCEPT** in circumstances that involve danger to yourself and/or others, where information has been supplied to us confidentially by others, or **if the information has been gathered in a reasonable anticipation of or specifically for use in litigation**, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence or have them forwarded to another mental

health professional, so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $1.00 for the first page and $.50 for each additional page (and for certain other expenses). If we refuse your request for access to your records, you have a right of review in some instances, which we will discuss with you upon request. In some instances, there is no right to have a review of the decision to refuse your request to inspect and/or copy the protected health information of your record.

Forms and Letters: Please allow for at minimum 3 business days for all forms and letters to be completed. Please allow for a minimum of 10 business days for Psychological Evaluation Reports to be completed after the date of feedback. If payment for Evaluations is not paid in full at date of feedback, please allow for a minimum of 10 business days for the report to be completed after payment is received.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is our policy to request an agreement from parents that they will give up their access to their child's records. If they agree, during treatment we will provide them with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have. We reserve the right to refuse to provide services to a child if a parent will not agree to accept these conditions. Parents should be aware that the agreement constitutes a binding contract.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company.

Sometimes insurance companies require additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report WE submit, if you request it. **If your insurance denies reimbursement, you will be responsible for payment of the provided services.**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____

Client Signature Date

USE OF EMAIL FOR DISTRIBUTION OF INFORMATION OR RECORD

With permission, you may be able to receive your medical records (e.g., psychological evaluation report) via email. We do not receive emails. Please read the following and chose an option.

- When we send you an email, the information that is sent may not be encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website.
- The guidelines state that if a patient/client has been made aware of the risks of unencrypted email, and that same patient/client provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

Option 1 – Allow Unencrypted Email

I understand the risks of unencrypted email and do hereby give permission to CCW to send me personal health information via unencrypted email

_____

Signature Printed Name Date

_____

Email address

Option 2 – Do Not Allow Unencrypted Email

I do not wish to receive personal health information via email

_____

Signature Printed Name Date

COMMANDER
COUNSELING & WELLNESS

BACKGROUND INFORMATION FORM

Name: _____ Sex: _____

Date of Birth: _____/_____/_____ Age: _____

Who referred you here? _____

Presenting Problems or Concerns

In your own words, what are the problems or concerns that you are experiencing? _____

_____

_____

When would you say these problems first began? _____

Family History

Please fill in the names, ages, etc. of your family: (Please indicate if half, step, or adopted relatives)

	Name	Age	Level of Education	Occupation
Father(s)				
Mother(s)				
Sibling(s)				

Are your parents currently married?_____For how long?_____Divorced?_____For how long?_____

Where were you born? and raised? _____

Did anyone else help raise you? _____

Please circle any of the following which were problems for you as a child and/or adolescent:

Stealing	tiredness/fatigue	clumsiness	lying	eating problems
over activity	school problems	sex problems	underactivity	running away
shyness	easily upset	extreme fears	self-critical	temper tantrums
depression	sleeping problems	cruelty	nervousness	overly sensitive

Who currently lives with you?

Name	Relationship	Age	Level of Education	Occupation

What things do you like to do for fun? _____

Who have you felt close to in your life? _____

Who do you get along best with?_____Worst?_____

What religion does your family belong to? _____

How would you describe your sexual orientation? _____

How would you describe your relationship status? Any problems? _____

_____

Who do you go to for help with your problems? _____

How many times have you been married? _____

Are there any aspects to your cultural identify or background that cause stress?_____

Do you belong to any social or academic organizations?_____

School and Work History

Highest Completed Grade:_____Major:_____GPA:_____

Schools/Universities attended: _____

_____

What grades did you repeat or skip? _____

Where you ever diagnosed with any learning disabilities? _____

What type of special educational or gifted services did you receive? _____

Did you receive speech and language therapy? _____

Have you ever been suspended from school?_____How many times?_____Expelled? _____
Did you have problems getting along with peers?_____Teachers? _____

Check what most describes your school achievement:

- Below Average (mostly D's & F's)
- Low Average (mostly C's & D's)
- Average (mostly C's)
- High Average (mostly B's & C's)
- Above Average (mostly A's & B's)

What were your favorite classes? _____

What were you least favorite classes? _____

How often did you miss school? _____

How hard did you have to try in school to get your grades?_____

Please list your previous work experience:

Employer	Job Title	Dates	Full/Part Time	Reason for leaving?

How did you get along with your supervisors? _____
How did you get along with your co-workers? _____
Have you ever been fired from a job? _____

Biomedical and Developmental History

Where there any complications during your birth? _____

What have you been hospitalized for in the past? _____

What medical conditions or serious injuries or illness have you experienced? And when? _____

_____

Have you ever received a head injury or lost consciousness? Yes No

If "yes" approximately how many times have you been knocked out? _____ How long? _____

Check below if you have any problems with:

- Hearing
- Motor Coordination
- Speech
- Vision

What aches, pains or physical discomforts do you have? _____

Please list your current and previously prescribed medications:

Name of Meds	Dosage	Started Taking	Stopped Taking

What medical/physical problems have your family members experienced? _____

_____

What previous experiences have you had with counseling or psychological testing?

Dates	Therapist or Institution	Nature of problem

What have you been previously diagnosed with? _____

Have you witnessed or experienced abuse? _____

Do you have any problems with eating? _____

Have you ever been hospitalized for emotional or psychological reasons?_____

Are you currently experiencing any suicidal thoughts?_____Homicidal thoughts?_____

How many suicidal attempts have you experienced?_____When?_____

Do you see or hear things that others do not see or hear?_____

Substance Abuse and Legal History

Please describe your current substance use:

Substance	Times used a week	Most in a day	Age first used
Alcohol			
Tobacco			
Marijuana			
Non-prescribed pills			
Other:			

Have you ever received any substance abuse treatment? _____

Have you ever tried to cut down on your drinking?_____

How often do you experience blackouts (not remembering)? _____

Have you ever had any legal trouble due to substance use? _____

Who in your family has/had a problem with alcohol or other substances? _____

Legal History

What type of legal problems have you been in? _____

_____

Are you currently on probation or parole? _____

What troubles has your family had with the law? _____

What other information do you think would be helpful for us to know? _____

_____

_____

_____

Childhood ADHD Symptoms Scale Self-Report

Please mark the answer that best describes your behavior when you were a child age 5 to 12 years old.

1. Failed to give close attention to details or make careless mistakes in my work.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

2. Fidgeted with hands or feet or squirm in seat.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

3. Left my seat in classroom or in other situations in which seating was expected.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

4. Didn't listen when spoken to directly.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

5. Felt restless.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

6. Didn't follow through on instructions and failed to finish work.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

7. Had difficulty engaging in leisure activities or doing fun things quietly.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

8. Had difficulty organizing tasks and activities.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

9. Felt "on the go" or "driven by a motor."
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

10. Avoided, disliked, or was reluctant to engage in work that requires sustained mental effort.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

11. Talked excessively.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

12. Lost things necessary for tasks or activities.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

13. Blurted out answers before questions had been completed.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

14. Easily distracted.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

15. Had difficulty awaiting turn.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

16. Forgetful in daily activities.
   - Never or Rarely
   - Sometimes
   - Often

- Very Often

17. Interrupted or intruded on others.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

Current ADHD Symptoms Scale Self-Report

Please mark the answer that best describes your behavior during the past 6 months.

1. Failed to give close attention to details or make careless mistakes in my work.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

2. Fidgeted with hands or feet or squirm in seat.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

3. Left my seat in classroom or in other situations in which seating was expected.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

4. Didn't listen when spoken to directly.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

5. Felt restless.
    - Never or Rarely
    - Sometimes
    - Often

- Very Often

6. Didn't follow through on instructions and failed to finish work.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

7. Had difficulty engaging in leisure activities or doing fun things quietly.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

8. Had difficulty organizing tasks and activities.
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

9. Felt "on the go" or "driven by a motor."
   - Never or Rarely
   - Sometimes
   - Often
   - Very Often

10. Avoided, disliked, or was reluctant to engage in work that requires sustained mental effort.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

11. Talked excessively.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

12. Lost things necessary for tasks or activities.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

13. Blurted out answers before questions had been completed.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

14. Easily distracted.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

15. Had difficulty awaiting turn.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

16. Forgetful in daily activities.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often

17. Interrupted or intruded on others.
    - Never or Rarely
    - Sometimes
    - Often
    - Very Often