Comprehensive Holistic Health & House Calls
Division of Holzer Enterprises
Lynne Odell-Holzer, MSN, FNP, NPP
Registered Nurse Practitioner in Family Medicine & Psychiatry

7751 Treadmill Circle
Liverpool, NY 13090
315-622-9241 Voice & Fax
315-506-0015 Urgent Only
hhh@holzerent.com

YOUR MEDICATION RECORD

Date: _____
Name:_____ Home Phone:_____ Work Phone: _____
Allergies (Foods, Environmental, Drugs):_____
Record <u>any</u> vitamins, supplements, herbal preparations, homeopathic remedies, and Over-The-Counter Medications:

	Medication Name	Generic Name	Purpose	Dose and How Often I Take It	Prescriber's Name	Prescriber's Number
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						

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4.					
5.					
6.					
7.					
8.					
9.					
10.					
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12.					
13.					
14.					
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17.					
18.					
19.					
20.					
21.					

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How to Avoid Medication Accidents

In the United States, one person dies each day and 1.3 million people are injured annually due to medication errors. To ensure your own safety, here are some tips to follow:

- Get in the habit of locking all prescribed, over-the-counter medications, herbal and vitamin preparations in a metal lockbox. Many medication injuries are accidental ingestion by children or pets, or suicide attempts by distraught people.
- Tell your prescriber about adverse reactions you have had to medications, foods, or other substances. Sometimes these non-medication subetances have derivatives in the vehicle substances the medication is in.
- Make your prescriber and pharmacist aware of drug allergies.
- Make a list of your prescription, over-the-counter, herbal and vitamin supplements. This will alert your prescriber and pharmacist to any possible interactions and will come in handy in case of an emergency.
- Bring a notepad to health care visits. Note the exact spelling of the medications you are prescribed. Many medications have similar spellings and could be easily mistaken by the pharmacist.
- Watch punctuation. If the decimal point is not visible, 5.0 mg. can be easily misread as 50 mg. which is ten times the proper dose.
- Read labels carefully to ensure that the name of the medicine dispensed matches what you wrote down in your prescriber's office.
- If the size, color, shape, markings, or consistency of a medication differs from the medication you typically take, show it to your pharmacist before taking it.
- Ask for and write down your prescriber's instructions about medication frequency and any other precautions about food, activities, alcohol, and driving.
- Make certain you receive and understand printed information about your medication from your pharmacist. It will alert you to any possible side effects or interactions.
- Store medications in their original bottles; dispense a week's supply in a four-compartment pillbox with morning, noon, evening, and bedtime compartments to avoid mistakes, such as taking nighttime sleep medications before your morning drive.
- If you have an adverse reaction to a new supply of your medication, call your prescriber or pharmacist immediately.
- Do not store family members' medications all in a jumble in the locked box. Consider grouping or color coding the medication containers for easier identification.
- Discard expired or unused medications.
- Use of some medications may require periodic blood, liver, or kidney tests. Be aware of whether the drugs you are taking require such test, and, if so, remind your prescriber when these tests are due.
- Ask your prescriber for both the brand name and generic name of all drugs prescribed so you can confirm that you are receiving the correct medication.
- Read the label of ingredients of any over-the-counter medications you may consider taking. Many of them have the same few medications in different quantities. Some of these medications may also have been prescribed for a similar condition and taking both the prescription and over-the-counter drugs may cause an accidental overdose.

Preventing Adverse Drug Reactions

Additional Notes:

Prescription drugs are supposed to make you feel better, but in some cases they can make you feel worse.

On average, 360 people die each day because of adverse drug events—a rare reaction a person may experience if he takes a prescription incorrectly. Adverse drug events also can occur when drugs interact with other drugs or with certain foods. Often, adverse drug events happen because of poor communication between patients and their clinicians or pharmacists.

Protect yourself by sharing information.

Since you will receive a prescription about 75% of the time you visit your health care provider, you should ensure that you are not at risk for an adverse drug event. If you take five or more prescriptions, you need to be especially careful to tell your clinician and pharmacist all of the drugs you take, since you are at the highest risk for experiencing an adverse drug event.

Tips to make sure you use your medications safely and effectively:

- Know your medicines. This means prescription and over-the-counter medicines, including vitamins and herbal remedies. If you go to several health care providers or pharmacists, make sure you tell each of them what drugs you take.
- Know your medical history. Keep a detailed record of all of your surgeries, hospitalizations, immunizations, allergies and your family's history of illnesses or diseases. Also, tell your health care provider if there are any changes in your life, such as if you are now working night shift or are on a special diet. Let your health care provider know if you are pregnant or breastfeeding, or if you plan to. Additionally, let her know if you suspect you might have had an adverse drug event in the past.
- Ask about a drug's side effects. If you think you're experiencing any unusual effects that you weren't told about, call your health care provider or pharmacist *immediately*. Read any package inserts or pamphlets you were given with the drug—they, too, will list side effects.
- Follow prescription directions. Ask your health care provider or pharmacist how often and how long you should take your prescription, and follow the directions provided. Taking too much of a drug can cause an adverse drug event, and taking too little of a drug or stopping it before you're supposed to can provide little benefit to your health. Don't start taking new over-the-counter drugs unless you ask your health care provider or pharmacist first.
- Keep a personal medication record. Write down the medication name, whether it's available by prescription or over the counter, how and how often you should take the medication, the date it was prescribed to you, the health care provider who prescribed it to you (and his phone number), and your pharmacist's name and phone number. Also write down why you are taking the drug and any side effects you experience when on the drug.

Communication reduces risk.

When you, your health care provider and pharmacist communicate about your prescriptions, your diet, your health and your lifestyle, you will greatly reduce your chances of experiencing an adverse drug event. Taking drugs responsibly is more than just swallowing a pill, it's also using your good common sense.

Information adapted from Ortho-McNeil Pharmaceutical Inc.'s Web site "Prescription for Safety" at http://www.prescriptionforsafety.com.

Your nurse practitioner has given you this patient education handout to further explain or remind you about principles related to your medical condition. This handout is a general guide only. If you have specific questions, be sure to discuss them with your nurse practitioner.

CHHHC HEDIS Tracking---Name:

Test/Screen	Provider	Telephone	Date	Date	Date	Date	Date
Eye Exam							
GYN/GU Exam							
Mammogram							
TSE/BSE							
Colonoscopy							
Dental Exam							
Flu Vaccine							
Pneumonia							
Tetanus							
Hepatitis B							
All OtherVaccines							
Helmets							
Seatbelts							
Locking Meds							
Guns/Weapons							
Substances:							
ETOH							
Nicotine							
THC							
Crack							
Speed							
Hallucinogens							
Others							
Diet Education							
Hi-Risk Sports							
Exercise Habits							
Sleep Habits							
Last H & P							
DomesticViolence							
BMI							

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PRECURSORS FOR ESTIMATING CAPACITY FOR THERAPEUTIC CHANGE

Patient:_____ DATE:_____ Evaluator:_____

Precursor & Its Markers	None (0)	Trace (1)	Small (2)	Adequate (3)	Abundant (4)
Sense of necessity Expresses desire for change Feels a sense of urgency					
Readiness for anxiety Openness to experience Likely to take risks					
Awareness Able to identify problems Identifies thoughts, feelings					
Confronting the problem Courageously faces problems Sustained attention to issues					
Effort or will toward change Eagerly does homework High energy; active cooperation					
Hope for change Positive outlook:open to future High coping; therapeutic humor					
Social support for change Wide network of friends & family Many confiding relationships					

TOTAL SCORE:

Scoring Guide*

0-6:	Change unlikely. Educate client on change. Focus on precursors with lowest ratings.
7-14:	Change limited or erratic. Educate client & focus on precursors with lowest ratings.
15-21:	Change is steady & noticeable. Use the lowest rated precursors to stay on track.
22-28:	Highly motivated & inspired client. Change occurs easily. Standard approaches work well.

*Scoring in intended only as a general guide to a complex process.
Some precursors may be more potent.

From: "Precursors of Change: Pivotal Points of Involvement & Resistance in Psychotherapy"
F. J. Hana, 1996, *J of Psychotherapy Integration* 6, p 248. Plenum Publishing

HAMILTON DEPRESSION SCALE

NAME | DATE OF BIRTH | DATE

Formedic

1. DEPRESSED MOOD
(Sadness, hopelessness, helplessness, worthlessness)

0 = Absent
1 = These feeling states indicated only on questioning
2 = These feeling states spontaneously reported verbally
3 = Communicates feeling states non-verbally - i.e., through facial expression, posture, voice, and tendency to weep
4 = Patient reports VIRTUALLY ONLY these feeling states in his own spontaneous and non-verbal communication

2. FEELINGS OF GUILT

0 = Absent
1 = Self-reproach, feels he has let people down
2 = Ideas of guilt or rumination over past errors or sinful deeds
3 = Present illness is a punishment. Delusions of guilt
4 = Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. SUICIDE

0 = Absent
1 = Feels life is not worth living
2 = Wishes he were dead or any possible death to self
3 = Suicide ideas or gesture
4 = Attempts at suicide (any serious attempt rates 4)

4. INSOMNIA EARLY

0 = No difficulty falling asleep
1 = Complains of occasional difficulty falling asleep - i.e., more than 1/2 hour
2 = Complains of nightly difficulty falling asleep

5. INSOMNIA MIDDLE

0 = No difficulty
1 = Patient complains of being restless and disturbed during the night
2 = Waking during the night - any getting out of bed rates 2 (except for purpose of voiding)

6. INSOMNIA LATE

0 = No difficulty
1 = Waking in early hours of the morning but goes back to sleep
2 = Unable to fall asleep again if he gets out of bed

COLUMN SCORE

7. WORK AND ACTIVITIES

0 = No difficulty
1 = Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies
2 = Loss of interest in activity; hobbies or work - either directly reported by patient or indirectly in listlessness, indecision and vacillation (feels he has to push self to work or activities)
3 = Decrease in actual time spent in activities or decrease in productivity. In hospital, rate 3 if patient does not spend at least three hours a day in activities (hospital, job or hobbies) exclusive of ward chores
4 = Stopped working because of present illness. In hospital, rate 4, if patient engages in no activity except ward chores,or if patient fails to perform ward chores unassisted

8. RETARDATION
(Slowness of thought and speech; impaired ability to concentrate; decreased activity)

0 = Normal speech and thought
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

9. AGITATION

0 = None
1 = "Playing with" hands, hair, etc.
2 = Hand wringing, nail-biting, hair pulling, biting of lips

10. ANXIETY PSYCHIC

0 = No difficulty
1 = Subjective tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude apparent in face or speech
4 = Fears expressed without questioning

11. ANXIETY SOMATIC

0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

Physiological concomitants of anxiety such as:
Gastro intestinal - dry mouth, wind, indigestion, diarrhea, cramps, belching
Cardiovascular - palpitations, headaches,
Respiratory - hyperventilation, sighing
Urinary frequency
Sweating

12. SOMATIC SYMPTOMS GASTROINTESTINAL

0 = None
1 = Loss of appetite but eating without staff/family encouragement. Heavy feelings in abdomen
2 = Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for G.I. symptoms

COLUMN SCORE

HAMILTON DEPRESSION SCALE

Formedic

13. SOMATIC SYMPTOMS GENERAL

0 = None
1 = Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy, easily fatigued
2 = Any clear-cut symptom rates 2

14. GENITAL SYMPTOMS

0 = Absent
1 = Mild
2 = Severe

Symptoms such as: Loss of libido, Menstrual disturbances

15. HYPOCHONDRIASIS

0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Frequent complaints, requests for help, etc.
4 = Hypochondriacal delusions

16. LOSS OF WEIGHT (rate **either** a or b)

a. When rating by history:

0 = No weight loss
1 = Probable weight loss associated with present illness
2 = Definite (according to patient) weight loss
3 = Not assessed

b. On a weekly ratings by ward psychiatrist, when actual weight changes are measured:

0 = Less than 1 lb. weight loss in one week
1 = Greater than 1 lb. weight loss in one week
2 = Greater than 2 lb. weight loss in one week
3 = Not assessed

COLUMN SCORE

17. INSIGHT

0 = Acknowledges being depressed and ill
1 = Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
3 = Denies being ill at all

18. DIURNAL VARIATION

a. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark one
0 = No variation
1 = Worse in A.M.
2 = Worse in P.M.

b. When present, mark the severity of the variation. Mark "None" if NO variation
0 = None
1 = Mild
2 = Severe

19. DEPERSONALIZATION AND DEREALIZATION

0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

Such as: Feelings of unreality, Nihilistic ideas

20. PARANOID SYMPTOMS

0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution

21. OBSESSIONAL AND COMPULSIVE SYMPTOMS

0 = None
1 = Mild
2 = Severe

COLUMN SCORE

TOTAL SCORE

ADDITIONAL NOTES

NEXT APPOINTMENT

LITHO IN CANADA

Symptom Tracking----Name: ____________________

Symptom	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:

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Thoughtful Questions

NAME: _____ DATE: _____

Please fill in the rest of the sentence with whatever seems the most appropriate to you at the time. There are no right or wrong answers. This is geared to evaluate your current mood and has no diagnostic or other evaluation purpose. Feel free to ask any questions you may have during this process.

1. I like people who.....
2. Mom was.....
3. When people try to boss me.....
4. As a child.....
5. I get angry when.....
6. What worries me.....
7. The trouble with women.....
8. Most of all, I want to.....
9. I am ashamed.....
10. They.....
11. A good person.....
12. The trouble with my home.....
13. I dislike people who.....
14. When I was a kid, I liked.....
15. I can't stand it when.....
16. I am afraid .....
17. Compared to women, men.....
18. I used to wish.....
19. If I do something wrong.....
20. I am .....
21. A good friend.....
22. The important fact about my dad.....
23. I don't like people who.....
24. When I was young, my greatest trouble.....
25. I might lose self-control.....

26. I need.....
27. It is wrong.....
28. God is.....
29. If people praise me.....
30. A sister.....
31. If someone tells me, "You can't do it."
32. When I went to school.....
33. I could kill someone if.....
34. I feel tense when.....
35. The worst thing a man could do to a woman.....
36. The most important thing in my life was.....
37. You get punished for.....
38. Death.....
39. When people trust me.....
40. A brother.....
41. When I am criticized.....
42. My favorite game, as a kid.....
43. I hate.....
44. I can't think right when.....
45. Love.....
46. I should like.....
47. I wish I had not.....
48. Life.....
49. When my mom.....
50. Someday I.....

FAMILY AND PERSONAL HEALTH HISTORY

Note: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name _____ Age _____ Birth date _____ Today's Date _____

Occupation _____ Last Physical Examination Date _____ Daytime Phone _____

FAMILY RECORD Check (✓) condition(s) and relationship of any blood relative who has or has had any of the conditions listed below.	Yes	No	Father	Mother	Brother(s)	Sister(s)	Other
Alcoholism							
Allergies							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Tendency							
Cancer, tumor							
Colitis							
Congenital Heart							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Goiter							
Hay Fever							
Heart Attack							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Leukemia							
Liver Disease							
Mental Illness							
Migraine							
Nervous Breakdown							
Obesity							
Rheumatism							
Rheumatic Fever							
Sickle-Cell Anemia							
Stomach Ulcer							
Stroke							
Suicide							
Tuberculosis							

FAMILY MEMBERS

Living					Deceased	
	Age	Health ✓ Good	✓ Fair	✓ Poor	Age	Cause of Death
Father						
Mother						
Brother(s)						
Sister(s)						

OPERATIONS	✓ Yes	✓ No	Date
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Breast (women)			
Uterus (women)			
Ovaries (women)			
Prostate (men)			
Other - If yes, what:			

Do You: If yes, daily consumption			
Smoke	Pkgs.		
Drink Coffee	Cups		
Beer	ozs.		
Hard liquor	ozs.		

IMMUNIZATIONS			
Pneumonia Vaccine			
Tetanus			
Booster			
Measles			
Influenza			
German Measles/Mumps			
Other - If yes, what:			

X-RAYS When was last mammogram?			
Back			
Chest			
Colon			
Extremities			
Gall Bladder			
Kidney			
Stomach			
Treatments			
Other - If yes, what:			

Doctor's Use Only — Summary

Item 4700

PAST AND PRESENT MEDICAL PROBLEMS

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date
Asthma				
Abnormal Electrocardiogram				
Angina				
Anemia (Type)				
Arthritis				
Blindness Either Eye				
Broken Bones				
Cataracts				
Chronic Bronchitis/Chronic Lung Disease				
Cirrhosis of Liver				
Colon or Bowel Trouble				
Deafness				
Dysentery				
Diabetes				
Ear Infections				
Emphysema				
Enlarged Heart				
Glaucoma				
Gall Stones				
Gout				
Goiter				
Gonorrhea				
Hay Fever				
Heart Murmur as Adult				
Heart Attack				
High Blood Pressure				
Hepatitis				
Hemorrhoids				
Kidney Infection				
Kidney Stones				
Nervous Breakdown				
Poor Blood Clotting				
Polio				
Phlebitis				
Rheumatic Fever				
Rectal Trouble				
Recurrent Boils				
Stroke				
Stomach or Duodenal Ulcer				
Syphilis				

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date
Skin Disease				
Serious Depression				
Serious Emotional Problems				
Tuberculosis				
Thyroid (overactive)				
Thyroid (underactive)				
Varicose Veins				
Men				
Prostate Problems				
Women				
Menstrual Difficulties				
Cystitis				
Mastitis				
Ovarian Cyst				
Breast Cancer				
Other Breast Disease*				
Other Gynecological Problems*				
Still Menstruating				

Age Period Started _____

Age Periods Stopped _____

Why Periods Stopped _____

Number of Pregnancies _____

Number of Children _____

Number of Miscarriages _____

*Explain:

Hospitalizations/Reason Date

Do you wear artificial devices? Yes No

Please list

Do you have allergies? Yes No

Please list

Doctor's Use Only — Summary

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for** –

Items or Services:	**Approximately 50% of your mental health visits costs as well as any annual deductibles.**
Because:	**Federal regulations. This will mean you are responsible for approximately $45.00-$70.00 per visit. You may have supplemental insurance that reduces this expense typically $10.00-$15.00 per visit.**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $_____ See Above**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

Client Information

ID _____

Today's date_____

Your name_____

Your age_____

Male ❑ Female ❑

Your marital status_____

Your race/ethnic group_____

Highest level of education_____

Instructions

The purpose of this questionnaire is for you to describe the kind of person you are. When answering the questions, think about how you have tended to feel, think, and *act over the past several years.* To remind you of this, on the top of each page you will find the statement: "**Over the past several years...**"

Please answer either **T**rue or **F**alse to each item.
Where:
T (True) means that the statement is generally true for you.

F (False) means that the statement is generally false for you.

Even if you are not entirely sure about the answer, indicate "T" or "F" for every question.

For example, for the question:

xx. I tend to be stubborn. T F

If, in fact you have been stubborn over the past several years, you would answer True by circling T.

If, this was not true at all for you, you would answer False by circling F.

There are no correct answers.

You may take as much time as you wish.

Over the past several years...

1.	I avoid working with others who may criticize me.	T F
2.	I can't make decisions without the advice, or reassurance, of others.	T F
3.	I often get lost in details and lose sight of the "big picture."	T F
4.	I need to be the center of attention.	T F
5.	I have accomplished far more than others give me credit for.	T F
6.	I'll go to extremes to prevent those who I love from ever leaving me.	T F
7.	Others have complained that I do not keep up with my work or commitments.	T F
8.	I've been in trouble with the law several times (or would have been if I had been caught).	T F
9.	Spending time with family or friends just doesn't interest me.	T F
10.	I get special messages from things happening around me.	T F
11.	I know that people will take advantage of me, or try to cheat me, if I let them.	T F
12.	Sometimes I get upset.	T F

13. I make friends with people only when I am sure they like me. T F

14. I am usually depressed. T F

15. I prefer that other people assume responsibility for me. T F

16. I waste time trying to make things too perfect. T F

17. I am "sexier" than most people. T F

18. I often find myself thinking about how great a person I am, or will be. T F

19. I either love someone or hate them, with nothing in between. T F

20. I get into a lot of physical fights. T F

21. I feel that others don't understand or appreciate me. T F

22. I would rather do things by myself than with other people. T F

23. I have the ability to know that some things will happen before they actually do. T F

24. I often wonder whether the people I know can really be trusted. T F

25. Occasionally I talk about people behind their backs. T F

26. I am inhibited in my intimate relationships because I am afraid of being ridiculed. T F

27. I fear losing the support of others if I disagree with them. T F

28. I have many shortcomings. T F

29. I put my work ahead of being with my family or friends or having fun. T F

30. I show my emotions easily. T F

31. Only certain special people can really appreciate and understand me. T F

32. I often wonder who I really am. T F

33. I have difficulty paying bills because I don't stay at any one job for very long. T F

34. Sex just doesn't interest me. T F

35. Others consider me moody and "hot tempered." T F

36. I can often sense, or feel things, that others can't. T F

37. Others will use what I tell them against me. T F

38. There are some people I don't like. T F

39. I am more sensitive to criticism or rejection than most people. T F

40. I find it difficult to start something if I have to do it by myself. T F

41. I have a higher sense of morality than other people. T F

42. I am my own worst critic. T F

43. I use my "looks" to get the attention that I need. T F

44. I very much need other people to take notice of me or compliment me. T F

45. I have tried to hurt or kill myself. T F

46. I do a lot of things without considering the consequences. T F

47. There are few activities that I have any interest in. T F

48. People often have difficulty understanding what I say T F

49. I object to supervisors telling me how I should do my job. T F

50. I keep alert to figure out the real meaning of what people are saying. T F

51. I have never told a lie. T F

52. I am afraid to meet new people because I feel inadequate. T F

53. I want people to like me so much that I volunteer to do things that I'd rather not do. T F

54. I have accumulated lots of things that I don't need but I can't bear to throw out. T F

55. Even though I talk a lot, people say that I have trouble getting to the point. T F

56. I worry a lot. T F

57. I expect other people to do favors for me even though I do not usually do favors for them. T F

58. I am a very moody person. T F

59. Lying comes easily to me and I often do it. T F

60. I am not interested in having close friends. T F

61. I am often on guard against being taken advantage of. T F

62. I never forget, or forgive, those who do me wrong. T F

63. I resent those who have more "luck" than I. T F

64. A nuclear war may not be such a bad idea. T F

65. When alone, I feel helpless and unable to care for myself. T F

66. If others can't do things correctly, I would prefer to do them myself. T F

67. I have a flair for the dramatic. T F

68. Some people think that I take advantage of others. T F

69. I feel that my life is dull and meaningless. T F

70. I am critical of others. T F

71. I don't care what others have to say about me. T F

72. I have difficulties relating to in a one-to-one situation. T F

73. People have often complained that I did not realise that they were upset. T F

74. By looking at me, people might think that I'm pretty odd, eccentric or weird. T F

75. I enjoy doing risky things. T F

76. I have lied a lot on this questionnaire. T F

77. I complain a lot about my hardships. T F

78. I have difficulty controlling my anger, or temper T F

79. Some people are jealous of me. T F

80. I am easily influenced by others. T F

81. I see myself as thrifty but others see me as being cheap. T F

82. When a close relationship ends, I need to get involved with someone else immediately. T F

83. I suffer from low self-esteem. T F

84. I am a pessimist. T F

85. I waste no time in getting back at people who insult me. T F

86. Being around other people makes me nervous. T F

87. In new situations, I fear being embarrassed. T F

88. I am terrified of being left to care for myself. T F

89. People complain that I'm "stubborn as a mule." T F

90. I take relationships more seriously than do those who I'm involved with. T F

91. I can be nasty with someone one minute, then find myself apologizing to them the next minute. T F

92. Others consider me to be stuck up. T F

93. When stressed, things happen. Like I get paranoid or just "black out." T F

94. I don't care if others get hurt so long as I get what I want. T F

95. I keep my distance from others. T F

96. I often wonder whether my wife (husband, girlfriend, or boyfriend) has been unfaithful to me. T F

97. I often feel guilty T F

98. I have done things on impulse (such as those below ↘) that could have gotten me into trouble. T F

If you answered true, please check all that apply to you:

a. Spending more money than I have ❑
b. Having sex with people I hardly know ❑
c. Drinking too much ❑
d. Taking drugs ❑
e. Eating binges ❑
f. Reckless driving ❑

99. When I was a kid (before age 15), I was somewhat of a juvenile delinquent, doing some of the things below.

T F

Now, Check ✓ all that apply to you:

(1) I was considered a bully. . . . . ☐
(2) I used to start fights with other kids. . . . . ☐
(3) I used a weapon in fights that I had. . . . . ☐
(4) I robbed or mugged other people. . . . . ☐
(5) I was physically cruel to other people. . . . . ☐
(6) I was physically cruel to animals. . . . . ☐
(7) I forced someone to have sex with me. . . . . ☐
(8) I lied a lot. . . . . ☐
(9) I stayed out at night without my parents permission. . . . . ☐
(10) I stole things from others. . . . . ☐
(11) I set fires. . . . . ☐
(12) I broke windows or destroyed property. . . . . ☐
(13) I ran away from home overnight more than once. . . . . ☐
(14) I began skipping school, a lot, before age 13. . . . . ☐
(15) I broke into someone's house, building or car. . . . . ☐

Thank-you for your time

TREATMENT PLANNER

PROBLEM NUMBER/ DATE IDENTIFIED		PROBLEM DESCRIPTION	TREATMENT GOAL(S) TO ADDRESS THE IDENTIFIED PROBLEM(S) (state goal in terms of observable behavior)	INTERVENTIONS TO ACHIEVE THE GOALS (including meds)	RESOLUTION DATES	
					Targeted	Achieved

Discussed treatment plan with patient?

Patient/Guardian signature_____

PATIENT NAME/ID NUMBER_____

TREATMENT PLANNER

PROBLEM NUMBER/ DATE IDENTIFIED		PROBLEM DESCRIPTION	TREATMENT GOAL(S) TO ADDRESS THE IDENTIFIED PROBLEM(S) (state goal in terms of observable behavior)	INTERVENTIONS TO ACHIEVE THE GOALS (including meds)	RESOLUTION DATES	
					Targeted	Achieved

Discussed treatment plan with patient?

Patient/Guardian signature_____

PATIENT NAME/ID NUMBER_____

Who We Are

Comprehensive Holistic Health & House Calls (CHHHC) is an organization of Nurse Practitioners who provide primary physical and health care services like those found in a traditional health care provider's office. This includes histories and physicals, follow up on many common physical and mental health conditions (from Attention Deficit Disorder to Zoster!), and treatment, including prescriptions. We have a number of physicians as our back-ups for any advice about care that might be beyond our scopes of practice.

We are a mobile primary care service established to provide routine medical care in your home by appointment. If you have a rapidly deteriorating health condition, still call 911.

If You Already Have A Primary Health Care Provider

Many people prefer to keep their health care provider with whom they have had a long term relationship. If you wish CHHHC, NP's can provide the medical evaluation, treatment and coordinate these findings with your primary health care provider.

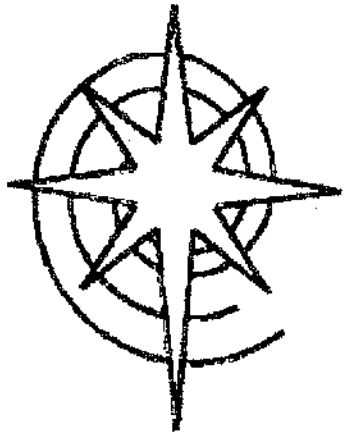
Hours Of Operation

Hours for visits often vary according to CHHHC staff and your schedules. Please feel free to call during standard business hours for more complete information.

We are a mobile primary care service established to provide routine medical care in your home. As always, 911 should be called in any non-routine health matter.

COMPREHENSIVE HOLISTIC HEALTH & HOUSE CALLS

(Division of Holzer Enterprises)



Lynne Odell-Holzer, RN, NP
Registered Nurse Practitioner
in Family Medicine & Psychiatry

7751 TREADMILL CIRCLE
LIVERPOOL, NY 13090-2427
315-441-4411 Pager
315-622-9241 Voice & Fax
hhh@holzerent.com

Our Philosophy

We believe that people are integrated, complex, beings who work hard to feel comfortable and to improve their lives. We believe that the mind and the body affect each other intimately. We believe that people are each complete individuals living and growing in the contexts of their environment and their genetic endowments. There are times when people cannot maintain their best health function. At those times, people may benefit from evaluation, management, treatment and education about their condition so that they can reach or return to independence and maximum function.

As a medically based health care service established to provide both mental and physical medical care, we use health priniciples of Western medicine to -

1) prevent dysfunction,
2) prevent complications from an unavoidable dysfunction, or
3) restore as much function as possible in chronic conditions.

Since an estimated 20% of the US population utilizes alternative, herbal, or non-Western health therapies, we have developed a familiarity with most of them. This way we can coordinate, teach, or refer those self-help strategies to safely combine them with traditional Western health care methods. We support and encourage self-help, self-determination, and return to independence of the individual. With that philosophy in mind, you can see why we expect that the person being 'treated' takes an active part to best meet this goal. We operate on a strengths-based philosophy. We strive to use what capacities the person already has to build, or re-build for maximum health and function.

What We Provide

We provide care on a mobile basis to meet the person (patient) where the person best functions - the home. We are nurse practitioners trained to provide primary uncomplicated acute and chronic stable health care to people of any age.

We carry pagers for 24 hour coverage in the rare event that you have a health question that cannot wait for usual office hours.

How To Pay

Since we are medically based and operate much like the "country doctor" of old, we are able to utilize most health insurances.

To Reach Us

Leave a voice message and someone will usually return your call within 4 hours. You are also welcome to leave short messages at 622-9241.

Comprehensive Holistic Health & House Calls **Patient Demographic Data**
7751 Treadmill Circle, Liverpool, NY 13090
(315) 622-9241

Patient's Information:

Patient: _____ DOB: _____
Address: _____
_____
Home Phone: _____ Gender: ☐ M ☐ F
Work Phone: _____
Cell Phone: _____
Other Phone (Specify): _____
Email: _____
SSN: _____
Marital Status: ☐ S ☐ M ☐ W ☐ D
Employment: ☐ Full time ☐ Part time ☐ Retired ☐ Disabled ☐ Student
Employer (if applicable): _____
Referred by: _____
Family doctor: _____

Parent's Information (If applicable):

Parents' Names: _____
Parents' address(es): ☐ Same as patient
_____
Parents' Home Phone(s): _____
Parents' Work Phone(s): _____
Parents' Cell Phone(s):
_____
Parents' Other Phone(s) (Specify): _____
Parent's Email(s): _____

Guarantor's Information (Person financially responsible for the patient):

Guarantor: ☐ Self ☐ Parent (If self or parent skip to the next section)
Guarantor's Name: _____
Relationship to the patient: _____
Guarantor's address: ☐ Same as patient
_____
Guarantor's Home Phone: _____
Guarantor's Work Phone: _____
Guarantor's Cell Phone: _____
Guarantor's Other Phone (Specify): _____
Guarantor's Email: _____

Insurance Information:

Primary	Secondary
Company: _____	Company: _____
ID # _____	ID # _____
Group # _____	Group # _____
Subscriber's Information:	Subscriber's Information:
Name: _____	Name: _____
DOB: _____	DOB: _____
SSN: _____	SSN: _____
Employer: _____	Employer: _____

Other Information:

Emergency Contact: _____
Other: _____
Signature: _____ Date: _____

Pt. Name:_____ Date:_____

Comprehensive Holistic Health & House Calls
Division of Holzer Enterprises
Lynne Odell-Holzer, MSN, FNP, NPP
Registered Nurse Practitioner in Family Medicine & Psychiatry

7751 Treadmill Circle
Liverpool, NY 13090
315-622-9241 Voice & Fax
hhh@holzerent.com

PSYCHIATRIC EVALUATION---ADMISSION EVALUATION

1. Alerts: (List risk factors including danger to self & others [specify degree of risk and targets]; physical health condition/needs; ALLERGIES; CPL status/legal issues).

2. Chief Complaint: (Include the sources of the information and reliability).

3. History of the Present Illness: (Include onset of illness & circumstances leading to screening/admission, information from treatment providers/referring agencies.)

4. Significant History: Consider the following:

a. Mental Health: (Include first psychiatric symptom, circumstances and frequency of previous hospitalizations, medication response and major side effects and dangerous behaviors. Also include current treatment providers, medications, medication response and major side effects [including over-the-counter, herbals and vitamins], name & phone numbers of prescribing physicians, treatment compliance, family history of mental illness, physical/sexual abuse as a victim or a perpetrator, decompensation and hospitalization patterns [nature, frequency, circumstances, and outcomes]).

Pt. Name:_____ Date:_____

b. Physical Health: (medications [including over the counter, herbals, and vitamins], & prescribers on reverse high risk behaviors for HIV, STDs, history of communicable illnesses.) Add any significant findings on Physical Examination & Assessment, any potential interactions between mental and physical problems/needs
Eating D/O?
Cutting hx?

c. Alcohol/Substance Abuse: (Include substance(s) of abuse, length of dependency frequency and amount, any withdrawal symptoms, treatment or detox admissions.)

Nicotine
THC
ETOH
Others:

d. Education/Work hx:

e. Developmental/Family: (genogram on reverse when appropriate)

f. Cultural/Spiritual Issues:

5. Mental Status Examination: (Use direct quotes from patient when possible, and describe the tests used to determine cognition and estimation of intelligence.)

Relationship to Interviewer: Pleasant Indifferent Passive Aggressive Suspicious Dramatic Manipulative Seductive Cooperative Guarded Uncooperative Belligerent **Comments:**

Appearance: Neat and appropriately dressed Disheveled Inappropriate for weather Dirty **Comments:**

Attitude: Cooperative Uncooperative Attempts to answer to the point **Comments:**

Behavior: Normal motoric Mannerisms Agitated Restless Paucity of movement **Comments:**

Speech: Normal rate, flow & articulation Pressured Slurred Inarticulate Slow Dysarthric **Comments:**

Thought Process: Goal Directed Goal Achieved Tangential Circumstantial Loose Incoherent Perseveration Blocking Neologisms Vague **Comments:**

Memory:

Thought Content: No abnormal content Delusions Paranoia Ideas of Reference Obsessions Phobias Hopeless Poverty of Content Helpless **Comments:**

Perceptual Disorders: Hallucinations (Auditory__ Visual__ Tactile__ Olfactory__ Gustatory__) **Comments:**

Mood: Euthymic Sad Elated Anxious Angry Fluctuating Labile Irritable **Comments:**

Affect: Normal Range & Intensity Appropriate Blunted Flat Congruent Labile **Comments:**

Impulse Control: No Evidence of Problems Fights Alcohol or Substance Abuse Intrusiveness Criminal Conduct **Comments:**

Sensorium/L of C: Alert Lethargic Fluctuating **Comments:**

Attention Span: Serial sevens (three or more) "WORLD" backwards Normal Impaired **Comments:**

Immediate: Digit Span 85296 Can repeat Yes No

Pt. Name:_____ Date:_____

Can repeat: brown, honesty, tulip Yes No
Remembers all three after 5 minutes Yes No __/3

Immediate retention and recall: Normal Impaired

Comments: _____

Recent: Can recall yesterday's supper Yes No

Remote: Can recall: Date of Birth Yes No
Phone Number Yes No
Birth Place Yes No
Where raised Yes No
Last grade Yes No

Ability to Abstract and Generalize:

Meaning of "All that glitters is not gold."
Answer:_____

What is the similarity between and apple and an orange?
Answer:_____

Ability to Abstract: Good Impaired
Comments:_____

Estimate of Intelligence: [Bush, Clinton, Reagan, Carter]

Can name last four presidents Yes No

Can name four large US cities Yes No

Answers "iron" to "What metal is attracted to a magnet?" Yes No

Answers "60" to "How many minutes are there in an hour?" Yes No

Answers "40" to "What is 8 x 5?" Yes No

Can spell "telephone" Yes No

Intelligence is rated: Per the above As per formal IQ testing Above average Average Below average
Comments:_____

Insight and Judgement:

Is patient aware of his/her problems or mental illness? Yes No

Does patient answer "Mail it" to "What would you do if you found a stamped addressed envelope lying on the street?" Yes No

Insight is: Good Impaired Markedly Impaired **Judgement** is: Good Impaired Markedly Impaired

Comments:_____

Add descriptions on the right

Suicidality: (Include family history)

Current	Past History
0= Unknown	0= Unknown
1=None	1=None
2=Mild	2=Mild
3=Moderate	3=Moderate
4=Severe	4=Severe
5=Extreme	5=Extreme

Self-Injurious (non-suicidal) Behavior:
(Type, frequency, circumstances, direct harm).

Current	Past History
0= Unknown	0= Unknown
1=None	1=None
2=Mild	2=Mild
3=Moderate	3=Moderate
4=Severe	4=Severe
5=Extreme	5=Extreme

Interpersonal Violence: (Ideation, intent, threats, prior acts, predatory behavior; consider family history).

Current	Past History
0= Unknown	0= Unknown
1=None	1=None
2=Mild	2=Mild
3=Moderate	3=Moderate
4=Severe	4=Severe
5=Extreme	5=Extreme

Non-Compliance Level: (psychiatric/medical/substance abuse treatment, basic needs, legal requirements)

Current	Past History
0= Unknown	0= Unknown
1=None	1=None
2=Mild	2=Mild
3=Moderate	3=Moderate
4=Severe	4=Severe
5=Extreme	5=Extreme

Current Life Stress: (Stressors, interpersonal support systems, basic needs supports).

Current	Past History
0= Unknown	0= Unknown
1=None	1=None
2=Mild	2=Mild
3=Moderate	3=Moderate
4=Severe	4=Severe
5=Extreme	5=Extreme

Medical Stressor: (Acute or Chronic)

Current	Past History
0= Unknown	0= Unknown
1=None	1=None
2=Mild	2=Mild
3=Moderate	3=Moderate
4=Severe	4=Severe
5=Extreme	5=Extreme

Criminality: (Nature relationship to mental illness)

Current	Past History
0= Unknown	0= Unknown
1=None	1=None
2=Mild	2=Mild
3=Moderate	3=Moderate
4=Severe	4=Severe
5=Extreme	5=Extreme

Pt. Name:_____ Date:_____

High Profile Behavior: (Dangerousness, potential for arrest, high level of community attention.)

Current	Past History	2=Mild	2=Mild
0= Unknown	0= Unknown	3=Moderate	3=Moderate
1=None	1=None	4=Severe	4=Severe
		5=Extreme	5=Extreme

Has anyone physically hurt the patient by pushing, grabbing, slapping, hitting, choking or kicking, forcing sex or sexual acts the patient did not want to do?

Has the patient been threatened to be hurt or with having someone close to them hurt?

Has the patient been constantly put down or told that he/she is worthless?

Does the patient feel he/she has been stalked, checked up upon, or followed?

Does the patient identify anyone who has made him/her afraid?

If any of the above have 'Y' for 'Yes", please explain here & list response_____

_____

6. Strengths/Weaknesses:

7. DIAGNOSIS:

Axis I: 1
2
3

Axis II:

Axis III:

Axis IV: PSYCHOSOCIAL STRESSORS:

1. Stressor(s):

2. Severity: 1__None 2__Mild 3__Moderate 4__Severe 5__Extreme 6__Catastrophic
0__Inadequate Information/No Change
3. Duration: Predominantly 1__Acute Event 2__Enduring Circumstances

Axis V: GAF Current: GAF Highest in Last Year: GAF Goal-

8. NEEDS/RECOMMENDATIONS/INITIAL GOALS:

9. NOTIFICATION TO OTHER TREATMENT PROVIDERS: (Use Reverse for more names & numbers)

Signature: _____Title:_____ Date: _____

New York State Department of Health

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ Both (non-HIV medical and HIV-related information)
- ☐ My non-HIV medical information **

Information in the box below must be completed.

Name and address of facility/person disclosing HIV-related and/or medical information:

_____

_____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____

_____

Relationship to person whose information will be released: _____

_____

Describe information to be released: _____

Reason for release of information: _____

Time Period During Which Release of Information is Authorized From: _____ To: _____

Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any:

_____

_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligiblity for benefits (Note: Federal privacy regulations may restrict some consequences):

_____

_____

All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature _____ Date _____

*Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

Please Complete Information on Page 2.

Complete information for each facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

Comprehensive Holistic Health & House Calls
7751 Treadmill Circle
Liverpool, N.Y. 13090-2427

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____

Complete information for each facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. Blank lines may be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature ______________________________ Date ____________

Client/Patient Number ______________________________

☐ Personal
☐ **History**
☐ **Checklist™**
☐ **for Adults**
☑

LYNNE ODELL-HOLZER, NP, MSN
Registered Nurse Practitioner in Family Health & Psychiatry
Fax: (315) 622-9241
hhh@holzerent.com
Health & Illness
Treatment & Education

John A. Schinka, Ph.D.

Name _____
Last First Initial

Age _____ Sex _____ Today's Date _____

DIRECTIONS

This checklist asks questions about your personal history and current life. Begin by entering your name, age, sex, and the date at the top of this page. Then turn to the inside of this booklet and answer the questions. All of the questions are numbered in order. For each question, make a mark (X) next to the answer that describes your history or current life. Many questions have a space labeled *Other* for writing in an answer if the correct answer is not provided. Questions followed by the symbol (✓✓✓) should be marked with all the answers that apply. For questions that do not apply, mark the answer *Does not apply.*

EXAMPLE

28. Did you start school in kindergarten or the first grade?

___ A. Kindergarten

___ B. First grade

___ C. Other _____

PAR Psychological Assessment Resources, Inc./P.O. Box 998/Odessa, FL 33556/TOLL-FREE 1-800-331-TEST

I. PRESENTING INFORMATION

1. What is your race?
   - __A. White
   - __B. Black
   - __C. Oriental
   - __D. Hispanic
   - __E. Asian
   - __F. Native American
   - __G. Other_____

2. Who referred you here, or recommended that you come here?
   - __A. No one, came by yourself
   - __B. A friend
   - __C. A member of your family
   - __D. Family doctor
   - __E. Doctor treating you for a medical problem
   - __F. A community agency
   - __G. A priest, pastor, or other religious staff person
   - __H. The police
   - __I. A judge
   - __J. Other _____

3. What is the main problem that led to your coming here?
   - __A. Have no problem
   - __B. Depression
   - __C. Anxiety
   - __D. Problems with thinking clearly
   - __E. Problems with marriage
   - __F. Problems with family
   - __G. Problems with job
   - __H. Problems with alcohol
   - __I. Problems with drugs
   - __J. Health problem
   - __K. Facing criminal charges
   - __L. Being physically abused
   - __M. Other _____

4. In your own opinion, how severe is this problem?
   - __A. Does not apply
   - __B. Mild
   - __C. Moderate
   - __D. Severe
   - __E. So bad that you are unable to meet any of your responsibilities

5. How long have you had this problem?
   - __A. Does not apply
   - __B. For the past several days
   - __C. For the past several weeks
   - __D. For the past several months
   - __E. For the past year
   - __F. For the past two years
   - __G. For the past several years

6. Which of the following has this problem affected (✓✓✓)?
   - __A. Does not apply
   - __B. None
   - __C. Your performance at work
   - __D. Your personal relationships
   - __E. Your health

7. Have you been treated for this problem before?
   - __A. Does not apply
   - __B. No
   - __C. Yes, with success
   - __D. Yes, but with only partial success
   - __E. Yes, but without success

8. What other problems are you having (✓✓✓)?
   - __A. None
   - __B. Depression
   - __C. Anxiety
   - __D. Problems with thinking clearly
   - __E. Problems with marriage
   - __F. Problems with family
   - __G. Problems with job
   - __H. Problems with alcohol
   - __I. Problems with drugs
   - __J. Facing criminal charges
   - __K. Being physically abused
   - __L. Other _____

II. FAMILY BACKGROUND

9. Who primarily raised you?
   - __A. Natural parents
   - __B. Natural father
   - __C. Natural mother
   - __D. Natural father and stepmother
   - __E. Natural mother and stepfather
   - __F. Grandparents on father's side
   - __G. Grandparents on mother's side
   - __H. Aunt and uncle
   - __I. Aunt
   - __J. Uncle
   - __K. Older brother
   - __L. Older sister
   - __M. Adoptive parents
   - __N. Foster parents
   - __O. Orphanage
   - __P. Charitable institution
   - __Q. Other _____

10. When growing up, how many children were in your family?
    - __A. Does not apply
    - __B. You were an only child
    - __C. 2 including yourself
    - __D. 3 including yourself
    - __E. 4 including yourself
    - __F. 5 including yourself
    - __G. 6 including yourself
    - __H. 7 including yourself
    - __I. 8 including yourself
    - __J. 9 including yourself
    - __K. 10 including yourself
    - __L. More than 10 including yourself

11. Of the other children in your family, how many were stepbrothers and stepsisters?
    - __A. Does not apply
    - __B. None
    - __C. 1
    - __D. 2
    - __E. 3
    - __F. 4
    - __G. 5
    - __H. 6
    - __I. 7
    - __J. 8
    - __K. More than 8

12. Which child were you?
    - __A. Does not apply, you were an only child
    - __B. The youngest child
    - __C. A middle child
    - __D. The oldest child
    - __E. Other _____

13. Where were you born?
    - __A. In United States
    - __B. In Canada
    - __C. In Mexico
    - __D. In Europe
    - __E. In Asia
    - __F. In South America
    - __G. In Central America
    - __H. In the West Indies
    - __I. Other _____

14. As a child, where did you primarily live?
- __A. On a farm
- __B. In a rural area
- __C. In a small town
- __D. In a small city
- __E. In a large city
- __F. In a suburb
- __G. In many different places
- __H. Other _____

15. As a child, where did you live?
- __A. In United States
- __B. In Canada
- __C. In Mexico
- __D. In Europe
- __E. In Asia
- __F. In South America
- __G. In Central America
- __H. In West Indies
- __I. In many different countries
- __J. Other _____

16. How much education did your father complete?
- __A. Does not apply
- __B. Do not know
- __C. Less than eighth grade
- __D. Eighth grade
- __E. Some high school
- __F. High school graduate
- __G. Some college
- __H. College graduate
- __I. Postgraduate work
- __J. Postgraduate degree

17. When you were growing up, what was the main type of work your father did?
- __A. Does not apply
- __B. Was primarily unemployed
- __C. Worked in many different occupations
- __D. Unskilled worker
- __E. Skilled worker
- __F. Clerical worker
- __G. Salesperson
- __H. Small business owner
- __I. Technical specialist
- __J. Business manager
- __K. Health professional
- __L. Social services professional
- __M. Business executive
- __N. Not employed outside the home
- __O. Military service
- __P. Other _____

18. How much education did your mother complete?
- __A. Does not apply
- __B. Do not know
- __C. Less than eighth grade
- __D. Eighth grade
- __E. Some high school
- __F. High school graduate
- __G. Some college
- __H. College graduate
- __I. Postgraduate work
- __J. Postgraduate degree

19. When you were growing up, what was the main type of work your mother did?
- __A. Does not apply
- __B. Was primarily unemployed
- __C. Worked in many different occupations
- __D. Unskilled worker
- __E. Skilled worker
- __F. Clerical worker
- __G. Salesperson
- __H. Small business owner
- __I. Technical specialist
- __J. Business manager
- __K. Health professional
- __L. Social services professional
- __M. Business executive
- __N. Not employed outside the home
- __O. Military service
- __P. Other _____

20. When you were growing up, what was the main source of income for your family?
- __A. Does not apply
- __B. Father's job
- __C. Mother's job
- __D. Both parents' jobs
- __E. Welfare
- __F. Alimony
- __G. Child support payments
- __H. Other _____

21. When you were growing up, how would you characterize your family?
- __A. Does not apply
- __B. Poverty level
- __C. Lower class
- __D. Middle class
- __E. Upper class

III. CHILDHOOD AND ADOLESCENCE

22. How old was your father at the time of your birth?
- __A. Do not know
- __B. 15-19
- __C. 20-29
- __D. 30-39
- __E. 40-49
- __F. 50 or older

23. How old was your mother at the time of your birth?
- __A. Do not know
- __B. 15-19
- __C. 20-29
- __D. 30-39
- __E. 40-49
- __F. 50 or older

24. To your knowledge, what were the conditions of your birth? (✓✓✓)
- __A. Do not know
- __B. Normal, no unusual problems
- __C. Premature birth
- __D. Long labor
- __E. Complications with delivery
- __F. Mother ill at time of birth
- __G. Treated in intensive care after birth
- __H. Other _____

25. To your knowledge, when did you learn to walk and talk?
- __A. Do not know
- __B. At the normal age
- __C. Earlier than most children
- __D. Later than most children

26. Which of the following childhood illnesses or injuries did you have (✓✓✓)?
- __A. None
- __B. Do not remember
- __C. Measles
- __D. German measles
- __E. Mumps
- __F. Chicken pox
- __G. Polio
- __H. Asthma
- __I. Diabetes
- __J. Rheumatic fever
- __K. Tuberculosis
- __L. Meningitis
- __M. Broken arm
- __N. Broken leg
- __O. Serious head injury
- __P. Other _____

27. Which of the following operations did you have as a child (✓✓✓)?
- __A. None
- __B. Appendectomy
- __C. Tonsillectomy
- __D. Other _____

28. Did you start school in kindergarten or the first grade?
- __A. Kindergarten
- __B. First grade
- __C. Other _____

29. How old were you when you started school?
__A. 4
__B. 5
__C. 6
__D. 7
__E. 8
__F. Other _____

30. What types of schools did you attend from grades 1-8 (✓✓✓)?
__A. Public school
__B. Private school
__C. Parochial school
__D. School for the handicapped
__E. Orphanage school
__F. Military academy
__G. Boarding school
__H. Other _____

31. Did you have any problems when you first started school (✓✓✓)?
__A. No problems that you remember
__B. Were afraid of school and did not want to go
__C. Were sick a lot and missed a lot of school
__D. Had to be punished to force you to go to school
__E. Other _____

32. Which of the following describes your experiences in grades 1-8?
__A. Generally received excellent grades
__B. Generally received good grades
__C. Generally received average grades
__D. Generally received poor grades

33. Which of the following describe your experiences in grades 1-8 (✓✓✓)?
__A. None
__B. Had special classes for a learning disability
__C. Had to repeat a grade
__D. Had to repeat more than one grade
__E. Had special tutoring

34. Which of the following describes your experiences in grades 1-8?
__A. Enjoyed school
__B. Felt neutral about school
__C. Disliked school

35. Which of the following describes your experiences in grades 1-8?
__A. Got along well with all your teachers
__B. Got along well with all but a few of your teachers
__C. Usually got along poorly with your teachers

36. Which of the following describe your experiences in grades 1-8 (✓✓✓)?
__A. None
__B. Had to be disciplined in school frequently
__C. Were suspended
__D. Were expelled from school
__E. Other _____

37. Which of the following describes your experiences from ages 5-13?
__A. Had many friends
__B. Had several friends
__C. Had few friends
__D. Had no friends

38. Which of the following describes your experiences from ages 5-13?
__A. Rarely got into trouble
__B. Frequently got into trouble
__C. Were always getting into trouble
__D. Were considered a delinquent child

39. Which of the following describe your experiences from ages 5-13 (✓✓✓)?
__A. None
__B. Parents did not get along
__C. Parents got divorced
__D. Family moved a lot
__E. Family had financial problems
__F. Did not get along with brothers and/or sisters
__G. Had a lot of medical problems
__H. Were physically abused
__I. Were sexually abused
__J. Other _____

40. How would you describe yourself as a child from ages 5-13 (✓✓✓)?
__A. Active
__B. Passive
__C. Happy
__D. Content
__E. Unhappy
__F. Calm
__G. Nervous
__H. Fearful
__I. Moody
__J. Outgoing
__K. Shy
__L. Lonely
__M. Quiet
__N. Noisy
__O. Coordinated
__P. Clumsy
__Q. Intelligent
__R. Dull
__S. Other _____

41. How would you describe your family relationships while you were a child from ages 5-13 (✓✓✓)?
__A. Does not apply
__B. Marked by frequent arguments
__C. Marked by physical fights
__D. Unsupportive
__E. Supportive
__F. Warm, close
__G. Cold, distant
__H. Other _____

42. How old were you when you started the 9th grade?
__A. Did not attend the 9th grade
__B. 11
__C. 12
__D. 13
__E. 14
__F. 15
__G. 16
__H. Other _____

43. What types of schools did you attend from grades 9-12 (✓✓✓)?
__A. Does not apply
__B. Public school
__C. Private school
__D. Parochial school
__E. School for the handicapped
__F. Orphanage school
__G. Military academy
__H. Boarding school
__I. Other _____

44. Did you have any problems when you first started the 9th grade (✓✓✓)?

__A. Does not apply
__B. No problems that you remember
__C. Were anxious about starting high school
__D. Were sick a lot and missed a lot of school
__E. Were afraid you would not do well academically
__F. Were afraid you would not fit in
__G. Other _____

45. Which of the following describe your experiences in high school (✓✓✓)?

__A. Does not apply
__B. Received excellent grades
__C. Received good grades
__D. Received average grades
__E. Received poor grades

46. Which of the following describe your experiences in high school (✓✓✓)?

__A. Does not apply
__B. None
__C. Had special classes for learning disability
__D. Had to repeat a grade
__E. Had to repeat more than one grade
__F. Had special tutoring

47. Which of the following describes your experiences in high school?

__A. Does not apply
__B. Enjoyed school
__C. Felt neutral about school
__D. Disliked school

48. Which of the following describes your experiences in high school?

__A. Does not apply
__B. Got along well with all your teachers
__C. Got along well with all but a few of your teachers
__D. Usually got along poorly with your teachers

49. Which of the following describe your experiences in high school (✓✓✓)?

__A. Does not apply
__B. None
__C. Had to be disciplined in school frequently
__D. Were suspended
__E. Were expelled from school
__F. Other _____

50. Which activities did you engage in while in high school (✓✓✓)?

__A. Does not apply
__B. None
__C. Team sports (junior or senior varsity)
__D. Intramural sports
__E. Choir
__F. Glee club
__G. Cheerleading
__H. Student government
__I. Academic clubs (math club, science club, etc.)
__J. Hobby clubs (chess club, stamp club, etc.)
__K. Yearbook
__L. Student newspaper
__M. Band
__N. Other _____

51. Did you graduate from high school?

__A. Yes
__B. No, dropped out because of poor grades
__C. No, dropped out because of discipline problems
__D. No, dropped out to work to support family
__E. No, dropped out because of drug problems
__F. No, dropped out because of health problems
__G. No, dropped out because you got pregnant
__H. No, dropped out because girlfriend got pregnant
__I. No, because _____

52. Which of the following describes your experiences from ages 14-18?

__A. Had many close friends
__B. Had several close friends
__C. Had few close friends
__D. Had no close friends

53. Which of the following describes your experiences from ages 14-18?

__A. Did not date
__B. Dated infrequently
__C. Dated regularly
__D. Usually had a steady girlfriend/boyfriend

54. Which of the following describes your experiences from ages 14-18?

__A. Rarely got into trouble
__B. Frequently got into trouble
__C. Were always getting into trouble
__D. Were considered a delinquent child

55. Which of the following describe your experiences from ages 14-18 (✓✓✓)?

__A. None
__B. Parents did not get along
__C. Parents got divorced
__D. Family moved a lot
__E. Family had financial problems
__F. Did not get along with brothers and/or sisters
__G. Had a lot of medical problems
__H. Were physically abused
__I. Were sexually abused
__J. Other _____

56. How would you describe yourself from ages 14-18 (✓✓✓)?

__A. Active
__B. Passive
__C. Happy
__D. Content
__E. Unhappy
__F. Calm
__G. Nervous
__H. Fearful
__I. Moody
__J. Outgoing
__K. Shy
__L. Lonely
__M. Quiet
__N. Noisy
__O. Coordinated
__P. Clumsy
__Q. Intelligent
__R. Dull
__S. Other _____

57. How would you describe your family relationships when you were age 14-18 (✓✓✓)?
- __A. Does not apply
- __B. Marked by frequent arguments
- __C. Marked by physical fights
- __D. Unsupportive
- __E. Supportive
- __F. Warm, close
- __G. Cold, distant
- __H. Other _____

58. What were your plans when you left high school (✓✓✓)?
- __A. Did not really have any plans
- __B. Planned to go to work
- __C. Planned to continue education
- __D. Planned to get married
- __E. Planned to enter the armed services
- __F. Other _____

IV. EDUCATIONAL AND OCCUPATIONAL HISTORY

59. Have you completed any formal post-high school education (✓✓✓)?
- __A. No
- __B. Attended but did not complete junior college
- __C. Have a degree from a junior college
- __D. Attended college or university but did not complete degree
- __E. Have a degree from a college or university
- __F. Attended but did not complete technical school
- __G. Have a degree from a technical school
- __H. Attended but did not complete a business school
- __I. Have a degree from a business school
- __J. Attended but did not complete a secretarial school
- __K. Have a degree from a secretarial school
- __L. Other _____

60. Have you completed any postgraduate work?
- __A. No
- __B. Began but did not complete a postgraduate degree
- __C. Obtained Master's degree
- __D. Obtained Doctorate
- __E. Obtained medical degree
- __F. Obtained law degree
- __G. Other _____

61. Have you served in the military?
- __A. No
- __B. No, were a conscientious objector
- __C. No, left country to avoid the draft
- __D. Yes, drafted into Army
- __E. Yes, enlisted in the Army
- __F. Yes, enlisted in the Navy
- __G. Yes, enlisted in the Air Force
- __H. Yes, enlisted in the Marines
- __I. Yes, enlisted in the Coast Guard
- __J. Currently serving in the Army
- __K. Currently serving in the Navy
- __L. Currently serving in the Air Force
- __M. Currently serving in the Marines
- __N. Currently serving in the Coast Guard

62. How long did you serve, or have you served, in the military?
- __A. Does not apply
- __B. Less than 1 year
- __C. 1 year
- __D. 13-23 months
- __E. 2 years
- __F. 3-4 years
- __G. 5-6 years
- __H. 7-10 years
- __I. 11-15 years
- __J. 16-19 years
- __K. 20 years
- __L. More than 20 years

63. Have you served in the military during a war or conflict (✓✓✓)?
- __A. Does not apply
- __B. Served during peace time only
- __C. World War II
- __D. Korean War
- __E. Viet Nam Conflict

64. Has your service in the military included being stationed outside of the United States?
- __A. Does not apply
- __B. Yes
- __C. No

65. Were you, or have you been, injured during your time in the service (✓✓✓)?
- __A. Does not apply
- __B. No
- __C. Yes, wounded in combat
- __D. Yes, but not as a result of combat

66. Were you, or have you been, evaluated or treated for emotional or psychological problems while in the service (✓✓✓)?
- __A. Does not apply
- __B. No
- __C. Evaluated
- __D. Treated on outpatient basis
- __E. Treated on inpatient basis

67. Which of the following did you experience, or have you experienced, during your time in the service (✓✓✓)?
- __A. Does not apply
- __B. None
- __C. Disciplinary problems
- __D. Court-marshal
- __E. Sentenced to stockade
- __F. Drug use
- __G. Alcohol abuse
- __H. AWOL
- __I. Your refusal to follow orders
- __J. Fights with fellow servicemen
- __K. Fights with superior officers
- __L. Reduction in rank
- __M. Other _____

68. What type of discharge from the military did you receive?
- __A. Does not apply
- __B. Still in service
- __C. Honorable discharge
- __D. Medical discharge
- __E. Dishonorable discharge
- __F. Left AWOL, were never discharged

69. What was your rank on discharge from the military (current rank if still in service)?
- __A. Does not apply
- __B. Officer
- __C. Noncommissioned officer
- __D. Enlisted personnel
- __E. Other _____

70. Do you have a service-connected disability rating?
- __A. Does not apply
- __B. No
- __C. 0-49% for medical disorder
- __D. 0-49% for psychological disorder
- __E. 50-100% for medical disorder
- __F. 50-100% for psychological disorder

71. At what age did you begin working full- time?
- __A. Have never worked full-time
- __B. Before age 17
- __C. 17
- __D. 18
- __E. 19
- __F. 20
- __G. 21
- __H. 22 or older

72. What is your employment status?
- __A. Employed
- __B. Retired
- __C. Homemaker
- __D. Employed part-time
- __E. Disabled
- __F. Student
- __G. Unemployed
- __H. Other _____

73. What is or has been your primary occupation?
- __A. Unemployed
- __B. Unskilled worker
- __C. Skilled worker
- __D. Clerical worker
- __E. Salesperson
- __F. Small business owner
- __G. Technical specialist
- __H. Manager
- __I. Health professional
- __J. Social services professional
- __K. Business executive
- __L. Not employed outside the home
- __M. Military service
- __N. Other _____

74. How long have you been working in your current job?
- __A. Not employed
- __B. less than 1 year
- __C. 1 year
- __D. 2-3 years
- __E. 4-5 years
- __F. over 5 years

75. What other types of work have you done (✍✍✍)?
- __A. None
- __B. Unskilled worker
- __C. Skilled worker
- __D. Clerical worker
- __E. Salesperson
- __F. Small business owner
- __G. Technical specialist
- __H. Manager
- __I. Health professional
- __J. Social services professional
- __K. Business executive
- __L. Other _____

76. Since finishing your education, what is the longest period of time you have been unemployed when you were looking for a job?
- __A. Does not appiy
- __B. Less than 3 months
- __C. 4-6 months
- __D. 7 months to 1 year
- __E. More than 1 year

77. Since finishing your education, how many different full-time jobs have you had?
- __A. Does not apply
- __B. 1
- __C. 2
- __D. 3
- __E. 4
- __F. 5
- __G. 6
- __H. More than 6

78. Since finishing your education, how many different part-time jobs have you had?
- __A. Does not apply
- __B. 1
- __C. 2
- __D. 3
- __E. 4
- __F. 5
- __G. 6
- __H. More than 6

79. How many times have you been fired or laid off from a job?
- __A. Does not apply
- __B. None
- __C. 1
- __D. 2
- __E. 3
- __F. 4
- __G. 5
- __H. 6
- __I. More than 6

V. MEDICAL HISTORY AND HEALTH

80. Which of the following have you been treated for as an adult (✍✍✍)?
- __A. None
- __B. Arthritis
- __C. Cancer
- __D. Diabetes
- __E. Epilepsy (seizures)
- __F. Heart problems
- __G. Hypertension
- __H. Low back pain
- __I. Problems with lungs or breathing
- __J. Problems with digestive system
- __K. Other _____

81. What are you currently being treated for (✍✍✍)?
- __A. Not being treated
- __B. Arthritis
- __C. Cancer
- __D. Diabetes
- __E. Epilepsy (seizures)
- __F. Heart problems
- __G. Hypertension
- __H. Low back pain
- __I. Problems with lungs or breathing
- __J. Problems with digestive system
- __K. Other _____

82. Do you currently have any physical problems that are not being treated by a medical doctor, but should be (✍✍✍)?
- __A. No
- __B. Chest pain
- __C. Difficulty with breathing
- __D. Dizziness
- __E. Loss of consciousness
- __F. Pain
- __G. Stomach problems
- __H. Vision problems
- __I. Other _____

83. How many cigarettes a day do you smoke?
- __A. None, have never smoked
- __B. None, but used to smoke
- __C. Less than one pack per day
- __D. One pack per day
- __E. More than one pack per day

84. How long have you been smoking (or did you smoke) cigarettes?
- __A. Have never smoked
- __B. Less than five years
- __C. 5 to 10 years
- __D. More than 10 years
- __E. More than 15 years
- __F. More than 20 years

85. Do you drink alcohol?
__A. No
__B. Occasionally
__C. Regularly
__D. Daily

86. When you drink alcohol, how many drinks do you usually have?
__A. Does not apply
__B. One
__C. Two
__D. Three
__E. Four
__F. Five or more

87. Which of the following have you experienced (✓✓✓)?
__A. None
__B. Lost a job because of drinking
__C. Missed work because of drinking
__D. Were in fights because of drinking
__E. Were arrested for being drunk and disorderly
__F. Had an automobile accident because of drinking
__G. Received a ticket for drinking and driving
__H. Lost driver's license because of drinking
__I. Had arguments with friends or relatives because of your drinking

88. Do you use any illegal drugs?
__A. No
__B. No, but did in the past
__C. Occasionally
__D. Regularly
__E. Daily

89. Which drugs do you, or did you, abuse (✓✓✓)?
__A. Does not apply
__B. Narcotics
__C. Recreational
__D. Prescription
__E. Other _____

90. How long have you been using, or did you use, illegal drugs?
__A. Does not apply
__B. Less than one year
__C. One year
__D. Two years
__E. Three years
__F. Four years
__G. Five years
__H. Over five years

91. Has there been a recent change in your weight?
__A. No
__B. Yes, a weight gain
__C. Yes, a weight loss
__D. Yes, a weight loss due to dieting

92. Has there been a recent change in your appetite?
__A. No
__B. Yes, an increase in appetite
__C. Yes, a loss of appetite

93. What problems do you have with your sleep (✓✓✓)?
__A. None
__B. Trouble getting to sleep
__C. Wake up a lot at night
__D. Don't get enough sleep
__E. Sleep too much
__F. Restlessness
__G. Wake up too early in the morning
__H. Sleep enough, but don't feel rested
__I. Other _____

94. Which is true about your sex life?
__A. Prefer not to answer
__B. Have an active sex life
__C. Are interested in sex, but not active at this time
__D. Have no interest in sex
__E. Are interested, but are abstaining from sex

95. Has there been a recent change in your interest in sex?
__A. Prefer not to answer
__B. No
__C. Yes, an increase in interest
__D. Yes, a decrease in interest

VI. FAMILY HISTORY

96. Which of the following is true about your natural mother?
__A. Does not apply
__B. Do not know if she is alive or deceased
__C. She is alive and well
__D. She is alive but in poor health
__E. She is deceased

97. Which of the following medical problems has your mother had (✓✓✓)?
__A. Does not apply
__B. Do not know
__C. None
__D. Arthritis
__E. Cancer
__F. Diabetes
__G. Epilepsy (seizures)
__H. Heart problems
__I. Hypertension
__J. Low back pain
__K. Problems with lungs or breathing
__L. Problems with digestive system
__M. Other _____

98. Which of the following is true about your natural father?
__A. Does not apply
__B. Do not know if he is alive or deceased
__C. He is alive and well
__D. He is alive but in poor health
__E. He is deceased

99. Which of the following medical problems has your father had (✓✓✓)?
__A. Does not apply
__B. Do not know
__C. None
__D. Arthritis
__E. Cancer
__F. Diabetes
__G. Epilepsy (seizures)
__H. Heart problems
__I. Hypertension
__J. Low back pain
__K. Problems with lungs or breathing
__L. Problems with digestive system
__M. Other _____

100. Which of the following medical problems have any of your brothers, sisters, or children had (✓✓✓)?
__A. Does not apply
__B. Do not know
__C. None
__D. Arthritis
__E. Cancer
__F. Diabetes
__G. Epilepsy (seizures)
__H. Heart problems
__I. Hypertension
__J. Low back pain
__K. Problems with lungs or breathing
__L. Problems with digestive system
__M. Other _____

101. Which of the following have been treated for psychological problems (either as an inpatient or outpatient), other than alcohol or drug abuse (✓✓✓)?
- __A. Does not apply
- __B. Do not know
- __C. None
- __D. Mother
- __E. Father
- __F. Sister
- __G. Brother
- __H. Child

102. Which of the following have had problems with alcohol (✓✓✓)?
- __A. Does not apply
- __B. Do not know
- __C. None
- __D. Mother
- __E. Father
- __F. Sister
- __G. Brother
- __H. Child

103. Which of the following have had problems with drugs (✓✓✓)?
- __A. Does not apply
- __B. Do not know
- __C. None
- __D. Mother
- __E. Father
- __F. Sister
- __G. Brother
- __H. Child

VII. CURRENT SITUATION

104. What is your current marital status?
- __A. Never married
- __B. Never married, but living with a partner
- __C. Married
- __D. Divorced
- __E. Divorced, but living with a partner
- __F. Separated
- __G. Separated, but living with a partner
- __H. Widowed
- __I. Widowed, but living with a partner

105. How many times have you been married?
- __A. None
- __B. One
- __C. Two
- __D. Three
- __E. Four
- __F. Five
- __G. Six or more

106. How long have you been living with your current spouse or partner?
- __A. Does not apply
- __B. Less than 1 year
- __C. 1 year
- __D. 2 years
- __E. 3 years
- __F. 4 years
- __G. 5 years
- __H. 6-10 years
- __I. 11-15 years
- __J. 16-20 years
- __K. More than 20 years

107. What is your current spouse's or partner's employment status?
- __A. Does not apply
- __B. Employed full-time
- __C. Retired
- __D. Homemaker
- __E. Employed part-time
- __F. Disabled
- __G. Student
- __H. Unemployed
- __I. Other _____

108. What is or has been your current spouse's or partner's main occupation?
- __A. Does not apply
- __B. Unskilled worker
- __C. Skilled worker
- __D. Clerical worker
- __E. Salesperson
- __F. Small business owner
- __G. Technical specialist
- __H. Manager
- __I. Health professional
- __J. Social services professional
- __K. Business executive
- __L. Not employed outside the home
- __M. Military service
- __N. Other _____

109. Where do you live?
- __A. None, homeless
- __B. House
- __C. Apartment
- __D. Trailer
- __E. Condominium
- __F. With parents
- __G. With friends
- __H. With relatives
- __I. Other _____

110. What is your household income from all sources?
- __A. None
- __B. Less than 3 thousand
- __C. 3-6 thousand
- __D. 7-9 thousand
- __E. 10-12 thousand
- __F. 13-15 thousand
- __G. 16-20 thousand
- __H. 21-25 thousand
- __I. 26-30 thousand
- __J. 31-40 thousand
- __K. 41-50 thousand
- __L. More than 50 thousand

111. What is the major source of your household's income?
- __A. Does not apply
- __B. Your job
- __C. Your spouse's or partner's job
- __D. Your children
- __E. Your parents
- __F. Illegal means
- __G. Social Security
- __H. Pension
- __I. Disability payments
- __J. Welfare payments
- __K. Investments
- __L. Other _____

112. How many children have you had (count only your natural offspring)?
- __A. None
- __B. 1
- __C. 2
- __D. 3
- __E. 4
- __F. 5
- __G. 6
- __H. More than 6

113. How many children currently live with you?
- __A. Does not apply
- __B. None
- __C. 1
- __D. 2
- __E. 3
- __F. 4
- __G. 5
- __H. 6
- __I. More than 6

114. Of the children living with you, how many are stepchildren?
- __A. Does not apply
- __B. None
- __C. 1
- __D. 2
- __E. 3
- __F. 4
- __G. 5
- __H. 6
- __I. More than 6

115. How would you describe your relationship with your spouse or partner?
- __A. Does not apply
- __B. Good
- __C. Fair
- __D. Poor
- __E. Other _____

116. Which of the following do you and your spouse or partner have arguments about (✓✓✓)?

__A. Does not apply
__B. None
__C. Money matters
__D. Household chores
__E. Disciplining the children
__F. Sex
__G. Relationships with relatives
__H. Relationships with friends
__I. Issues related to work
__J. Manners
__K. Alcohol use
__L. Drug use
__M. Religious issues
__N. Other _____

117. How often do you and your spouse or partner have arguments?

__A. Does not apply
__B. Rarely
__C. Every day
__D. Several times a week
__E. About once a week
__F. About two or three times a month
__G. Once a month or less

118. How would you describe the quality of relationships in your own family (spouse or partner and children)?

__A. Does not apply
__B. Good
__C. Fair
__D. Poor
__E. Other _____

119. Which of the following have you experienced in the past year (✓✓✓)?

__A. None
__B. Separation
__C. Divorce
__D. Marriage
__E. Birth of child
__F. Serious illness or injury
__G. Spouse or partner being seriously ill or injured
__H. Death of spouse or partner
__I. Child being seriously ill or injured
__J. Death of child
__K. Parent being seriously ill or injured
__L. Death of a parent
__M. Loss of job
__N. Spouse or partner losing job
__O. Change of jobs
__P. Spouse or partner changing jobs
__Q. Financial problems
__R. Legal problems
__S. Other _____

Notes:

Comprehensive Holistic Health & House Calls
Lynne Odell-Holzer, MSN, FNP, NPP 315-622-9241 Voice & Fax
Registered Nurse Practitioner in Family Medicine & Psychiatry hhh@holzerent.com

WELCOME TO COMPREHENSIVE HOLISTIC HEALTH & HOUSE CALLS

Who We Are:
Comprehensive Holistic Health & House Calls (CHHHC) is an organization of Nurse Practitioners who primarily provide medical type house calls. As Nurse Practitioners, we can provide various combinations of health services for people primarily in the person's own home. (It is easy to do so, but we are not to be confused with a visiting nurse service). As Nurse Practitioners we have advanced training that prepares us to offer the full range of basic physical and health care services usually found in a primary care provider's office. These include histories and physicals, follow up on many common physical and mental health conditions (from Attention Deficit Disorder to Zoster!), and treatment including prescriptions. In situations where you have chosen the NP to be your primary physical health care provider, the NP will collaborate with his/her physicians for any situations that might be beyond that NP's scope of practice. In situations where you have chosen the NP from CHHHC to be an adjunct to your current health care provider, because you cannot get to the office, the NP will coordinate with your usual primary care provider.
Please note: we are a mobile primary care service, NOT an emergency service. If you believe you are having a condition that cannot wait, ***call 911*** for emergency help.

Our Philosophy:
We believe that people are integrated, complex, beings who work hard to feel comfortable and to improve their lives. We believe that people are whole, complex beings in whom the mind and the body affect each other intimately. We believe that each person is a complete individual living and growing in the context of their environment and their genetic endowments. We further believe that there are times when people cannot effectively maintain their innate abilities. At those times, people may benefit from our evaluation, management, treatment, education and referral to reach or return to independence and maximum function.

As a medically based health care service established to provide both mental and physical medical care, we use health principles of Western medicine to 1) prevent dysfunction, 2) prevent complications from an unavoidable dysfunction, or 3) restore as much function as possible. Since an estimated 20% of the US population utilizes alternative, herbal, or non-Western health therapies, we have developed a familiarity with most of them. This way we can coordinate, teach, or refer those self-help strategies to safely combine them with traditional Western health care methods. We support and encourage self-help, self-determination, and independence of the individual. With that philosophy in mind, you can see why we expect that the person being 'treated' takes an active part to best meet this goal. We operate on a strengths-based philosophy. We strive to use what capacities the 'patient' already has to attain maximum health and function.

What We Do:
We provide a full range of primary health care on a mobile basis to meet the person (patient) where the person best functions —the home. We are nurse practitioners trained to provide primary uncomplicated acute and chronic stable health care to people of any age. Due to the state of portable technology, we are not always able to provide the full range of testing found in the traditional primary health care office. If a test is required that cannot be performed on site, the CHHHC staff will help you arrange for testing in alternative sites. If you already have an office based primary health care provider, we will be glad to work as an adjunct with your provider if he/she wishes. Please note that although home delivered medical services are expensive in terms of time, *your current health care provider may already provide house calls* under some circumstances. It would be useful for you to *ask your current health care provider if this service is available before requesting CHHHC*. If you use our services, we will also request Releases of Information to coordinate our services with your other health care providers.

24 Hour Coverage:
We are available for 24 hour coverage in the rare event that you have a health question that cannot wait for usual office hours. The number is on the business card your Nurse Practitioner leaves. If you believe that your health is deteriorating rapidly (i. e., within hours), please be seen in the local walk-in clinic or emergency room as soon as possible. While we may be able to give some general advice over the phone, we do not have capacity for emergency house calls.

Cost:
Since we are medically based and operate much like the "country doctor" of old, we are able to utilize most health insurances. We will accept assignment of benefits unless you choose not. We also try hard to keep the cost of health care down. Therefore, the 'patient' or responsible party will be expected to pay the copay or any non-covered services at the time of service so we don't have to pay billing & collection services. Since some insurances will not cover our type of services, please call the office manager & billing person at 423-4152 or hgreenier@aol.com for clarification of any insurance coverage or charge questions before a visit is scheduled.

We also request as much advance notice as possible if there needs to be a cancellation of services. If cancellation under 24 hours is unavoidable, we may have to charge a 50% fee to recover some of our lost time and unavailability to our other patients.

Confidentiality:
All of your records are considered confidential and will only be released with your advance knowledge and for the express purposes of your insurances, or as required by a court of law. At other times, CHHHC will request records and information to be sent/received with other health care providers involved in your situation. Your consent is requested in order to coordinate services and a signature to that effect is required below. You will be told of the purpose of these requests at the time they occur. You can expect your personal information to be kept under the strictest confidence and only what is absolutely necessary divulged when required. This is in full compliance with HIPAA requirements at all times.

Statements of Agreement and Consent:
By the signature(s) below, I/we state that I/we have read, understand and agree with the conditions of treatment by the staff of CHHHC as stated above.

By the signature(s) below, I/we state that I/we have read, understand and agree to authorize CHHHC professionals to administer evaluate, and manage my/our health, including treatments or prescriptions. I/we have been informed of the nature, purpose, alternatives and risks of the proposed treatments and have had an opportunity to participate in the treatment planning.

I/we have had an opportunity to discuss Advance Directive, Living Will, Health Care Proxy and Do Not Resuscitate information with a CHHHC representative and I/we have made my/our wishes known to CHHHC.

I/we authorize release of pertinent health records by other health care providers to CHHHC necessary for the appropriate and safe health care delivery. These records may include, but are not limited to, examination and progress notes, X-rays, photographs, reports, charts and other information pertinent to my/our ongoing health care.

Patient Signature	Witness Signature
Signature of Responsible Party/Relationship	Witness Signature
Date	Date

(original signature page to CHHHC record. Copy of page 2 + first page to patient/representative)

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