APPENDIX E- MINOR CUSTODY FORMS

AGREEMENT REGARDING CHILD THERAPY SERVICES WITH THE OLSON MARRIAGE AND FAMILY THERAPY CLINIC

This document contains additional information about our services, specifically when working with minor children, families, and those families who are experiencing or have experienced a divorce/separation. If you have any question or concerns, please ask for clarification at any time.

Confidentiality
In general, the privacy of all communications between a client and a counselor is protected by law. When working with families, confidentiality if maintained within the family members attending therapy sessions. We use clinical discretion to determine what information is helpful to share in the therapy process. We want children to feel confident that what we talk about is confidential. We also know that parents need updates regarding progress, goals, and know that it is important for parents to be active participants in their child's treatment. In divorce situations, when appropriate, a signed release is required by both parents in order for us to release any information regarding the child and family to any person or entity. Please see the general office policies for further information regarding confidentiality.

By law, confidentiality must be breached if a Student Therapist suspects that any minor is being or has been abused, if a person plans to physically harm another person, or if a person plans to harm themselves. Additionally, breaching of confidentiality will occur if a Student Therapist suspects that an elder or dependent adult is being or has been abused.

Professional Records
Our policy is to encourage that any parent having rights to the child be involved in services to the degree that is appropriate or beneficial to the child. We make every attempt to contact any parent having rights to the child, so that they are able to give consent or dissent to treatment. For therapeutic reasons, it is our policy to request that parents allow their child privacy in treatment and ask that they reframe from seeking copies of their child's mental health file. This allows the child to take ownership of his or her work in therapy and prevents information from being used in a way that could be possibly detrimental or damaging to the child.

Court Testimony
As your child's mental health provider, it is our ethical duty to provide your child the best care possible. If asked to provide records or testimony about treatment to the court, this can contribute to a "dual-role" relationship between your child and their therapist. This relationship means that I your child's therapist is no longer in a therapeutic role with your child; rather, the therapist would serve as a "witness," and this could potentially damage your child's past, present, or future experience in therapy. Confidentiality and trust are paramount in therapy. In addition, we have an ethical responsibility to only release records to persons who are qualified and trained to interpret the information; once records are released in a court setting, we are unable to control who may have access to your child's and family's information. We assume that parents want to work toward the best interest of their child, which includes maintaining a safe and confidential therapeutic environment with their therapist.

With this in mind, we will not provide therapy records, notes, or testimony to the court as a part of litigation without a court order. Furthermore, Student Therapists at the Olson Clinic are not trained to testify in court disputes. For the reasons noted above, if any therapist at the Olson Clinic is required to provide testimony or records to the court under a court order, we reserve the right to terminate services and make an appropriate referral.

Custody and Visitation Issues
We do not provide custody evaluations. We cannot make recommendations about custody or visitation issues.

Informed Consent to Treatment

I have read the office policies provided to me, and agree to allow my child to participate in services. I further agree to the policies presented to me in this and other documents.

_____	_____
My child's name	Date of birth
_____	_____
Parent/legal guardian signature	Date
_____	_____
Parent/legal guardian signature	Date

JOINT CUSTODY PARENT CONTACT FORM

At The Olson Marriage and Family Therapy Clinic, unless Sole Physical Custody can be verified by a custody agreement, both parents need to consent for treatment of a minor. Please provide us with the information to contact the other parent. We will be calling them and/or sending them a letter offering them the opportunity to deny consent. If they do not reply, services will continue.

Parent Name: _____

Address: _____

_____

Phone: _____

Have you discussed therapy services with them? Yes: _____ No: _____

Are there any concerns that we should be aware of:

_____

_____

_____

_____

Thank you,

_____

JOINT CUSTODY CONSENT FORM

Dear _____,

The purpose of this letter is to inform you that your child, _____, is receiving mental health services at The Olson Marriage and Family Therapy Clinic. If you have questions or concerns about these services, please contact their therapist, _____, at (319)368-6493. Parents with joint legal custody have equal rights in consenting to medical/therapeutic treatment for their child, unless otherwise noted in a custody or divorce decree. If you do NOT wish for your child to be receiving therapy, please sign and return the bottom of this letter within 14 business days to 1650 Matterhorn Drive NE, Cedar Rapids, IA 52402. If we do not receive this, we will assume that you consent to treatment.

Thank you,

_____

Return form to:
The Olson Marriage and Family Therapy Clinic
1650 Matterhorn Drive NE
Cedar Rapids, IA 52402, 52402

I, _____, the parent of _____, wish to inform you that I do NOT consent to mental health services by The Olson Marriage and Family Therapy Clinic. Please discontinue treatment.

_____ _____
Signature Date

APPENDIX F – MINOR ASSENT FORM: COMPLETED BY TEENS AGE 13+

Therapy is a great way to work on problems and/or concerns relevant to you and your parents and/or caretakers. Part of successful treatment includes being open and honest with your therapist and trying out the things we talk about in treatment in your daily life.

Your therapist will make every effort to be clear about your privacy. Typically, your therapist will share general information with your parents/caretakers, such as whether you attended sessions and if you appear to be participating in treatment. Unless one of the situations your therapist discussed with you comes up (issues of child abuse, wanting to hurt yourself or others, or very risky behavior), your therapist will keep the specifics of therapy private. Sometimes you and your therapist may agree to involve your parents/caretakers in treatment, or to consult with them to get more information. However, you should also know it is legal in Iowa for parents and/or caretakers to access your treatment records. ***Signing below indicates that you have reviewed the policies described above and understand the limits to your confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time***.

Minor's Signature _____ Date_____

Parent/Guardian: ***Initial the points below and include your signature at the bottom to indicate your agreement to respect your child's privacy***:

___ I will refrain from requesting detailed information about individual therapy sessions with my child in efforts to respect their rights to confidentiality with their therapist.

___ I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

___ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's treatment before speaking with my child and/or their therapist.

___ I understand that I will be informed about situations that could seriously endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and legal obligations.

Parent/Caretaker Signature _____ Date_____

Parent/Caretaker Signature _____ Date_____

Parent/Caretaker Signature _____ Date_____

Parent/Caretaker Signature _____ Date_____

ROI WITH MULTIPLE SIGNATURE LINES FOR PARENT/GUARDIAN RELEASE

I, _____, hereby authorize the Gerald and Audrey Olson Marriage and Family Therapy Clinic (hereinafter referred to as the Olson MFT Clinic) to release verbal and/or written information to:

_____ _____ _____

Full name of person or entity | Phone | Fax

_____

Address

For the following purposes:

□ Treatment and assessment □ Coordination of care □ Referral of new or additional services

□Other_____

Specific information to be released includes:

□ Assessment and diagnosis □ Treatment goals □ Session Content □ Discharge

□ Other: _____

I understand that by signing this General Authorization I am authorizing the Olson MFT Clinic to disclose my health information to the persons and entities listed above and that any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to the Olson MFT Clinic.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to the Olson MFT Clinic. I understand that my revocation of this General Authorization will not affect a disclosure that the Olson MFT Clinic has already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Olson MFT Clinic's confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

I understand that signing this is not a condition of receiving services.

This authorization will expire 12 months from the date it was signed or on the specified date of ____/____/_____.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.
(INITIAL ANY CATEGORY NOT TO BE RELEASED)

_____Mental Health _____Substance Abuse _____HIV/AIDS _____ Genetic information including genetic test results

_____ _____ _____

Printed name Client and/or Client's Parent or Legal Guardian | Signature | Date

_____ _____ _____

Printed name Client and/or Client's Parent or Legal Guardian | Signature | Date

_____ _____ _____

Printed name Client and/or Client's Parent or Legal Guardian | Signature | Date

DEMOGRAPHIC FORM - TEEN

Name: _____

Name of parent/guardian (if under 18 years):_____

Age: _____

I identify my gender as: _____

I identify my race and/or ethnicity as: _____

My religious affiliation is (if any):_____

What grade are you in? _____
Number of individuals in my household is:_____.

Please mark if applicable:

- ☐ I am a veteran / a family member of a veteran.
- ☐ I am a Mount Mercy University faculty, staff, student and/or a family member of a Mount Mercy University faculty or staff member

How did you hear about us?

_____

_____

The Olson Marriage & Family Therapy Clinic

Current Symptom Checklist

MY CHILD IS FEELING…	Never	Rarely	Sometimes	Frequently	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement of Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about the future					
Excessive feelings of guilt					
Low self-esteem					

MY CHILD IS EXPERIENCING…	Never	Rarely	Sometimes	Frequently	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
“Flashbacks” as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about a traumatic experience					

I NOTICE MY CHILD…	Never	Rarely	Sometimes	Frequently	For how long?
Is Angry, Irritable, Hostile					
Is euphoric, energized and highly optimistic					
Has racing thoughts					
Is needing less sleep than usual					
Is more talkative					
Mood fluctuates: go up and down					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Risk-taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

MY CHILD'S EATING INVOLVES…	Never	Rarely	Sometimes	Frequently	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss					
A lot of weight gain					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Concern about my sexual function					
Discomfort engaging in my sexual activity					
Questions about my sexual orientation					

EMPLOYMENT & SELF CARE	Never	Rarely	Sometimes	Frequently	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

Psychiatric History

Prior outpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior inpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior and/or current medication use? YES NO

Medication	Dosage	Frequency	Start Date	End Date	Physician

Has any family member had mental or emotional problems that warrant treatment? YES NO
yes, who / what / why (list all):

_____

_____

List family members

Name	Age	Gender	Relationship to Client

Describe any past or current significant issues in intimate relationships or immediate family relationships:

Medical History

Describe current physical health ☐ Good ☐ Fair ☐ Poor

Comments:

List any non-psychiatric medications and supplements currently being taken (give dosage and reason ☐ Not applicable

List any known allergies ☐ Not applicable

Substance and Alcohol Use History

I USE THE FOLLOWING…	Never	Rarely	Sometimes	Frequently	For how long?
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

Client Treatment History

- ☐ Outpatient (age[s]) _____
- ☐ Inpatient (age[s]) _____
- ☐ 12-step program (age[s]) ____
- ☐ Stopped on own (age[s]) _____
- ☐ Other (age[s]) _____

Family alcohol/drug abuse history

- ☐ father
- ☐ mother
- ☐ grandparent(s)
- ☐ Sibling(s)
- ☐ other_____
- ☐ stepparent/live-in
- ☐ uncle(s) and/or aunt(s)
- ☐ /significant other
- ☐ children

Uses of Substance and/or Alcohol Use

- ☐ hangovers
- ☐ seizures
- ☐ blackouts
- ☐ Accidental overdose
- ☐ Binges
- ☐ Arrest(s)
- ☐ Withdrawal symptoms
- ☐ Medical Conditions
- ☐ Increase of Tolerance
- ☐ Loss of Control over amount used
- ☐ Job Loss
- ☐ Other_____
- ☐ Sleep disturbances
- ☐ Assault (s)
- ☐ Suicide Attempt(s)
- ☐ Suicide Impulse/Thoughts
- ☐ Sleep disturbances

Socio-Economic Status History

Living Situation

- ☐ housing adequate
- ☐ homeless
- ☐ housing overcrowded
- ☐ dependent on others for housing
- ☐ housing dangerous/deteriorating
- ☐ living companions dysfunctional

Social support system

- ☐ supportive network
- ☐ few friends
- ☐ substance-use-based friends
- ☐ no friends
- ☐ distant from family of origin

Financial situation

- ☐ no current financial problems
- ☐ large indebtedness
- ☐ poverty or below-poverty income
- ☐ impulsive spending
- ☐ relationship conflicts over finances

Employment

- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ unemployed
- ☐ coworker conflicts
- ☐ Supervisor conflicts
- ☐ unstable work history
- ☐ disabled:_____

Legal history

- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court ordered this treatment
- ☐ jail/prison _____ time(s), total time served: _____

The Olson Marriage & Family Therapy Clinic

Current Symptom Checklist

I AM FEELING…	Never	Rarely	Sometimes	Frequently	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement of Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about the future					
Excessive feelings of guilt					
Low self-esteem					

I AM EXPERIENCING…	Never	Rarely	Sometimes	Frequently	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about a traumatic experience					

I HAVE…	Never	Rarely	Sometimes	Frequently	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE…	**Never**	**Rarely**	**Sometimes**	**Frequently**	**For how long?**
Risk-taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

EMPLOYMENT & SELF CARE	Never	Rarely	Sometimes	Frequently	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

MY EATING INVOLVES…	**Never**	**Rarely**	**Sometimes**	**Frequently**	**For how long?**
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss					
A lot of weight gain					

I HAVE…	**Never**	**Rarely**	**Sometimes**	**Frequently**	**For how long?**
Concern about my sexual function					
Discomfort engaging in my sexual activity					
Questions about my sexual orientation					

Psychiatric History

Prior outpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior inpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior and/or current medication use? YES NO

Medication	Dosage	Frequency	Start Date	End Date	Physician

Has any family member had mental or emotional problems that warrant treatment? YES NO
If yes, who / what / why (list all):

_____

_____

_____

Relationship and Family History

Relational status

- ☐ Single
- ☐ Married
- ☐ Separated/Divorced
- ☐ Cohabitating
- ☐ Other _____

Intimate relationship

- ☐ never been in a serious relationship
- ☐ not currently in relationship
- ☐ currently in a serious relationship

Relationship satisfaction

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied with relationshi
- ☐ dissatisfied with relationship
- ☐ very dissatisfied with relationship

List family members

Name	**Age**	**Gender**	**Relationship to Client**

Describe any past or current significant issues in intimate relationships or immediate family relationships:

_____

_____

_____

MEDICAL HISTORY

Describe current physical health ☐ Good ☐ Fair ☐ Poor

Comments:

_____

_____

_____

List any non-psychiatric medications and supplements currently being taken (give dosage and reason ☐ **Not applicable**

_____

_____

_____

List any known allergies ☐ **Not applicable**

_____

_____

_____

Substance and Alcohol Use History

I USE THE FOLLOWING…	Never	Rarely	Sometimes	Frequently	For how long?
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

Client Treatment History

- ☐ Outpatient (age[s]) _____
- ☐ Inpatient (age[s]) _____
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- ☐ Stopped on own (age[s]) _____
- ☐ Other (age[s]) _____

Family alcohol/drug abuse history

- ☐ father
- ☐ mother
- ☐ grandparent(s)
- ☐ Sibling(s)
- ☐ stepparent/live-in
- ☐ uncle(s) and/or aunt(s)
- ☐ /significant other
- ☐ children
- ☐ other_____

Uses of Substance and/or Alcohol Use

- ☐ hangovers
- ☐ seizures
- ☐ blackouts
- ☐ Accidental overdose
- ☐ Binges
- ☐ Arrest(s)
- ☐ Withdrawal symptoms
- ☐ Medical Conditions
- ☐ Increase of Tolerance
- ☐ Loss of Control over amount used
- ☐ Job Loss
- ☐ Other_____
- ☐ Sleep disturbances
- ☐ Assault (s)
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Socio-Economic Status History

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- ☐ relationship conflicts over finances

Legal history

- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court ordered this treatment
- ☐ jail/prison _____ time(s), total time served: _____

services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The fee for a 45-minute psychotherapy visit (in-person or via telehealth) is $_____. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Based upon a fee of $_____ per visit, if you attend one psychotherapy visit per week, your estimated charge would be $_____for four visits provided over the course of one month; $_____for eight visits over two months; or $_____for 12 visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate _____

SCREENER – TEEN: COMPLETED WITH TEEN

Client Name:
_____

Student Therapist Name: _____

Student Therapists must use this form to screen for any conditions that might rule out a particular teen and their family sytem from receiving services at the Olson MFT Clinic. Student therapists must complete this form during the course of the intake procedure and upload a copy to the client's file. These questions should be asked of the teenage client. Additional screening and assessment should be done with the parent(s), but completing a screener with the parent(s) is not required.

Clients who exceed the cutoff scores must be informed that the student therapist is required to consult with their supervisor to ensure appropriateness, and that the client will be informed if a referral needs to be made. *However, student therapists should still schedule a second appointment with the client, especially if they feel that the client is appropriate for services even though they exceeded the cutoff. The completed form should be uploaded to the client file.*

THE SCREENING WITH THE TEENAGE CLIENT SHOULD BE DONE INDIVIDUALLY, WITH NO ONE ELSE IN THE ROOM

Drug and Alcohol and Drug Screening (CAGE-AID)

Please read the following questions out loud and record the patient's answers.

Have you ever felt you ought to cut down on your drinking or drug use?	YES	NO
Have people annoyed you by criticizing your drinking or drug use?	YES	NO
Have you felt bad or guilty about your drinking or drug use?	YES	NO
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	YES	NO

Scoring: Item responses on questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol and/or drug problems.

Score: _____

A total score of two or greater is considered clinically significant and you should consult your clinical Supervisor if the identified patient obtains this score.

HITS Tools for Intimate Partner Violence

*This measure is to be administered **one-on-one** with your teenage client if they report that they currently have a partner or partners.*

Please read each of the following activities, pick the box that best indicates the frequency with which their partner acts in the way depicted.

Does your partner physically hurt you?

1. Never
2. Rarely
3. Sometimes
4. Fairly often
5. Frequently

Does your partner threaten you with harm?

1. Never
2. Rarely
3. Sometimes
4. Fairly often
5. Frequently

Does your partner insult or talk down to you?

1. Never
2. Rarely
3. Sometimes
4. Fairly often
5. Frequently

Does your partner scream and/or curse at you?

1. Never
2. Rarely
3. Sometimes
4. Fairly often
5. Frequently

Total the numbers in front of the responses that were circled. The maximum score is 20.

Score: _____

Individuals with scores of 10 or above total; or scoring "sometimes" or higher on questions 1 and/or 2 will require discussion with your supervisor.

Bully and Violence Screening

1. Do you have concerns about being bullied?	YES	NO
2. Do you have concerns about being a bully?	YES	NO
3. Has anyone every hit, slapped, or punched you?	**YES**	**NO**
4. Has anyone every touched you in a way that made you feel made you feel scared or uncomfortable?	**YES**	**NO**
5. Have you ever touched someone in a way that made them feel scared or uncomfortable?	**YES**	**NO**

If your client responds with "yes" to any of the questions in in bold, you will need to discuss the case with your supervisor.

Mental Health Screening

Have you ever been diagnosed with a severe mental illness. What was this diagnosis?

Record response here: _____

Please note that it is traditionally inappropriate to diagnose a child or teen with severe mental illness such as schizophrenia, psychotic disorders, bipolar, schizoaffective disorders, or personality disorders. If a teenage client reports that they have received a severe mental illness diagnosis, please explore this diagnosis with the child's parent(s)/guardian(s) and then discuss this diagnosis with your practicum Supervisor.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past 3 months**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***	**YES**	**NO**

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu