We are pleased that you have chosen Lone Star Circle of Care (LSCC) as your healthcare provider. We look forward to providing you and/or your family members with exceptional and patient centered health services. This information provides information to help you understand the therapy process.

LSCC provides therapy to individuals, families, and couples, and group therapy to children, adolescents, and adults. Its providers will use different methods or procedures in your meetings depending on your specific needs. If LSCC's providers determine that it they unable to help you with your needs, they will discuss this with you and provide you with referrals.

**The Benefits of Counseling and the Therapeutic Relationship:**

The therapeutic relationship should empower you or your child(ren) to learn how to: manage difficult feelings and behaviors; set and reach goals; increase self-awareness; improve communication in relationships; improve positive coping skills, and lower symptoms of anxiety and depression, among other benefits.

The therapist-client relationship is a professional relationship. Your therapist does not attend social gatherings, write references, or become involved with patients outside of the therapy sessions.

To protect your privacy, if an LSCC provider sees you in public, the provider will limit any interaction with you. By keeping the relationship professional, rather than personal, LSCC providers uphold the integrity and privacy of the therapeutic relationship.

**Risks:**

There is a risk when participating in therapy because talking about unpleasant events from your past can cause unpleasant feelings. Negative feelings can arise in the process of healing and finding balance.

There is no guarantee of achieving a certain outcome through therapy. But some benefits of therapy are that the symptoms and problems discussed during the therapy session may be reduced or resolved.

**Confidentiality** is required by law and professional ethical standards. There are **exceptions to keeping your personal information confidential, including:**

1. If you make a serious threat to cause harm to a victim that can be identified.

2. If you make a serious threat to cause harm to yourself.

3. If our providers suspect abuse or neglect of any child.

4. If our providers suspect abuse or neglect of a vulnerable, disabled, or elderly adult.

5. If you file a lawsuit or complaint against our providers and they are required to respond.

6. If our providers are ordered by a court of law to share your information or a disclosure is otherwise required by law.

7. If you direct our providers, in writing, to share your information.

8. Under most circumstances, minors (under 18) do not have full confidentiality from requests made by their parents/guardians.

9. While our providers are as careful as possible, they cannot promise total confidentiality of other group members for those in group therapy.

10. The healthcare insurance company that is paying for your therapy services (if applicable) has the right to review your medical records.

**Social Media Policy**:

To protect your confidentiality and in line with professional ethics, LSCC providers do not accept friend or connection requests from patients on any social media platform, such as Facebook or LinkedIn. You may follow our providers' public social media accounts but please do not make any comments that would let others know you are their patient. If you do make this type of comment, your comments will be deleted to help protect your privacy.

**Treatment of Children:**

If your current representative capacity as parent, legal guardian, or other, of an individual under LSCC's health care is subject to the terms and conditions of a custody agreement or court order, you must provide a signed complete copy of the corresponding agreement or court approved and signed order to LSCC before Behavioral Health Care services can be delivered to the child. A copy of the document attesting to your representative capacity will be maintained in the minor patient's medical record. Once treatment begins, if your representative capacity as parent or legal guardian, is terminated, modified, or changed, for any reason, you must notify LSCC immediately, and request in writing the revocation or amendment of this consent.

**Confidentiality for Child Patients:**

In working with child patients (under 18) LSCC providers try to honor what the child does or says in their sessions as confidential whenever possible and safe. When appropriate, LSCC providers will deliver summaries of treatment goals, the plan and progress, and recommendations to the parent(s) or legal guardian(s).

**If You Are Not Satisfied with Services:**

If you are not satisfied with the services of our providers for any reason, please bring your concerns to our attention. If we are unable to address your concerns, you may report complaints to:

Discipline and Complaints – Texas Behavioral Health Executive Council
Or call (800) 821-3205

**Emergency:**

**In the event of a crisis or emergency, please call:**

- **General Emergency: 911**
- https://988lifeline.org

Printed Name of Patient: _____

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____ Date: _____

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Name: _____ DOB: _____ Date:_____

For ages 12 & up

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Use "✓" to indicate your answer)* | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| **Not difficult at all** | **Somewhat difficult** | **Very difficult** | **Extremely difficult** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

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Name: _____ DOB: _____ Date:_____

# Screening to Brief Intervention (S2BI): For ages 12-17

| In the **PAST YEAR**, how many times have you used: | **Never** | **Once or twice** | **Monthly** | **Weekly** |
|---|---|---|---|---|
| Tobacco | | | | |
| Alcohol | | | | |
| Marijuana | | | | |
| Prescription drugs that were not prescribed for you: (such as pain medication or Adderall) | | | | |
| Illegal drugs: (such as cocaine or ecstasy) | | | | |
| Inhalants: (such as nitrous oxide) | | | | |
| Herbs or synthetic drugs: (such as salvia, "K2", or bath salts) | | | | |

# Audit-C Questionnaire: For ages 18 & up

1. How often do you have a drink containing alcohol?
    - o Never
    - o Monthly or Less
    - o 2-4 times a month.
    - o 2-3 times a week
    - o 4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day?
    - o 1 or 2
    - o 3 or 4
    - o 5 or 6
    - o 7 to 9
    - o 10 or more
3. How often do you have six or more drinks on one occasion?
    - o Never
    - o Less then monthly
    - o Monthly
    - o Weekly
    - o Daily or almost daily

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Patient Name: _____ DOB: _____ Caregiver/Guardian Name: _____ Today's Date: _____

**In order to help us better understand you/your child and meet your needs, please answer the questions below. Some of these questions might not apply to you/your child. In that case, please answer "No."**

What is your pain level on a scale of 0 (none) – 10 (worst)? _____ Location/Nature of Pain: _____

- ○ Yes ○ No Have you had a full medical exam in the last year?
  When? _____ By whom? _____ Where _____
  If not, would you like to be referred to primary care?
  - ○ Not applicable
  - ○ No thank you.
  - ○ I will seek out PCP on my own.
  - ○ I will accept a referral to PCP.

  Other physical health concerns: _____
- ○ Yes ○ No Do you have a Psychiatric Advanced Directive (PAD)? *A Psychiatric Advanced Directive is a legal document that allows another person to act on your behalf if you become acutely ill and unable to make decisions about treatment.*
- ○ Yes ○ No Are there any legal documents that say who may make medical decisions for the patient? (ex: custody document, guardianship, etc.) If so, please provide a copy.
- ○ Yes ○ No Do you have any of the concerns listed below:
  - ○ Unintended weight change of 10 or more pounds in the last 3-6 months?
  - ○ An illness or problem that made you change the kind and/or amount of food you eat?
  - ○ Tooth or mouth problems that make it hard for you to eat?
  - ○ A big change in desire to eat, or food intake, over the last 2 weeks?
  - ○ Do you worry that you have lost control over how much you eat?
  - ○ Do you make yourself vomit when you feel uncomfortably full?
  - ○ Do you eat in secret?
- ○ Yes ○ No Are you able to take care of yourself like you used to?
- ○ Yes ○ No Are you able to do things like you used to?
- ○ Yes ○ No Are you having trouble with your finances? Are you unable to pay for the things you need?
- ○ Yes ○ No Do you have constant, repeated difficulties with gambling that impact your quality of life?
- ○ Yes ○ No Are there things about your cultural identity that impact your reasons for seeking help or that are causing difficulties for you?
- ○ Yes ○ No Is anyone sexually threatening you or touching you in a way that makes you uncomfortable?
- ○ Yes ○ No Is anyone physically, verbally or emotionally threatening, hurting or bullying you?
- ○ Yes ○ No Is anyone keeping you from talking to who you want to, going where you want, having food, water, a place to stay or using your money?

Name: _____ Date of Birth:_____ Today's Date:_____

# COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann


## RISK ASSESSMENT

**Instructions:** Check all risk and protective factors that apply.

| Past 3 Months | Suicidal and Self-Injurious Behavior | Lifetime |
|---|---|---|
| ☐ | Have you attempted suicide? | ☐ |
| ☐ | Has a suicide attempt been interrupted? | ☐ |
| ☐ | Has there been a time where you started to do something to end your life, but you stopped yourself? | ☐ |
| ☐ | Have you taken any steps to end your life? | ☐ |
| ☐ | Have you harmed yourself without intending to kill yourself? | ☐ |

| Suicidal Ideation Check Most Severe in Past Month | |
|---|---|
| ☐ | Do you wish to be dead? |
| ☐ | Have you had suicidal thoughts? |
| ☐ | Have you thought about how you would harm or kill yourself? |
| ☐ | Do you intend to harm or kill yourself? |
| ☐ | Do you intend on harming or killing yourself and have a plan? |

| Activating Events (Recent) | |
|---|---|
| ☐ | Have you had recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)? |
| Describe: | |
| ☐ | Are you at risk for going to jail/prison or being homeless? |
| ☐ | Do you feel alone? |

| Treatment History | |
|---|---|
| ☐ | Have you had previous psychiatric diagnoses and/or treatments? |
| ☐ | Do you feel hopeless or dissatisfied with treatment? |
| ☐ | Have you had difficulty following a treatment plan? |
| ☐ | Never received treatment |

| Other Risk Factors | |
|---|---|
| ☐ | |
| ☐ | |
| ☐ | |

| Check all that applies (Recent) | |
|---|---|
| ☐ | Do you feel hopeless? |
| ☐ | Have you felt depressed? |
| ☐ | Have you experienced an increase in energy with needing little to no sleep? |
| ☐ | Do you hear voices that tell you to harm or kill yourself? |
| ☐ | Have you acted without thinking or have felt out of control? |
| ☐ | Do you abuse drugs or alcohol? |
| ☐ | Do you feel agitated or have severe anxiety? |
| ☐ | Do you feel like a burden to family or others? |
| ☐ | Do you have chronic physical pain or other serious medical issues? |
| ☐ | Do you have thoughts of harming others? |
| ☐ | Have you been aggressive towards others? |
| ☐ | Do you have the means to attempt suicide (gun, pills, etc.)? |
| ☐ | Do you feel unable to agree to safety plan? |
| ☐ | Have you had a history of being sexually abused/assaulted? |
| ☐ | Do you have a family history of suicide? |

| Protective Factors (Recent) | |
|---|---|
| ☐ | Can you list reasons for living? |
| ☐ | Do you feel responsible to family or others; are you living with family? |
| ☐ | Do you have a supportive social network or family? |
| ☐ | Do you have a fear of death or dying due to pain and suffering? |
| ☐ | Do you believe that it is wrong to kill yourself, or is it against your religious beliefs? |
| ☐ | Do you work or attend school? |

| Other Protective Factors | |
|---|---|
| ☐ | |
| ☐ | |
| ☐ | |