

New Growth Counseling Services

Introduction to Couples Counseling

Welcome to counseling. People and their situations are often very complex – your counselor will need to understand as much of the context as possible in order to help with a solution. The following paperwork (though extensive) is designed to provide that context quickly. Please complete it and bring it to your initial appointment.

- The informed consent is your formal agreement to enter therapy – please be sure that you understand all the items, if not, ask your therapist about them before you sign the form. Each adult needs to sign the consent form.
- The “questionnaire” follows – only one person needs to complete it.
- With two people come two perspectives – each adult needs to complete the “reasons for seeking counseling” the “problems and other symptoms” and the “substance use checklist” paperwork – two copies of each form are included. Please complete these three sections without input from the other person.

Thank you for completing these forms.

Sincerely,

New Growth Counseling Services

Name _____ Date _____

Each person please compete this form

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occa- sionally Disagree	Fre- quently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	0	0	0	0	0	0
2. Matters of recreation	0	0	0	0	0	0
3. Religious matters	0	0	0	0	0	0
4. Demonstrations of affection	0	0	0	0	0	0
5. Friends	0	0	0	0	0	0
6. Sex relations	0	0	0	0	0	0
7. Conventionality (correct or proper behavior)	0	0	0	0	0	0
8. Philosophy of life	0	0	0	0	0	0
9. Ways of dealing with parents or in-laws	0	0	0	0	0	0
10. Aims, goals, and things believed important	0	0	0	0	0	0
11. Amount of time spent together	0	0	0	0	0	0
12. Making major decisions	0	0	0	0	0	0
13. Household tasks	0	0	0	0	0	0
14. Leisure time interests and activities	0	0	0	0	0	0
15. Career decisions	0	0	0	0	0	0

	All the time	Most of the time	More often than not	Occa- sionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	0	0	0	0	0
17. How often do you or your mate leave the house after a fight?	0	0	0	0	0	0
18. In general, how often do you think that things between you and your partner are going well?	0	0	0	0	0	0
19. Do you confide in your mate?	0	0	0	0	0	0
20. Do you ever regret that you married? (or lived together)	0	0	0	0	0	0
21. How often do you and your partner quarrel?	0	0	0	0	0	0
22. How often do you and your mate "get on each other's nerves?"	0	0	0	0	0	0

	Every Day	Almost Every Day	Occasionally	Rarely	Never
23. Do you kiss your mate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	All of them	Most of them	Some of them	Very few of them	None of them
24. Do you and your mate engage in outside interests together?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating exchange of ideas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Laugh together	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Calmly discuss something	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Work together on a project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These are some things about which couples sometimes agree and sometime disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no)

	Yes	No
29. <input type="radio"/> <input type="radio"/> Being too tired for sex.	<input type="radio"/>	<input type="radio"/>
30. <input type="radio"/> <input type="radio"/> Not showing love.	<input type="radio"/>	<input type="radio"/>

31. The circles on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please fill in the circle which best describes the degree of happiness, all things considered, of your relationship.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship? I want desperately for my relationship to succeed, and *would go to almost any length* to see that it does.

- I want very much for my relationship to succeed, and *will do all I can* to see that it does.
- I want very much for my relationship to succeed, and *will do my fair share* to see that it does.
- It would be nice if my relationship succeeded, but *I can't do much more than I am doing now* to help it succeed.
- It would be nice if it succeeded, but *I refuse to do any more than I am doing now* to keep the relationship going.
- My relationship can never succeed, and *there is no more that I can do* to keep the relationship going.

Name _____ Date _____

Each person please compete this form

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	0	0	0	0	0	0
2. Matters of recreation	0	0	0	0	0	0
3. Religious matters	0	0	0	0	0	0
4. Demonstrations of affection	0	0	0	0	0	0
5. Friends	0	0	0	0	0	0
6. Sex relations	0	0	0	0	0	0
7. Conventionality (correct or proper behavior)	0	0	0	0	0	0
8. Philosophy of life	0	0	0	0	0	0
9. Ways of dealing with parents or in-laws	0	0	0	0	0	0
10. Aims, goals, and things believed important	0	0	0	0	0	0
11. Amount of time spent together	0	0	0	0	0	0
12. Making major decisions	0	0	0	0	0	0
13. Household tasks	0	0	0	0	0	0
14. Leisure time interests and activities	0	0	0	0	0	0
15. Career decisions	0	0	0	0	0	0

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	0	0	0	0	0
17. How often do you or your mate leave the house after a fight?	0	0	0	0	0	0
18. In general, how often do you think that things between you and your partner are going well?	0	0	0	0	0	0
19. Do you confide in your mate?	0	0	0	0	0	0
20. Do you ever regret that you married? (or lived together)	0	0	0	0	0	0
21. How often do you and your partner quarrel?	0	0	0	0	0	0
22. How often do you and your mate "get on each other's nerves?"	0	0	0	0	0	0

	Every Day	Almost Every Day	Occasionally	Rarely	Never
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27. Calmly discuss something	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Work together on a project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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- It would be nice if it succeeded, but I *refuse to do any more than I am doing now* to keep the relationship going.
- My relationship can never succeed, and *there is no more that I can do* to keep the relationship going.

New Growth Counseling Services - Informed Consent
(each adult should review, understand and sign below)

Your signature at the bottom of this page means that you understand and consent to the following policies and procedures:

Counseling is a collaborative process between therapist and patient(s) who work together on mutually agreed upon goals.

Participation is voluntary and is only effective when both patient(s) and therapist are actively striving for the patient's growth and change. Patients realize that participation in therapy can involve discussing issues that may be distressing – however, therapy is designed to help patients personally and in their relationships. When minors are involved, it may be necessary that parent(s)/guardian(s) participate in the counseling process with their child(ren) at the discretion of the therapist. Some problems may be best resolved with the participation of other family members or close relations.

Appointments are made in advance and start and end on time – a session lasts 50 minutes. If a patient is late, the session will still cost full price and end at the pre-arranged time. 24-hour advance notice is expected for cancellation or rescheduling. Any patient who fails to cancel, cancels at the “last minute,” or doesn't attend a regularly scheduled session *will be held responsible for full payment of the missed session*. Lateness, or cancellations made by the therapist will be rescheduled.

Emergencies: in the event of an emergency dial 911 or [\(888\) 724-7240](tel:8887247240). The therapist will discuss emergencies with you and may provide emergency contact information at their discretion. As a rule, most telephone calls will be returned during normal business hours on weekdays.

Payment is expected at the time of service and will be collected at the beginning of the session. Any check that is returned for insufficient funds will be assessed a \$25 fee.

Confidentiality is vital to trust - all sessions are confidential. This means the therapist will not discuss any aspect of the session or case with anyone outside of therapy without prior written consent of patient(s). It is important that a patient (especially children) has a confidential relationship with their therapist.

- **Interns** are pre-licensed counselors who are registered with the state of California and work under the clinical supervision of a licensed therapist. Interns are required to discuss and review cases with their supervisor as mandated by the professional and ethical codes of the profession – interns often use audio and video recording to do this.
- **Secrets** within relationships sometimes can be destructive or counter-productive to the goals of therapy. If a patient divulges such a secret to the therapist, the therapist will use his discretion about revealing it. Generally, the therapist will ask the patient to divulge the secret – if the therapist believes the secret is destructive or counter-productive to the counseling process, he may refuse to continue working with the patient until the patient reveals the secret. In cases of danger, the therapist may reveal the secret to maintain safety.

Limits of confidentiality: The following are exceptions to confidentiality and *MUST BE REPORTED* to the appropriate service and/or police. Please note – these reports are mandated by law and may be made without your consent or written permission.

1. If a patient (s) become a danger to himself/herself, steps will be taken to keep the person safe.
2. If the patient should become a danger to another identifiable person(s), the potential victim(s) will be warned and the police will be notified.
3. Any suspicion of child abuse (including physical, sexual, and/or emotional abuse as well as child neglect or endangerment) whether past or present, previously reported or not, will be reported.
4. Any suspicion of abuse or neglect of an elder or dependent adult will be reported to Adult Protective Services.

I authorize New Growth Counseling Services staff/ therapist to leave voice messages at my home or with a family member or friend regarding appointments, billing issues, or other pertinent information regarding my Behavioral Health Care.

YES / NO (choose one) _____

I agreed to the above policies: _____
Signature Date

I agreed to the above policies: _____
Signature Date

Consent to receive treatment from Registered Interns / videotape consent

New Growth Counseling Services employees Marriage & Family Therapist (MFT) Registered Interns. Registered interns have received their Master's degree from an accredited program and are registered with the state of CA – they are bound by the laws and ethical guidelines that govern the profession. During their unlicensed period, they receive weekly supervision from a licensed therapist. The supervisor maintains your confidentiality at all times.

Interns videotape sessions to share at supervision with the goal of providing you the highest level of care possible. This allows the supervisor to clearly see your situation and offer additional feedback. You will benefit greatly from having a second professional behind the scenes contributing insights and ideas that the intern will implement in helping you reach your goals. Videotapes are destroyed after review – all tapes stay in-house and remain locked and confidential at all times.

We understand that our counselor Mitzi Steele is an MFT registered intern with the state of California (registration IMF# 88087). We also understand that she will be working under the supervision of Jussi Light, CA Licensed Marriage and Family Therapist #39617. We may contact Jussi by calling the main number, 760-494-4394. We further understand that our counselor will discuss our case and share videotapes of sessions with Jussi.

We agree and give our consent by signing this form:

Signature: _____ Date: _____

Signature: _____ Date: _____

Email / text communications with New Growth Counseling

Please read the following disclosures about communicating with **New Growth Counseling** (NGCS):

1. NGCS does not conduct therapy, give advice, or communicate about therapy via email, text, instant message, or any other “telemedicine” technologies. Therapy is face-to-face. NGCS will only use texts/emails for the purposes of arranging meetings. If you have an urgent need to connect with your therapist and want a response, you must call by phone. NGCS will make every attempt to respond to your call in a timely manner.
2. Employees of NGCS may opt-out of texting or emailing with you for various reasons. They may also participate in texting and emailing with you. This is handled individually between you and the person you are working with.
3. Email/texting and other forms internet-based communications are non-secure and non-confidential form of communication. Hackers and unauthorized users can also attempt to access emails through malicious software such as spyware or a virus that may be located on your computer unbeknownst to you. Other people may look at your computer/phone when you are not aware.
4. Many people still feel comfortable communicating via email / text because they have taken measures to secure their computer/phone. Despite this fact, there is no guarantee that such measures will work 100%.
5. Emails/texts sent and received are stored on computers / phones of NGCS clinicians and on your computer until deleted. NGCS may or may not delete such emails and texts.
6. In addition, whenever you send an email/ text, it is stored in cyberspace and the authorities can access these emails / texts under various circumstances – this is not a policy of NGCS, but is due to the nature in which email / texts are transmitted using the internet and other services or networks. For more information on this, please contact your Internet Service Provider, email service, or cell phone provider.

By signing below, I agree that I understand the disclosures listed above regarding communicating with NGCS using email or text. I also agree that if I send an email / text to NGCS and request a response via email, that I am willing to accept the above-stated risks:

If you do not want to correspond via email do not sign your name – instead, write “declined.”

Print Name: _____ Signature _____ Date: _____

Print Name: _____ Signature _____ Date: _____

Permission for NGCS to initiate emails /texts to you

Sign below if you give your permission for NGCS to initiate sending emails/ texts to you. Example: NGCS may be the first one to send an email / text to you to cancel an appointment due to sickness. If you do not wish to have NGCS initiate emails to you, do not sign your name – instead, write “declined.”

Print Name: _____ Signature _____ Date: _____

Print your email clearly: _____

Print Name: _____ Signature _____ Date: _____

Print your email clearly: _____

New Growth Counseling Services

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that New Growth Counseling Services (NGCS hereafter) uses administrative staff to perform basic clerical and bookkeeping duties that are ordinary and typical to run a therapy practice. NGCS clerical staff will ONLY have access to the following types of information about those attending therapy:

1. Demographic information (names, addresses, telephone numbers, dates of birth, etc.) taken from client intake questionnaire.
2. Billing information (names, dates, charges, payments, payment methods, diagnostic codes, etc.).
3. Emergency contacts – in the unlikely event that your therapist becomes so ill or incapacitated that he/she is unable to contact me/us, staff may contact me/us regarding logistical issues (for example, staff may call to cancel an appointment when my therapist is sick).

Clerical staff will not have access to information about the content of counseling and therapy sessions. Clerical staff will not have access to information about any communications (such as telephone, email, mail) that pertain to counseling and therapy matters.

I further understand that administrative staff will send me a monthly statement which acts as a receipt for payments received. It includes billing information (such as a diagnosis, billing codes, patient name, etc.) and is typically sent to me via email. Please check only one:

- I will accept monthly statements by email. Please send them to the following email address:

please print clearly: _____

- I do not want my monthly statement sent via email. Please give them to me directly at sessions.

Signature: _____ Date: _____

Signature: _____ Date: _____

Couples Questionnaire – one adult completes this form for the couple

Today's Date	Full Name of person completing this form	Current Age	Place of Birth

Home Phone	OK to leave message?	Work phone	OK to leave messages?	Cell Phone	OK to leave messages?

Full name of person NOT completing this form	Current Age	Place of Birth

Home Phone	OK to leave message?	Work phone	OK to leave messages?	Cell Phone	OK to leave messages?

Primary address of couple - Street Address	City	State/Zip

circle all that apply	how long since married/ cohabiting/separated?	ever been married before?	how many times?	partner ever been married before?	how many times?
married / cohabiting / living apart		yes / no		yes / no	

	yourself	your spouse / partner
race / ethnicity		
religion / denomination		
date of birth		
sexual orientation		
names & ages of children conceived with current spouse/ partner		
names & ages of children conceived with previous spouse(s)/ partner(s)		
highest level school completed		
current occupation		
current employer / school		
hours worked each week		
how long worked here?		
second jobs		
how long at this job?		
hours worked each week		
any problems at work / school?		
unemployed?		
why?		
how long unemployed?		

	yourself	your spouse / partner
last physical exam date		
results of exam?		
current physical problems		
any head injuries / seizures? when?		
any major illness past or present? what & when?		
any operations? what & when?		
any prior hospitalizations? for what & when?		
any family history of alcoholism?	Y / N who?	Y / N who?
any family history of depression?	Y / N who?	Y / N who?
any family history of mental illness?	Y / N who?	Y / N who?
list personal strengths		
list personal weaknesses		
list personal hobbies		

Please list **everyone else** who lives in the household at least two days / week - please list from oldest to youngest

Full name

Date of Birth

Age

School / occupation

Full name	Date of Birth	Age	School / occupation

Who can I call in case of an emergency?

Phone

City

Relationship to patient

Who can I call in case of an emergency?	Phone	City	Relationship to patient

Is anyone currently getting counseling? **Yes / No** Who? _____ why? _____

for how long? _____ With whom? _____ telephone _____

Is anyone currently under the care of a physician for physical problems? **Yes / No** who? _____

For what? _____ With whom? _____ telephone: _____

Name of patient's primary physician _____ Telephone _____

Has anyone ever been arrested and/or committed a crime? **Yes / No** who? _____

When _____ For what? _____

Outcome of situation _____

Couples Questionnaire Continued

Summary of previous counseling

Please begin with the FIRST therapist you ever had and move forward to the most recent therapist
if you need more room, use back side.

	name of therapist and degree (MD, PhD, MFT, etc.)	start & end dates - - how often did you meet? (weekly?)	reasons for seeking treatment -- reasons for stopping treatment	what type of therapy? was it helpful? did you have any negative reactions?
1				
2				
3				
4				
5				
6				
7				

THANK YOU FOR FILLING OUT ALL THESE FORMS!

Problems and Other Symptoms

(each adult complete this form)

Name: _____ Date: _____

Please check any of the following which may apply to **anyone in the household** – this includes issues not relating to the reasons you are coming to counseling.

<input checked="" type="checkbox"/>	problem	who has problem?	<input checked="" type="checkbox"/>	problem	who has problem?
	alcohol use			inability to relax	
	angry outbursts			legal matters	
	anorexia or bulimia (past / present)			loneliness	
	anxiety			loss of interest in things	
	bad dreams			loss of sexual interest or desire	
	boredom			marriage problems	
	can't get motivated to do things they usually enjoy			memory problems	
	career choices			nervousness	
	crying easily			overeating	
	depression			parent - child conflict	
	difficulty concentrating			poor appetite	
	difficulty falling asleep or staying asleep			poor or decreased ambition	
	difficulty getting up in the morning			pornography use	
	difficulty making decisions			preoccupation with death	
	difficulty parenting			school problems	
	divorce			self-confidence	
	drug use			self-mutilation	
	easily annoyed or irritated			sexual problems	
	energy problems			shyness	
	extreme fear of places or events			stuttering	
	faintness or dizziness			suicidal attempts	
	fatigue			suicidal thoughts	
	feeling fearful			thoughts hard to get rid of	
	feeling inferior to others			trouble remembering things	
	feeling tense or nervous			uncontrollable outbursts of temper	
	financial problems			unhappiness	
	friendship problems			violent behavior	
	gambling			violent thoughts	
	guilt			work problems	
	impulsiveness			worrying about things	

Problems and Other Symptoms

(each adult complete this form)

Name: _____ Date: _____

Please check any of the following which may apply to **anyone in the household**. Please check issues even if they do not relate to the primary reasons you are coming to counseling.

<input checked="" type="checkbox"/>	problem	who has problem?	<input checked="" type="checkbox"/>	problem	who has problem?
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	career choices			nervousness	
	crying easily			overeating	
	depression			parent - child conflict	
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	difficulty falling asleep or staying asleep			poor or decreased ambition	
	difficulty getting up in the morning			pornography use	
	difficulty making decisions			preoccupation with death	
	difficulty parenting			school problems	
	divorce			self-confidence	
	drug use			self-mutilation	
	easily annoyed or irritated			sexual problems	
	energy problems			shyness	
	extreme fear of places or events			stuttering	
	faintness or dizziness			suicidal attempts	
	fatigue			suicidal thoughts	
	feeling fearful			thoughts hard to get rid of	
	feeling inferior to others			trouble remembering things	
	feeling tense or nervous			uncontrollable outbursts of temper	
	financial problems			unhappiness	
	friendship problems			violent behavior	
	gambling			violent thoughts	
	guilt			work problems	
	impulsiveness			worrying about things	

Substance use Checklist – Name _____

(Each Adult completes separate form)

I consume alcohol....	
<input type="checkbox"/>	never
<input type="checkbox"/>	1time/ month
<input type="checkbox"/>	2-4 times / month
<input type="checkbox"/>	2-4 times / week
<input type="checkbox"/>	daily

The following apply to me (check all that apply)	
<input type="checkbox"/>	I rarely or never drink – not even socially
<input type="checkbox"/>	I'm an occasional/ social drinker
<input type="checkbox"/>	I'm not sure if I have a problem
<input type="checkbox"/>	I probably have a problem
<input type="checkbox"/>	I have a problem, and I want to stop
<input type="checkbox"/>	I have a problem, but I don't want to stop

When I drink, I usually drink....	
<input type="checkbox"/>	none
<input type="checkbox"/>	1-2 drinks or beers
<input type="checkbox"/>	2-3 drinks or beers
<input type="checkbox"/>	3-4 drinks or beers
<input type="checkbox"/>	5+ drinks or beers

I've tried to control my drinking with....	
<input type="checkbox"/>	Nothing!
<input type="checkbox"/>	I stopped on my own
<input type="checkbox"/>	I've attended AA / other 12-step program a few times
<input type="checkbox"/>	I've attended AA / other 12-step program a regularly
<input type="checkbox"/>	I attended day or outpatient treatment
<input type="checkbox"/>	I attended inpatient / residential treatment
<input type="checkbox"/>	I attended a community-based program (e.g., church program, etc.)
<input type="checkbox"/>	I was forced to attend treatment of some kind

I get drunk....	
<input type="checkbox"/>	never
<input type="checkbox"/>	1x/ month
<input type="checkbox"/>	1-4x/month
<input type="checkbox"/>	2-4x / week
<input type="checkbox"/>	daily

I currently use / I once used / I only ever tried....				
	only tried	used regularly	age started	age stopped
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

I've been drinking like this for the...	
<input type="checkbox"/>	last month
<input type="checkbox"/>	2-6 months
<input type="checkbox"/>	6-12 months
<input type="checkbox"/>	more than a year
<input type="checkbox"/>	more than 3 years

My drinking has resulted in one or more of the following...	
<input type="checkbox"/>	passing out
<input type="checkbox"/>	sleep disturbances
<input type="checkbox"/>	can't stop once I start
<input type="checkbox"/>	blackouts
<input type="checkbox"/>	relationship problems
<input type="checkbox"/>	binges
<input type="checkbox"/>	work/school problems
<input type="checkbox"/>	seizures
<input type="checkbox"/>	Assaults &/or arrests
<input type="checkbox"/>	physical withdrawal
<input type="checkbox"/>	legal problems
<input type="checkbox"/>	medical complications

The following apply to me (check all that apply)	
<input type="checkbox"/>	I don't gamble
<input type="checkbox"/>	I gamble occasionally
<input type="checkbox"/>	I like to gamble
<input type="checkbox"/>	Gambling has caused me problems
<input type="checkbox"/>	I have gambled until all my money was gone
<input type="checkbox"/>	I have gambled more than I planned to
<input type="checkbox"/>	I like to gamble to escape worry or trouble
<input type="checkbox"/>	I have borrowed money in order to gamble
<input type="checkbox"/>	At times I've felt remorse after gambling
<input type="checkbox"/>	I've lost time from work or school due to gambling

Substance use Checklist – Name _____

(Each Adult completes separate form)

I consume alcohol....	
<input type="checkbox"/>	never
<input type="checkbox"/>	1time/ month
<input type="checkbox"/>	2-4 times / month
<input type="checkbox"/>	2-4 times / week
<input type="checkbox"/>	daily

The following apply to me (check all that apply)	
<input type="checkbox"/>	I rarely or never drink – not even socially
<input type="checkbox"/>	I'm an occasional/ social drinker
<input type="checkbox"/>	I'm not sure if I have a problem
<input type="checkbox"/>	I probably have a problem
<input type="checkbox"/>	I have a problem, and I want to stop
<input type="checkbox"/>	I have a problem, but I don't want to stop

When I drink, I usually drink....	
<input type="checkbox"/>	none
<input type="checkbox"/>	1-2 drinks or beers
<input type="checkbox"/>	2-3 drinks or beers
<input type="checkbox"/>	3-4 drinks or beers
<input type="checkbox"/>	5+ drinks or beers

I've tried to control my drinking with....	
<input type="checkbox"/>	Nothing!
<input type="checkbox"/>	I stopped on my own
<input type="checkbox"/>	I've attended AA / other 12-step program a few times
<input type="checkbox"/>	I've attended AA / other 12-step program a regularly
<input type="checkbox"/>	I attended day or outpatient treatment
<input type="checkbox"/>	I attended inpatient / residential treatment
<input type="checkbox"/>	I attended a community-based program (e.g., church program, etc.)
<input type="checkbox"/>	I was forced to attend treatment of some kind

I get drunk....	
<input type="checkbox"/>	never
<input type="checkbox"/>	1x/ month
<input type="checkbox"/>	1-4x/month
<input type="checkbox"/>	2-4x / week
<input type="checkbox"/>	daily

I currently use / I once used / I only ever tried....				
	only tried	used regularly	age started	age stopped
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
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<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

I've been drinking like this for the...	
<input type="checkbox"/>	last month
<input type="checkbox"/>	2-6 months
<input type="checkbox"/>	6-12 months
<input type="checkbox"/>	more than a year
<input type="checkbox"/>	more than 3 years

My drinking has resulted in one or more of the following...	
<input type="checkbox"/>	passing out
<input type="checkbox"/>	sleep disturbances
<input type="checkbox"/>	can't stop once I start
<input type="checkbox"/>	blackouts
<input type="checkbox"/>	relationship problems
<input type="checkbox"/>	binges
<input type="checkbox"/>	work/school problems
<input type="checkbox"/>	seizures
<input type="checkbox"/>	Assaults &/or arrests
<input type="checkbox"/>	physical withdrawal
<input type="checkbox"/>	legal problems
<input type="checkbox"/>	medical complications

The following apply to me (check all that apply)	
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