

Introduction to Family Counseling

Welcome to counseling. I look forward to meeting with you and getting started. People and their situations are often very complex – I need to understand as much of the context as I can in order to help with a solution. The following paperwork (though extensive) is designed to give me the context quickly. Please complete it and bring it to your initial appointment.

- The informed consent is our formal agreement to enter therapy – please be sure that you understand all the items, if not, ask me about them before you sign the form. Each parent needs to sign the consent form.
- If you are divorced from the child’s parent:
 - Please bring the *most recent* court documents that demonstrate the status of **legal custody**.
 - If you share **legal custody** (not the same as *physical custody*), your ex-spouse typically needs to consent for the treatment of your child. You should read my form on “joint-legal custody paperwork” (found at my website) – your ex-spouse should download, complete and then send this form to me as well. If this presents any difficulty or concerns for you, please call me immediately to discuss the situation.
- Two disclosure forms follow pertaining to the sharing of information as well as email communications – these are self-explanatory.
- The “caregiver’s authorization affidavit” is a form for adults who are caregivers, but not biological parents of children (e.g., grandparents or other family member who is raising the child). If you are a biological parent, you do not need to complete this form – step-parents do not need to complete this form either.
- The questionnaire follows. Please note – the questionnaire will ask you about your spouse – fill this out on your *current* spouse or partner if you are divorced from the child’s parent.
- Finally, each adult who is living with the child needs to complete the “substance use checklist.” If you are divorced, your ex-spouse does not need to fill these forms out; however, if you are remarried or cohabitating, then both adults need to complete these two forms.

I appreciate the opportunity to work with you. If you have any questions, feel free to call me directly, 760-494-4394.

Sincerely,

Jussi Light, M.A., LMFT

Informed Consent for Families with Minors (ages 17 and younger)

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 800-479-3339. The therapist is available via telephone (760-494-4394 – sorry text messages are not received at this number) during business hours and will return emergency calls at his discretion. However, most phone 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 all patients (especially children) have a confidential relationship with their therapist.

- Individuals attending therapy due to a **court mandate** or as consequence or condition of probation/parole may have to waive their rights to confidentiality and the therapist may be able to communicate to your probation/parole officer regarding your case.
- If you have **health insurance** that covers services, a minimum of information will need to be exchanged to insure reimbursement – however, you will be required to sign an authorization to release information.
- **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 client(s) become a danger to himself/herself, steps will be taken to keep the client safe.
2. If the client 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 abuse or neglect of an elder or dependent adult will be reported to Adult Protective Services.

I authorize Jussi light 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) _____

Only parent(s) or legal guardian(s) can give authorization for the treatment of minors. If both parents have legal custody, both parents' signatures are required for treatment. If someone other than the parent(s) holds guardianship, legal documentation must be presented prior to authorizing treatment. If there are legal stipulations (a court order) that both parents must consent to ongoing treatment, I agree to contact the other parent and forward his/her consent for treatment to my child's therapist prior to treatment.

I hereby consent to the treatment of my child(ren): _____
Print child(ren) name(s)

I agree to the above policies: _____
Parent/Legal Guardian Signature(s) Date

I agree to participate in counseling: _____
Child(ren) signature(s) Date

Joint legal custody issues:

I am glad that I will have an opportunity to work with your child/children. In order to get started, the paperwork that follows needs to be completed by both parents who have joint legal custody of the children who are coming for counseling. When divorced parents share legal custody, they are usually entitled to be involved in the mental health care of their child. This does not mean that both parents will be involved in the counseling process – it just means that both parents consent and know that they are entitled to know about their child’s mental health progress if they so choose. Please read this letter and all the paperwork that follows carefully and contact me directly (760-494-4394) if you have any questions.

Joint legal custody is defined by the courts – typically, it applies to the two biological parents of a child (or children) who have divorced, and gives each parent the ability to make decisions on behalf of their child/children. The court decides who has legal custody and notes this on the divorce documentation. Legal custody is not the same as visitation, physical custody, or where the child resides.

When a divorce has occurred, contact between former spouses can result in tension. To limit this I take the following position and set the following boundaries:

1. When a couple divorces, they essentially create two separate families – the child belongs to both families, but each spouse is typically excluded from the other – this is the basic premise of a divorce.
2. Because I am a family therapist, I am open to hearing from both parents, though I do not require it. I am interested in both parent’s perspective on their child’s mental health and behavior. The exceptions are extreme cases where I deem such communication unhelpful to the therapeutic process (e.g., the other parent is incarcerated, or is incapacitated due to chronic drug addiction).
3. I work directly with the family that initiates the counseling process, because they are the family who has hired me to help the situation. I work indirectly with the other parent, if they want to be involved.
4. If both parents are “friendly with each other” it is occasionally possible and sometimes helpful to have meetings that may involve both parents – this is rare, but in some cases, when all parties agree, it can be helpful. It is not required, however, and is dependant solely on the situation presented.
5. If both parents are “not friendly with each other” and I deem that they are incapable of working together, or that the direct involvement of both parents in counseling is detrimental, I will limit my work to the family that hired me; but I may remain open to communication with the other parent.
6. There are extreme situations in which I would not be open to communications from the other parent who may have legal custody (child abuse, incest, violence, other forms of abuse or danger). This is a matter of state law which gives mental health professionals discretion as to limit-setting within family therapy. If you have any questions, feel free to contact me directly (760-494-4394).

I have joint legal custody of _____
Child or children’s name(s)

I understand what is written above _____
Parent with joint legal custody

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that Jussi Light uses administrative staff to perform basic clerical functions that are ordinary and typical to run his therapy practice. Jussi Light's staff will ONLY have access to the following types of information about those attending therapy:

1. Demographic information (names, addresses, telephone numbers, email addresses, 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 Jussi Light becomes so ill or incapacitated that he is unable to contact me/us, staff may contact me/us regarding logistical issues (for example, to cancel an appointment for Jussi when he is sick).

Staff will not have access to information about the content of counseling and therapy sessions. 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/us directly at sessions.

By signing below, I understand and agree to the contents of this form.

Name: _____ date: _____

Name: _____ date: _____

Email communications with Jussi Light

Please read the following disclosures about communicating with Jussi Light using email:

1. Email is a 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.
2. Many people still feel comfortable communicating via email because they have installed firewalls or other programs designed to detect spyware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.
3. Sent and received emails are stored on both Jussi Light's and your computer until deleted. Jussi Light may or may not delete such emails. Generally, mundane emails (questions about appointments, billing, etc) will be deleted while other emails may be kept for archival purposes. Any such saved emails will be kept in a password-protected account that only Jussi Light has access to.
4. In addition, whenever you send an email, it is stored in cyberspace and the authorities can access these emails under various circumstances – this is not a policy of Jussi Light, but is due to the nature in which email is transmitted using the internet and other services or networks. For more information on this, please contact your Internet Service Provider or email service.
5. Jussi Light will use email to respond to emails that you send him. If you request that your billing statement be emailed to you, he will do so.
6. As a rule, Jussi Light does not conduct therapy via email. However, he may use email to handle certain questions/issues that pertain to therapy and related content if they can be easily and simply handled over email. He may also choose not to use email to handle such matters. He will tell you if this is the case.

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

Each Adult must complete – 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 Jussi light to initiate emails to you

Sign below if you give your permission for Jussi Light to initiate sending emails to you. Example: Jussi may be the first one to send an email to you, rather than just responding to your emails.

If you do not wish to have Jussi Light 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: _____

Caregiver's Authorization Affidavit

**This form does NOT need to be completed if you are the biological parent of the child.
This form is for caregivers or guardians who are not biological parents of the child.**

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1-4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5-8 is additionally required to authorize any other medical care (including mental health treatment). Please PRINT clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of Minor: _____
2. Minor's date of birth: _____
3. My name: _____
4. My home address: _____
5. I am a grandparent, aunt, uncle, or other qualified relative of the minor (see definitions below).
6. Check one or both (for example, if one parent was advised and the other cannot be located):
 I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care and have received no objections.

 I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time to notify them of my intended authorization.
7. My date of birth: _____
8. My California driver's license or identification card number: _____

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct:

Dated: _____ Signed: _____

DEFINITIONS/NOTICES

1. This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor.
2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.
3. The affidavit is not valid for more than one year after the date on which it is executed.

TO CAREGIVERS:

1. "Qualified relative" for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great" or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.
2. The law may require you, if you are not a relative or a currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions, please contact your local department of social services.
3. If the minor stops living with you, you are required to notify any school, health care provider, or health care service plan to which you have given this affidavit.
4. If you do not have the information requested in item 8 (California driver's license or ID) provide another form of identification such as your social security number.

TO HEALTHCARE PROVIDERS:

1. No person who acts in good faith reliance upon a caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit is subject to criminal liability or to civil liability to any person, or is subject to professional disciplinary action, for such reliance if the applicable portions of the form are completed.
2. This affidavit does not confer dependency for health care coverage purposes.

Patient Information

Today's Date		Completed by		Relationship to patient	
First Name (patient)		Last Name		M.	Date of Birth
Full Address (street, city, state, zip)				home telephone	OK to leave message?
					Yes / No
Religion / Denomination		Race / Ethnicity		Gender	current grade level
				M / F	
Name of Patient's Current School and city of school		Grade Level	Current GPA	Length at school	
Former School name and city		length attended		reason left:	
Former School name and city		length attended		reason left:	

All minors (17 and younger) have legal custodians or guardians – usually these are the biological parents. In the case of divorce, remarriage, adoption, or children living with other family members/adults, the legal custody or guardian is established by the courts. Please list all the parents and guardians of this patient (both living and deceased):

				male / female	living / deceased
				Has Full / Partial / No legal custody?	
Full Name		Street address		City / State / Zip	
Date of birth / age		primary telephone		other phone	
Occupation		current employer		length at job	
				hours worked / week	
				Been divorced? -----Y / N	
				Been remarried? -----Y / N	
				Biological parent of patient? -----Y / N	
				Step-parent of patient? ----- Y / N	
				Adoptive parent of patient-----Y / N	
				Other family member? ----- Y / N	

				male / female	living / deceased
				Has Full / Partial / No legal custody?	
Full Name		Street address		City / State / Zip	
Date of birth / age		primary telephone		other phone	
Occupation		current employer		length at job	
				hours worked / week	
				Been divorced? -----Y / N	
				Been remarried? -----Y / N	
				Biological parent of patient? -----Y / N	
				Step-parent of patient? ----- Y / N	
				Adoptive parent of patient-----Y / N	
				Other family member? ----- Y / N	

				male / female	living / deceased
				Has Full / Partial / No legal custody?	
Full Name		Street address		City / State / Zip	
Date of birth / age		primary telephone		other phone	
Occupation		current employer		length at job	
				hours worked / week	
				Been divorced? -----Y / N	
				Been remarried? -----Y / N	
				Biological parent of patient? -----Y / N	
				Step-parent of patient? ----- Y / N	
				Adoptive parent of patient-----Y / N	
				Other family member? ----- Y / N	

				male / female	living / deceased
				Has Full / Partial / No legal custody?	
Full Name	Street address	City / State / Zip		Been divorced? -----Y / N	
				Been remarried? -----Y / N	
Date of birth / age	primary telephone	other phone		Biological parent of patient? -----Y / N	
				Step-parent of patient? ----- Y / N	
				Adoptive parent of patient-----Y / N	
Occupation	current employer	length at job	hours worked / week	Other family member? ----- Y / N	

The following questions are being asked of you, the parent, and your current spouse/ partner.

	yourself	your <u>current</u> spouse or 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?		
last physical exam date		
results of exam?		
current physical problems		

May I have your permission to thank the person who referred you? **Yes / No** _____

signature authorization

What problems are you wanting to address in counseling?: _____

How long have these problems existed? _____

What makes these problems worse? _____

What makes these problems improve? _____

Overall, how motivated are you to change these problems? **Circle one:** Very motivated-----not motivated
10 - 9 - 8 - 7 - 6 - 5 - 4 - 3 - 2 - 1

What do you expect from therapy? _____

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

for how long? _____ With whom? _____ telephone _____

Any hospitalizations for mental health reasons? **Yes / No** who? _____

When? _____ Why? _____ Where? _____

Has anyone received help for any drug / alcohol use? **Yes / No**

who? _____ what for? _____ when? _____

who? _____ what for? _____ when? _____

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 _____

If need be, would other relatives be willing to come into therapy sessions? **Yes / No**

If not why? _____

Problems and Other Symptoms

Please check any of the following which may apply to **anyone who the child/children live with (include ex-spouse's household if applicable)**. 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?
	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	

Summary of Prior Counseling / Psychotherapy

**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				

Substance use Checklist – Name _____

(any adults who live with patient must complete this 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
none				
pot				
sedative				
stimulant				
cocaine				
meth				
inhalants				
Heroin/ opium				
prescription drugs				
LSD, mushrooms				
other				

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 _____

(any adults who live with patient must complete this 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
none				
pot				
sedative				
stimulant				
cocaine				
meth				
inhalants				
Heroin/ opium				
prescription drugs				
LSD, mushrooms				
other				

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

