

Symptom Checklist

Client: _____

Date: _____

Circle Yes or No if you have noticed any of the following symptoms, then please check the duration of the symptoms.

2 weeks or longer 2 years or longer

A sad or blue or depressed mood or loss of interest or pleasure in all or most of your usual activities?

YES or NO		
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Sad mood is worse in the mornings?

YES or NO		
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Wake at least two hours before your usual time of waking?

YES or NO		
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Decreased effectiveness or productivity at school, work, or home?

YES or NO		
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Social withdrawal (less involvement with friends and activities)?

YES or NO		
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Loss of interest in sex or decrease in sexual drive?

YES or NO		
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A loss of interest or pleasure in usual activities?

YES or NO		
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Feelings of worthlessness or low self-esteem?

YES or NO		
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Sluggish feeling (slowing down)?

YES or NO		
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Feelings of self-reproach or guilt?

YES or NO		
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Recurrent thoughts of death, suicidal thoughts, wishes to be dead?

YES or NO		
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Suicide attempts?

YES or NO		
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Feeling nervous or anxious or on edge? Any sudden feeling of fear or panic attack?

YES or NO		
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Diminished ability to think or concentrate, having a lot on your mind?

YES or NO		
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Irritability or excessive anger?

YES or NO		
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Difficulty with sleeping or sleeping too much?

YES or NO		
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Poor appetite or weight loss when not dieting or increased appetite or weight gain?

YES or NO		
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Making self vomit or taking laxatives?

YES or NO		
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Explain if necessary:

Have you experienced episodes of violence with destruction of property or assaults on other people or have you ever been arrested for this type of behavior? Yes or No

Have you been seriously troubled by impulses to gamble, steal, set fires, or behave in any way that is harmful to yourself or others? Yes or No

If yes, have you been arrested for any of these behaviors? Please describe.

Have you had or do you have thoughts of hurting someone else (homicidal thoughts)? Yes or No

Are you aware of any problem with your sexual functioning? Yes or No

Are you troubled by fear or avoidance of any situation or object that seems excessive or unreasonable to you or that interferes with normal functioning? (Examples: Fear of flying, crowds, etc.) Yes or No

Have you been troubled significantly enough to interfere with your relationship with others, with work, with enjoyment of life in any of the following situations:

Recurrent, persistent ideas or thoughts, impulses or images that intrude on your mind and are difficult to get rid of and keep popping back in despite attempts to ignore them or make them go away? Yes or No

By repetitive behaviors that have to be performed according to certain ideas or rules, that if not done would result in an increase in tension? Yes or No

Do you now or have you in the past noted any experience of voices talking about you or to you even though there are no people around? Yes or No

Have you noted any ideas that seem bizarre, strange or unusual to you that persisted or interfered with your functioning Yes or No

Do you feel that people or organizations are monitoring you, tapping your telephone or following you? Yes or No

Do you think you have a problem or have had a problem with alcohol or other chemicals prescribed or not? Yes or No

Do you think that others can read your mind or control your thoughts? Yes or No

**Valentine Counseling Services
6043 Hudson Road East
Suite 355
Woodbury, MN 55125
651-373-3886**

NOTICE OF PRIVACY RIGHTS

This notice, effective April 14, 2003, describes how health information and other private information about you may be used and shared with others and how you can get access to this information. Please review it carefully.

You have privacy rights under the Minnesota Government Data Practices Act and the Federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect your privacy, but also let us give information about you to others if a law requires it. We must tell you before we give the information.

What is Private Health Information (PHI)?

- Information about your mental or physical health, health care services, or payment for health care services.
- Information that identifies you or could be used to identify you, such as address, phone number, social security number, age, date of birth, names of family members, and health history.
- Information that is shared by you, created by KB Counseling Evaluation Mediation Services staff, or shared with us by related organizations.

Why do we ask you for this information?

- To determine if we are able to provide the treatment that you need, to develop a treatment plan with you, and to give you mental health treatment.
- To collect payment from insurance companies, HMOs or other payment sources.
- To assist in carrying out administrative, financial, legal and quality improvement activities necessary to run Valentine Counseling Services and to support the core functions of treatment and payment.

Do you have to answer the questions we ask?

- There is no law that says you must give us any information. However, if you choose not to give us some information, it can limit our ability to serve you.
- If you are here because of a court order, and you refuse to provide information, that refusal may affect your status with the court.

When Valentine Counseling Services may use and share your PHI with others:

With Your Permission:

- **Treatment.** To provide, coordinate, or manage mental health care and related services for you and to ensure that you are receiving appropriate and effective services. For example, we share information and consult with your other service providers.
- **Valentine Counseling Services Operations.** To assist in carrying out administrative, financial, legal and quality improvement activities necessary to run our business and to support the core functions of treatment and payment.
- **Payment.** To obtain payment or reimbursement for services provided to you. For example, we may need to disclose PHI to determine whether insurance will cover your treatment.
- **Business Associates.** Our business associates perform some health care administration and operation activities for us. An example of a business associate is our billing service. We may disclose private information to our business associates so that they can perform the job we have asked them to do. We require our business associates to protect PHI and to follow our privacy practices.
- **Individuals involved in your care or payment for your care.** We may disclose health information to a family member, service provider, relative or any person you identify, who is, based on your (or your guardian's) judgment, believed to be involved in your care or payment related to your treatment.

Without your permission, we may use and disclosure PHI for these reasons:

- **As required by law.** We must disclose PHI about you when required to do so by law or legal statute.
- **Abuse or Neglect.** We may make disclosures to government authorities or social service agencies as required by law in the reporting of abuse, neglect, or domestic violence.
- **To avert serious threat to public health and safety.** We may disclose PHI to avoid a serious and imminent threat to your health or safety or to the health or safety of others.

- **Legal proceedings.** We may disclose PHI for a judicial or administrative proceeding in response to a court order, written notice, or protective order.
- **To government agencies for compliance purposes.** We may use or disclose PHI to the Secretary of Health and Human Services to assist with a complaint investigation or compliance review.
- **For client and community safety purposes,** it is likely that we will report the client's name, history of harmful behaviors and functional level to local authorities. Also, any criminal activity engaged in at Valentine Counseling Services will be reported to local authorities.

Your written permission

We are required to get your written permission (authorization) before using or sharing your PHI for purposes other than those provided above, or as otherwise permitted or required by law. If you do not want to authorize a specific request for disclosure, you may do so without fear of being treated poorly.

You may withdraw your permission

If you do provide your written authorization and later want to take it back, you may do so in writing at any time. As soon as we receive your written revocation, we will stop using or sharing the PHI specified in your original authorization, except to the extent that we have already used it based on your written permission.

You have the right to the information we have about you

- You may ask to see any information we have about you and get copies. You may have to pay for the copies.
- You may give other people permission to see and have copies of private information about you.
- You may question the accuracy of any information we have about you.
- You have the right to ask us to share mental health information with you in a certain way. For example, you may ask us to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain why you are making the request. If we find that your request is reasonable, we will grant it.
- You can ask us to restrict uses or disclosures of your health information. Your request must be in writing. You must explain what information you want to restrict from being disclosed and to whom you want these restrictions to apply. You can request to end these restrictions at any time by writing to us. We are not required to agree to your restrictions.

- You have a right to receive a record of the people or organizations with whom we have shared your health information. We must keep a record of each time we share your health information from April 14, 2003. This record will NOT include those times when we have shared your information in order to treat you, bill for your services or to run our programs. If you want a copy of this record, you must send a request in writing to our HIPAA Officer.
- If you do not understand the information, you may ask to have it explained to you.

What if you believe the information we have about you is wrong?

Send us your concerns in writing, telling us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency.

Filing a complaint about your health information rights

If you believe your privacy rights have been violated, you can file a complaint with our HIPAA Officer or with the United States Department of Health and Human Services at:

HIPPA Officer
Valentine Counseling Services
6043 Hudson Road East
Suite 355
Woodbury, MN 55125
651-373-3886

Medical Privacy Complaint Division
Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019

We cannot deny you services or treat you poorly because you have filed a complaint against us.

If you have any questions about this information, ask any Valentine Counseling Services staff member.

Acknowledgement of Receipt of Notice of Privacy Practices

- you may refuse to sign this Acknowledgement •

I, _____, have been given a copy of
[Client's printed name]

Valentine Counseling Service's Notice of Privacy Practices. I have had a chance to ask questions about how my information will be used.

We ask that you and/or your guardian/conservator sign this form. We use this form to show that you have received the Notice of Privacy Practices. The information in the notice applies to all future contacts while you are at Valentine Counseling Services or after you leave. It applies to all contacts which are in person, on the phone, or by mail.

Client's Signature

Date

Substitute Decision Maker's Signature (if applicable)

Relationship

Date

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices; however, signature could not be obtained because the Individual refused to sign.

Staff Signature

Date