Chandra S. Nagireddy, Ph.D
Licensed Marriage & Family Therapist
EMDRIA Approved Consultant &
Trainer

Pikes Peak Psychotherapy, Inc.
2130 Academy Circle, Suite B
Colorado Springs, CO 80909
Ph.: 719-761-4444 Fax: 719-550-4100

REGISTRATION

Name_____ Date _____

Street _____City: _____

State _____ Zip _____ Email _____

Home Ph: _____ Work Ph: _____ Cell Phone: _____

Date of birth__/____ /_____SS#: _____/_____/_____

Employer:_____ Job Title: _____

Address:_____

Marital Status Single / Married / Cohabitate /Divorced / Separated / Widowed

Participating Members

Name_____ DOB_____ SS# _____

Name_____ DOB_____ SS# _____

Name_____ DOB_____ SS# _____

Name_____ DOB_____ SS# _____

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FINANCIAL POLICY AND FEE AGREEMENT

1. Payment is due at the time of service unless arrangements have been made with your therapist to pay otherwise, Our regular fees are as follows unless otherwise contracted:

   Diagnostic Intake interview……...$ 170
   50 minute psychotherapy ……..….$ 135

2. Extended phone calls, inpatient psychotherapy, or any other out of office services © rate of $ 135 per hour

3. All appointments missed without a 48 hrs notice (except medical and weather related emergencies) will be charged at a flat rate of $35 per missed session.

4. Our office will be happy to file all necessary insurance claims for you. This is a courtesy we extend to all clients. However, your insurance is a contract between you, your employer, and your insurance company. We are not party to that contract. You are ultimately responsible for the entire balance due on your account. All services are not covered benefits under all insurance policies. We are willing to assist you in determining what benefits you may be entitled to. Deductibles. Co-payments, denied charges, or required preauthorization are your responsibility. Any claim not paid by your insurance company within 45 days will be due and payable by you. We will continue to assist you with the appeals process

5. You agree to keep our office informed of any changes that may affect your ability to pay on this account.

I have read, full understand, and agree to abide by all of the terms of this financial policy and Fee Agreement

Name_____Date_____Signature_____

Name_____Date_____Signature_____

INSURANCE INFORMATION

Insurance Company's Name: _____ Phone_____

Street: _____City: _____

State: _____ Zip: _____ Group/Policy No: _____ ID Card No: _____

How much is your deductible for this year? $_____ Have you met it yet? _____ No____ Yes

Effective Date: _____ Valid up to _____ Is any Pre-authorization needed? _____ No _____ Yes

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INSURED (or Policy Holder) INFORMATION

Insured's relationship to the Client? (circle one) Self / Spouse / Child / Parent / Other:_____ _____

Name: _____ Date of Birth: ____/____/_____ **SS#**_____

Street: _____ City:_____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Employer: _____ City: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
Only the Client, or in the case of a minor, the minor's Legal Guardian may sign this. [One spouse may not sign this for the other spouse!]

I hereby authorize the release of any medical information necessary to process this and all future claims. I also certify that a photographic reproduction of this release is as good as the original.

Signed: _____Date: _____

ASSIGNMENT OF BENEFITS

I authorize payment of all medical benefits due to me for this claim and future claims to be sent directly to the provider of services.

Signed: _____Date: _____

SECOND INSURANCE INFORMATION

Name_____ DOB_____ SS #_____

Insurance Company's Name: _____ Phone_____

Street: _____City: _____

State: _____ Zip: _____ Group/Policy No: _____ ID Card No: _____

How much is your deductible for this year? $_____ Have you met it yet? _____ No____ Yes

Effective Date: _____ Valid up to _____ Is any Pre-authorization needed? _____ No _____ Yes

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
Only the Client, or in the case of a minor, the minor's Legal Guardian may sign this. [One spouse may not sign this for the other spouse!] *I hereby authorize the release of any medical information necessary to process this and all future claims. I also certify that a photographic reproduction of this release is as good as the original.*

Signed: _____ Date: _____

ASSIGNMENT OF BENEFITS
I authorize payment of all medical benefits due to me for this claim and future claims to be sent directly to the provider of services.

Signed: _____ Date: _____

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CONTACT INFORMATION

In the event in which the clinic or I must telephone you for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts will be made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. Please check where you may be reached by phone. Include phone numbers and how you would like us to identify ourselves when phoning you.

_____HOME Phone number: _____

How should we identify ourselves? _____

May we say the clinic name? _____Yes _____No

_____WORK Phone number: _____

How should we identify ourselves? _____

May we say the clinic name? _____Yes _____No

_____OTHER Phone number: _____

How should we identify ourselves? _____

May we say the clinic name? _____Yes _____No

Emergency Contacts:

Name _____ Phone No _____

Name _____ Phone No _____

ACKNOWLEDGEMENT OF RECEIPT OF THE AGREEMENT FOR PSYCHOTHERAPY SERVICES & HIPA NOTICE OF PRIVACY PRACTICES

I have read the office policies and the agreement for psychotherapy services and fully understand their meanings and implications. I acknowledge that I received a copy of THE AGREEMENT FOR PSYCHOTHERAPY SERVICES, FINANCIAL POLICY & FEE AGREEMENT, along with a copy of HIPA NOTICE OF PRIVACY PRACTICES

Name _____ Signature_____ Date_____

Name _____ Signature_____ Date_____

Name _____ Signature_____ Date_____

Name _____ Signature_____ Date_____

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HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, 1 am always legally required to follow the privacy practices described in this Notice. Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you can view a copy of it in my office or on my website, which is located at associatesforwellness.com.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example; If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control -1 might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons: (The following list is a compilation of federal and Colorado laws)

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to Colorado Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the Colorado Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the Colorado Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, 1 may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits 1 offer.

16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you.
18. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: 2130 Academy Cir, Ste B. Colorado Springs, Colorado, 80909. Ph# (719) 761-4444.

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OFFICE POLICIES & AGREEMENT FOR PSYCHOTHERAPY SERVICES

Licensed Marriage & Family Therapist #450, State of Colorado, 1998; MA in Psychology, State Univ. of West Georgia, 1992; Ph.D. in Marriage and Family Therapy, The Univ. of Georgia, 1996; EMDRIA Certified Therapist & Approved consultant, and Trainer.

Colorado law states that sexual intimacy is never appropriate in a professional relationship and should be reported to the State Grievance Board. A client is entitled to receive information about the techniques and methods of therapy used. You may seek a second opinion from another therapist and may discontinue therapy at any time. The Department of Regulatory Agencies regulates the practices of both licensed and unlicensed persons in the field of psychotherapy. The Colorado Grievance Board telephone number is (303) 894-7766. They are located at 1560 Broadway, Suite 1340, Denver, CO 80202.

This form provides you with information that is additional to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form. **In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information.** I will not release records to any outside party unless I am authorized to do so by **all adult family** members who were part of the treatment.

EMERGENCIES: If there is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided for emergency contact.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

CONSULTATION: I consult regularly with other professionals regarding my clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message in my voice mail at (719) 761-4444 and your call will be returned as soon as possible. I check my messages a few times a day, unless I am out of town. If you have an emergency situation, please the Police emergency assistance (911), or the 24-hour Psych crisis line at the Pikes Peak Mental Health (719) 635-7000.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by an agreement between the client(s) and me. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in El Paso County, Colorado, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. **Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment.** The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

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THERAPY PROCESS: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes, a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include Developmental, Family systems, or psycho-educational, EMDR, Ego State Therapy, Somatic Experiencing, Energy Psychotherapies, and EEG Entrainment Techniques.

TREATMENT PLAN: Within a reasonable period of time after the initiation of treatment, I will discuss with you (client) his/her working understanding of the problem, treatment plan, therapeutic objectives, and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

TERMINATION: As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. If at any point during psychotherapy, I assess that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you referrals that may be of help to you. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

FINANCIAL POLICY AND FEE AGREEMENT

1. Payment is due at the time of service unless arrangements have been made with your therapist to pay otherwise, Our regular fees are as follows unless otherwise contracted:

   Diagnostic Intake interview……...$ 170
   50 minute psychotherapy ……..….$ 135

2. Extended phone calls, inpatient psychotherapy, or any other out of office services © rate of $ 120 per hour
3. Scheduling of an appointment involves the reservation of time specifically for you. Any cancellation with out advance notice leaves an unusable time slot. Insurance companies do not reimburse missed or cancelled sessions. I therefore request a minimum of 48 hours of prior notice for any cancellations.

   Please note that all cancellations with out 48 hours of prior notice (with the exception of medical and family emergencies) will incur a flat fee of $35.

4. Our office will be happy to file all necessary insurance claims for you. This is a courtesy we extend to all clients. However, your insurance is a contract between you, your employer, and your insurance company. We are not party to that contract. You are ultimately responsible for the entire balance due on your account. All services are not covered benefits under all insurance policies. We are willing to assist you in determining what benefits you may be entitled to. Deductibles. Co-payments, denied charges, or required preauthorization are your responsibility. Any claim not paid by your insurance company with in 45 days will be due and payable by you. We will continue to assist you with the appeals process
5. You agree to keep our office informed of any changes that may affect your ability to pay on this account.

LEC-5

Name_____ **Date**_____

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally; (b) you *witnessed it* happen to someone else; (c) you *learned about it* happening to a close family member or close friend; (d) you were exposed to it as *part of your job* (for example, paramedic, police, military, or other first responder); (e) you're *not sure* if it fits; or (f) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

	Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Part of my job*	*Not Sure*	*Doesn't Apply*
1.	**Natural disaster (for example, flood, hurricane, tornado, earthquake)**						
2.	**Fire or explosion**						
3.	**Transportation accident (for example, car accident, boat accident, train wreck, plane crash)**						
4.	**Serious accident at work, home, or during recreational activity**						
5.	**Exposure to toxic substance (for example, dangerous chemicals, radiation)**						
6.	**Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)**						
7.	**Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)**						
8.	**Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)**						
9.	**Other unwanted or uncomfortable sexual experience**						
10.	**Combat or exposure to a war-zone (in the military or as a civilian)**						
11.	**Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)**						
12.	**Life-threatening illness or injury**						
13.	**Severe human suffering**						
14.	**Sudden violent death (for example, homicide, suicide)**						
15.	**Sudden accidental death**						
16.	**Serious injury, harm, or death you caused to someone else**						
17.	**Any other very stressful event or experience**						

PLEASE COMPLETE PART 2 ON THE FOLLOWING PAGE

PART 2:

A. If you checked anything for #17 in PART 1, briefly identify the event you were thinking of:

_____

B. If you have experienced more than one of the events in PART 1, think about the event you consider the *worst event*, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event *(check all options that apply)*:

1. Briefly describe the worst event *(for example, what happened, who was involved, etc.)*.

_____

_____

2. How long ago did it happen? *(please estimate if you are not sure)*

3. How did you experience it?

____ *It happened to me directly*

____ *I witnessed it*

____ *I learned about it happening to a close family member or close friend*

____ *I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)*

____ *Other, please describe:*

4. Was someone's life in danger?

____ *Yes, my life*

____*Yes, someone else's life*

____*No*

5. Was someone seriously injured or killed?

____ *Yes, I was seriously injured*

____ *Yes, someone else was seriously injured or killed*

____ *No*

6. Did it involve sexual violence? ____*Yes* ____*No*

7. If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

____ *Accident or violence*

____ *Natural causes*

____ *Not applicable (The event did not involve the death of a close family member or close friend)*

8. How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?

____ *Just once*

____ *More than once (please specify or estimate the total # of times you have had this experience* _____ *)*

PLEASE COMPLETE PART 3 ON THE FOLLOWING PAGE

Part 3: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem <u>in the past month.</u>

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	**0**	**1**	**2**	**3**	**4**
2. Repeated, disturbing dreams of the stressful experience?	**0**	**1**	**2**	**3**	**4**
3. Suddenly feeling or acting as if the stressful experience were actually happening again (*as if you were actually back there reliving it*)?	**0**	**1**	**2**	**3**	**4**
4. Feeling very upset when something reminded you of the stressful experience?	**0**	**1**	**2**	**3**	**4**
5. Having strong physical reactions when something reminded you of the stressful experience (*for example, heart pounding, trouble breathing, sweating*)?	**0**	**1**	**2**	**3**	**4**
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	**0**	**1**	**2**	**3**	**4**
7. Avoiding external reminders of the stressful experience (*for example, people, places, conversations, activities, objects, or situations*)?	**0**	**1**	**2**	**3**	**4**
8. Trouble remembering important parts of the stressful experience?	**0**	**1**	**2**	**3**	**4**
9. Having strong negative beliefs about yourself, other people, or the world (*for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous*)?	**0**	**1**	**2**	**3**	**4**
10. Blaming yourself or someone else for the stressful experience or what happened after it?	**0**	**1**	**2**	**3**	**4**
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	**0**	**1**	**2**	**3**	**4**
12. Loss of interest in activities that you used to enjoy?	**0**	**1**	**2**	**3**	**4**
13. Feeling distant or cut off from other people?	**0**	**1**	**2**	**3**	**4**
14. Trouble experiencing positive feelings (*for example, being unable to feel happiness or have loving feelings for people close to you*)?	**0**	**1**	**2**	**3**	**4**
15. Irritable behavior, angry outbursts, or acting aggressively?	**0**	**1**	**2**	**3**	**4**
16. Taking too many risks or doing things that could cause you harm?	**0**	**1**	**2**	**3**	**4**
17. Being "superalert" or watchful or on guard?	**0**	**1**	**2**	**3**	**4**
18. Feeling jumpy or easily startled?	**0**	**1**	**2**	**3**	**4**
19. Having difficulty concentrating?	**0**	**1**	**2**	**3**	**4**
20. Trouble falling or staying asleep?	**0**	**1**	**2**	**3**	**4**

Adverse Childhood Experiences (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
   Swear at you, insult you, put you down, or humiliate you? **Or** Act in a way that made you afraid that you might be physically hurt? Yes / No (If yes enter 1) ☐

2. Did a parent or other adult in the household **often** ...
   Push, grab, slap, or throw something at you? **Or Ever** hit you so hard that you had marks or were injured?
   Yes / No (If yes enter 1) ☐

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way? **Or** Try to or actually have oral, anal, or vaginal sex with you? Yes / No (If yes enter 1) ☐

4. Did you **often** feel that ...
   No one in your family loved you or thought you were important or special? **Or** Your family didn't look out for each other, feel close to each other, or support each other?
   Yes / No (If yes enter 1) ☐

5. Did you **often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes / No (If yes enter 1) ☐

6. Were your parents **ever** separated or divorced?
   Yes / No (If yes enter 1) ☐

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her? **Or Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **Or Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes / No (If yes enter 1) ☐

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes / No (If yes enter 1) ☐

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes / No (If yes enter 1) ☐

10. Did a household member go to prison?
    Yes / No (If yes enter 1) ☐

Now add up your "Yes" answers to get your ACE Score ☐

DES

Eve Bernstein Carison, Ph.D. & Frank W. Putnam, M.D.

Name Date Age Sex: M / F

Directions: This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

Example: (never) 0% 10 20 30 40 50 60 70 80 90 100%(always)

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle a number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Circle a number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle a number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

6. Some people sometimes find that they are approached by people who they do not know who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle a number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

8. Some people are told that they sometimes do not recognize friends or family members. Circle a number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle a number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

13. Some people have the experience of feeling that their body does not seem to belong to them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

19. Some people find that they sometimes are able to ignore pain. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Circle a number to show what percentage of the time this happens to von.

0% 10 20 30 40 50 60 70 80 90 100%

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have mailed a letter or have just thought about mailing it). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

25. Some people find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

26.Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

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
add columns:		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. 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** _____

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.

2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

3. ***Consider Major Depressive Disorder***
—if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
—if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.

2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3

3. Add together column scores to get a TOTAL score.

4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.

5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Client's Self-Report and Assessment (CSRA)

Chandra Nagireddy, Ph.D

Name_____ Date_____

I. Please list three major problems that you would like to address in your therapy?

Rate the severity of each one on a 10-point scale.

1----------2----------3----------4----------**5**----------6----------7----------8----------9----------**10**
Most Severe Moderately Severe Not A Problem

Description of the problem	Severity

II. Self-Assessment of Daily Functioning- Please rate how well you think you are currently functioning in your day-to-day life in the past month in each of the four areas listed below:

1----------2----------**3**----------4----------**5**----------6----------**7**----------8----------9----------**10**
Barely functioning Severe difficulty Moderate difficulty Mild difficulty Excellent functioning

General Mood _____ Family Relationships____ Social Relationships____ Work_____

1. In the **past month**, I have missed work or was unable to function because of my emotional or psychological state

☐ Yes ☐ No

2. If Yes

☐ More than 4 days ☐ 2 days ☐ 1 day ☐ Few hours

3. In my day to day life, when I have an upsetting situation

☐ I tend to fall apart and not be able to function for a day or more

☐ I tend to pick myself up in a few hours, but continue to ruminate on it

☐ I tend to get over it in a less than an hour and get on with the day

☐ I tend to deal with it in a positive way without letting it get to me

☐ Other_____

4. When I fall apart or get terribly upset

☐ I take some medications or tranquilizers

☐ I take alcohol/ drugs/ get some comfort food

☐ I seek out a friend to talk

☐ I am able to deal with it without any kind of help

☐ I shut down/get away/retreat/go to bed or _____

III. Medical Health- Rate your physical health condition and any major medical conditions you are dealing with now.

1----------2----------3----------4----------**5**----------6----------7----------8----------9----------**10**
Poor Fair Excellent

Medical Conditions	**Status**
Overall Physical Health	

1. List all the medications you are taking now

Medication	**Start Date**	**Dosage**	**Frequency**

2. List all the major medical illnesses or procedures you have had in the past

Age	**Medical illnesses/Procedures**

3. Have you suffered closed head injury or traumatic brain injury in the past? Yes ☐ No ☐

Age	**Nature of accident/traumatic brain injury**

IV. Mental Health

1. Have you ever planned or attempted self-harm or suicide in the past? ☐ Yes ☐ No.

If Yes, please list all instances of planned or attempted self-harm or suicide in the past

Age	Planned/Attempted	What led you to this?	What did you do?

2. History of past psychiatric in-patient hospitalization: ☐ None ☐ Yes

If Yes, please give the details below

Age	Reason for hospitalization	Diagnosis	Duration

3. History of past out-patient psychotherapy/ counseling ☐ None ☐ Yes

If Yes, please give the details below

Age	Reason for psychotherapy	Diagnosis	Duration

4. History of substance abuse

A) Have you abused any legal or illegal drugs at any time? ☐ Yes ☐ No

If Yes, list all the legal/illegal drugs you may have abused in the past and/or abusing in the present.

Substance/drug	Age From	To	Severity	Current use (Yes / No)

B) Have you ever had any in-patient or out-patient treatment for alcohol/drug abuse?

☐ Yes ☐ No

V. Life Long Functioning: Please indicate the best and worst times of your life with a brief comment

Age (Yrs)	Best Times	Worst Times
1-5		
Grade School		
Jr. High		
High School		
19-29		
30-39		
40-59		
60+		

VI. Symptom Check List

Condition	Yes / No	If yes, since when
Frequent headaches		
Dizziness		
Missing chunks of time		
Medically unexplained pain		
Fatigue		
Epilepsy		
Panic attacks		
Unexplained medical symptoms		
Unexplained fears/phobias		
Sleep problems		

VII. Traumatic Life Events Checklist

If you have experienced the traumatic event, put an [X] in each corresponding Age box

	EVENT AGE RANGE ⟶	0-5	6-12	13-18	18-50	>51
1	Natural disasters like earthquakes/hurricanes/tornados/wild fires					
2	Transportation Accident- motor vehicle/bicycle bus/train/boat/plane					
3	Other Accidents- fire/machinery/explosion/drowning/toxic chemicals					
4	Participation in war/international conflict/covert duty while in Military					
5	Exposure to armed conflict/gang violence/crime ridden neighborhood					
6	Terrorism- perceived threat of attack/witnessed attack/victim of attack					
7	Witnessing severe human or animal suffering/violent deaths					
8	Robbery or assault or threats to your life					
9	Witnessing attack/beatings/killing of a stranger					
10	Life threatening illness or injury or accident to loved one/close friend					
11	Sudden & unexpected death of a loved one/close friend					
12	Your own life threatening illness					
13	Traumatic medical procedure/surgery					
14	Physical/emotional/verbal abuse					
15	Witnessing domestic violence					
16	Sexual molestation/rape					
17	Sexual harassment/stalking					
18	Rejection/break-up/betrayal in relationships					
19	Miscarriage/abortion- self or romantic partner					
20	Divorce- self/parents					
21	Imprisonment- self/loved one					
22	Serious financial or legal problems- self/parents					
23	Serious medical/mental illness- self/loved one					
24	Work place harassment/abuse/violence					
25	Traumatic job loss/termination					

VIII. Current stressful situations in life

Legal_____ Financial_____ Marital_____ Family_____ Medical_____ Work_____

Describe:

IX. What situations, places or people trigger disturbing levels of upset or anxiety?

1.

2.

3.

4.

5.

X. What situations, places, or people have you been avoiding consciously or unintentionally in the past few years?

1.

2.

3.

4.

5.

XI. I would know that my therapy is being successful and nearing the end

1. When I (describe in terms of your internal experience and behavior)

2. When I (describe in terms of your internal experience and behavior)

3. When I (describe in terms of your internal experience and behavior)

XII. Please add anything else you would want me to know (like your religious/spiritual beliefs) ?

Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

1----------2----------3----------4----------5

almost never	sometimes	about half the time	most of the time	almost always
(0-10%)	(11-35%)	(36-65%)	(66-90%)	(91-100%)

_____ 1) I am clear about my feelings.
_____ 2) I pay attention to how I feel.
_____ 3) I experience my emotions as overwhelming and out of control.
_____ 4) I have no idea how I am feeling.
_____ 5) I have difficulty making sense out of my feelings.
_____ 6) I am attentive to my feelings.
_____ 7) I know exactly how I am feeling.
_____ 8) I care about what I am feeling.
_____ 9) I am confused about how I feel.
_____ 10) When I'm upset, I acknowledge my emotions.
_____ 11) When I'm upset, I become angry with myself for feeling that way.
_____ 12) When I'm upset, I become embarrassed for feeling that way.
_____ 13) When I'm upset, I have difficulty getting work done.
_____ 14) When I'm upset, I become out of control.
_____ 15) When I'm upset, I believe that I will remain that way for a long time.
_____ 16) When I'm upset, I believe that I will end up feeling very depressed.
_____ 17) When I'm upset, I believe that my feelings are valid and important.
_____ 18) When I'm upset, I have difficulty focusing on other things.
_____ 19) When I'm upset, I feel out of control.
_____ 20) When I'm upset, I can still get things done.
_____ 21) When I'm upset, I feel ashamed at myself for feeling that way.
_____ 22) When I'm upset, I know that I can find a way to eventually feel better.
_____ 23) When I'm upset, I feel like I am weak.
_____ 24) When I'm upset, I feel like I can remain in control of my behaviors.
_____ 25) When I'm upset, I feel guilty for feeling that way.
_____ 26) When I'm upset, I have difficulty concentrating.
_____ 27) When I'm upset, I have difficulty controlling my behaviors.
_____ 28) When I'm upset, I believe there is nothing I can do to make myself feel better.
_____ 29) When I'm upset, I become irritated at myself for feeling that way.
_____ 30) When I'm upset, I start to feel very bad about myself.
_____ 31) When I'm upset, I believe that wallowing in it is all I can do.
_____ 32) When I'm upset, I lose control over my behavior.
_____ 33) When I'm upset, I have difficulty thinking about anything else.
_____ 34) When I'm upset I take time to figure out what I'm really feeling.
_____ 35) When I'm upset, it takes me a long time to feel better.
_____ 36) When I'm upset, my emotions feel overwhelming.

Reverse-scored items (place a subtraction sign in front of them) are numbered 1, 2, 6, 7, 8, 10, 17, 20, 22, 24 and 34.

Calculate total score by adding everything up. Higher scores suggest greater problems with emotion regulation.

SUBSCALE SCORING:** The measure yields a total score (SUM) as well as scores on six sub-scales:

1. Nonacceptance of emotional responses (NONACCEPT): 11, 12, 21, 23, 25, 29
2. Difficulty engaging in Goal-directed behavior (GOALS): 13, 18, 20R, 26, 33
3. Impulse control difficulties (IMPULSE): 3, 14, 19, 24R, 27, 32
4. Lack of emotional awareness (AWARENESS): 2R, 6R, 8R, 10R, 17R, 34R
5. Limited access to emotion regulation strategies (STRATEGIES): 15, 16, 22R, 28, 30, 31, 35, 36
6. Lack of emotional clarity (CLARITY): 1R, 4, 5, 7R, 9

Total score: sum of all subscales

**"R" indicates reverse scored item

REFERENCE:

Gratz, K. L. & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26,* 41-54.

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
Program Support Bureau
MHSA Implementation Unit
PEIOutcomes@dmh.lacounty.gov

Purpose

- Emotional dysregulation is thought to be a central feature underlying many psychological difficulties and behavioral problems including deliberate self-harm
- The DERS has been shown to be a valid and reliable measure of emotional dysregulation
- The DERS can be used to track changes in a client's ability to self-regulate throughout the course of treatment

Administration.

- The DERS can be self-administered or administered over the phone as long as the client clearly understands the rating scale being utilized
- Clients are urged to complete **every item** on the DERS
- A DERS subscale should be considered invalid if more than one item is left blank. More than seven missing items invalidates the DERS total score.
- Valid but incomplete questionnaires may still be utilized by averaging the scores you have and substituting the average score for the missing item(s) on the DERS Total and each impacted sub-scale

DERS is available in English with an easy to use hand-scoring template through PEI Outcomes and Implementation

Revised September 23, 2014

DERS Quick Guide

Difficulties in Emotional Regulation Scale

Can be administered to clients 18 years of age and older.
Is to be administered during the first, last session and at the sixth month mark of treatment in the following EBP.

- DBT for PEI.

Clinical Utility of the DERS

- **It is a brief (36 items) instrument that can easily be administered and scored**
- **Yields a total score (DERS) and six subscale scores that can help inform treatment**
- **Can be administered to adults (18+) with a 5.3 grade reading level**
- **Utilizes a simple hand-scoring template to derive DERS total score and subscale scores**
- **Offers clinicians and support staff the option of using a preprogrammed excel scoring template to help eliminate addition and score reversal errors**

Scoring Information

An elevated score on the DERS is not synonymous with a diagnosis of Borderline Personality Disorder or any other diagnosis. While, there are no official clinical cut-offs for the DERS, it can still be a powerful resource in helping to track changes in a client's ability to self-regulate over time.

Item Response	Score
Almost Never (0% to 10%)	1
Sometimes (11% to 35%)	2
About Half the Time (36% to 65%)	3
Most of the Time (66% to 90%)	4
Almost Always (91% to 100%)	5

The DERS total score ranges from 36-180. NOTE: Some items need to be reverse scored. Scale estimates are based on adjusted scores only.

Subscale	GUIDELINES FOR UNDERSTANDING SUBSCALES
Non-acceptance	Tendency to have a negative secondary or non accepting reaction to one's own distress
Goals	Difficulty in concentrating and/or accomplishing tasks when experiencing negative emotions
Impulse	Difficulty remaining in control of one's behavior when experiencing negative emotions
Awareness	Reflects a lack of awareness or inattention to emotional responses
Strategies	Reflects the belief that there is little one can do to regulate oneself once upset
Clarity	Reflects the extent to which an individual knows and is clear about his or her emotions