An Interdisciplinary Masters of Arts
In
Psychopharmacology for Psychologists

MANUAL FOR PRACTICA

Offered by New Mexico State University
in Collaboration with the
Southwestern Institute for the Advancement of Psychotherapy

Revised August 2011

An Interdisciplinary Masters of Arts in
Psychopharmacology for Psychologists

INTRODUCTION
Dear Prescribing Psychology Student:

Congratulations on completing so much of your RxP program that you are now ready for your practica experiences. These practica will help you synthesize what you have learned and bring you to a new depth of understanding about psychopharmacology. In addition, the supervisors of previous RxP psychologists have indicated that they have learned much from the prescribing psychologist students about our bio-psychosocial model of intervention. So, as you participate in the practica, you will be helping to create a new model of interdisciplinary care.

You will be completing two practica. The first practicum is eighty hours in a primary care setting to be supervised by a physician in which you will practice basic assessment skills. The second practicum is your treatment of 100 patients for a minimum of 400 hours with psychotropic medication along with psychotherapy. In the sections of this manual that follow, the description of the 80-hour practicum with a primary care physician and forms related to it are discussed first followed by description of the 400-hour practicum and forms related to it.

There are many requirements within the Prescribing Psychologist Act and delineated in the regulations regarding the implementation of that Act that must be followed in order to qualify for a conditional and full prescribing psychologist license. It is strongly recommended that you read the Law and regulations for implementing the Law, which are posted on the SIAP website at www.siaprxp.com. Further, if you will read the instructions within this manual, carefully use the materials provided for documenting your work, and forward those documents to SIAP in a timely fashion, your progress through the steps will go smoothly.

The SIAP program and Training Director will try to stay in close contact with you to make sure that we have all the material necessary so that you will be ready to apply for your conditional prescribing license when you have completed your practica. However, please understand that it is ultimately your responsibility to make sure that appropriate material is sent to SIAP.

While you are a prescribing psychology student at the Southwestern Institute for the Advancement of Psychotherapy/New Mexico State University Program, your activities will be covered by your existing liability insurance. Any physical accidents that you incur or are caused by you to someone else are covered by the New Mexico State University insurance (relevant forms to document this to your supervisors are provided in later sections of this manual). However, now is a good time for you to determine if your liability insurance carrier will cover you as a prescribing psychologist once you receive your conditional prescribing license and full prescribing license. The APA Insurance Trust is presently covering prescribing psychologists and has given their commitment to continue to do so. However, not all insurance carriers are willing to cover prescribing psychologists. If your insurance carrier is not open to covering you for the minimum of $100,000 / $300,000 liability, you will need to look into alternate coverage.

WHAT YOU MUST REMEMBER WHEN SETTING UP YOUR 80-HOUR PRACTICUM WITH A PRIMARY CARE PHYSICIAN

During the classes in pathophysiology and physical/evidence based medicine, each student is required to obtain eighty hours of clinical experience, which is aimed at practicing physical assessment skills and integrating pathophysiological knowledge into clinical thinking. Students will need to make arrangements with a physician who agrees to allow them to accompany the physician as patients are seen for primary care. A letter to the supervising physician is attached that describes the objectives of this eighty-hour practicum to aid you in setting up the appropriate experience.

With the permission of the primary care physician, the student and the primary care provider explain to patients that you are in a postdoctoral program studying to improve skills in physical assessment and request the patient’s permission to review health history records and participate to the extent the primary health care provider deems appropriate. Most patients are interested in this process and happily cooperate with the practice.

Included here are forms to be used with the eighty-hour practicum in primary care. As explained above, SIAP Form 80-1 is a letter you may give to the physician explaining the purpose of the practicum. The second form (SIAP Form 80-2) is an evaluation form to be completed by supervising a primary care physician at the end of your eighty-hour practicum.
(SIAP Form 80-2) is an evaluation form to be completed by your primary care physician at the end of your eighty-hour practicum. SIAP/NMSU has permission from the New Mexico Board of Psychologist Examiners to use this form, which is the official form of the board, in our packet. A copy of this completed form must be returned to the Training Director of SIAP. Keep a copy of this form for yourself to submit to the Application Committee of the New Mexico Board of Psychologist Examiners when you apply for a Prescribing Psychology License.

Some institutions require a contract between New Mexico State University and the institution (hospital, clinic, etc.). The third form, SIAP Form 80-3, can be used in that way and can be signed by the Director of SIAP, if necessary.

Some institutions may want proof that the prescribing psychologist students are covered by the New Mexico State University insurance. The fourth form, SIAP Form 80-4, can be used to document that you are covered by university insurance.

SIAP FORM 80-1

Letter to the Primary Care Physician

The Southwestern Institute for the Advancement of Psychotherapy, LLC
1395 Missouri
Las Cruces, NM 88001
(575) 522-5466
Fax: (575) 521-8611

Date

Dear Medical Colleague (Name):

New Mexico State University Master of Arts, in collaboration with the Southwestern Institute for the Advancement of Psychotherapy, offers a training program in psychopharmacology for doctoral-trained psychologists in order to fulfill requirements for the Prescribing Psychologist Law. The trained doctoral level psychologists in this program participate in 450 hours of academic coursework as well as rigorous homework assignments and frequent testing of their skills.

An important part of the psychologists’ training is to gain practical experience. The psychologist must participate in two practica. The first practicum is to work with a physician for eighty hours within a primary care setting. The psychologist/psychopharmacology student is expected to “shadow” the physician, read records, ask appropriate questions, and learn and practice basic physical assessment skills as determined by the supervising primary care physician. At the end of the eighty-hour practicum, the primary care physician is asked to complete an evaluation form.

We would very much appreciate your willingness to supervise our prescribing psychology student in your setting. The student can make available to you forms which indicate that the program is sponsored by New Mexico State University and that the student is covered by the University insurance. As Training Director of the Southwestern Institute for the Advancement of Psychotherapy and Affiliate Associate Professor at New Mexico State University, I would be happy to answer any questions that you might have about this practicum experience.
If you would be willing to participate in this program, it would be a great benefit to our psychologists and to the patients we serve. We would appreciate your signing the form below.
Thank you so much for your consideration.

Sincerely yours,

Elaine S. LeVine, Ph.D., Training Director
Prescribing Psychologist
Affiliate Associate Professor, New Mexico State University
eslevine@hotmail.com

______________________________

__________________
Primary Care Physician Signature Date

Offering coursework in psychopharmacology for licensed psychologists in collaboration with the Department of Counseling and Educational Psychology and leading to a Masters Degree from New Mexico State University

SIAP FORM 80-2

Eighty-hour Practicum Evaluation Form

New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION
Board of Psychologist Examiners
Toney Anaya Building • 2550 Cerrillos Road • Santa Fe, New Mexico 87505
(505) 476-4960 • Fax (505) 476-4665 • www.rld.state.nm.us/psychology

SUPERVISOR VERIFICATION OF 80-HOUR PRACTICUM IN PRIMARY HEALTH CARE

Applicant Name: ________________________________________________________________

Mailing Address: ______________________________________________________________________

City, State Zip: ______________________________________________________________________

Telephone No: ______________________________________________________________________

To be completed by the supervisor

SUPERVISOR

Name: _______________________________________________________________________________

Mailing Address: ______________________________________________________________________

City, State Zip: ______________________________________________________________________

Telephone No: ______________________________________________________________________

Describe the area of practice in which you are formally trained and/or certified/licensed? If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications:

NEW MEXICO LICENSURE
Is your license current and unrestricted? Yes No

Date New Mexico medical license was issues: _______________________________________________

License Number and Type of License: ____________________________________________________

If you hold any other professional licenses in this or any other jurisdiction list below:
_______________________________________________________________

License No. Type State Status (Active/Inactive)
__________________________________________________________________________

Name and Address of Applicant’s Training Director: _______________________________________

__________________________________________________________________________________

Date Practicum Began: __________________________________________________________________
Date Practicum Ended: __________________________________________________________________

Have you sent an evaluation form about this applicant to the Director of Training discussing the student’s adequate development of skills in:

a. Assessing a diverse and significantly ill medical population? Yes No

b. Observing the progression of illness and continuity of care of individual patients? Yes No

c. Adequately assessing vital signs? Yes No

d. Demonstrating competent laboratory assessment? Yes No

e. Demonstrating competence in physical and health assessment techniques? Yes No

Has the student successfully completed the eighty-hours of supervised experience with you as specified in the Prescribing Psychologist Act? Yes No

The Board would appreciate any comments you might have regarding this applicant’s practicum. Please include any information you consider relevant regarding this applicant.
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

As the Clinical Supervisor of the 80-Hour Practicum, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

________________________________________________
Signature of Clinical Supervisor
The Regents of New Mexico State University for its operation of the postdoctoral prescribing psychologist program, specifically through its department of Counseling and Educational Psychology and the Southwestern Institute for the Advancement of Psychotherapy and the _____________________________ (the “Institution”), a health Institution, agree:

. RECITALS

. The purposes of this agreement are:
  1. To establish a practicum training program for doctoral level psychologists who have completed postdoctoral academic coursework towards obtaining a license as a prescribing psychologist
  2. To ensure a close working relationship between New Mexico State University and the Institution
  3. To benefit the University by providing a quality practicum experience for these psychologists in training
  4. To benefit the Institution in providing high quality psychological expertise in diagnosis, testing, and treatment of mental disorders
  5. To enable the participating psychologists to become knowledgeable about operational aspects of various types of health delivery systems

. RESPONSIBILITIES OF THE INSTITUTION

. The Institution will:
  1. Accept for training the number of psychologists to be determined jointly by the Institution and the University, but no more than three psychologists will be supervised by an individual staff member at the Institution.
  2. Make available its clinical and related facilities and its personnel to provide quality learning experiences for the psychologists during their educational rotation at the Institution under the supervision of qualified Institutional personnel
  3. Designate one or more clinical supervisors who will: (a) coordinate the psychologists’ clinical education experience with the appropriate university program director
  4. Make patients aware that the psychologists from New Mexico State University are postdoctoral students training in psychopharmacology
  5. Permit the University’s program director to work with the Institution’s clinical supervisors

. RESPONSIBILITIES OF THE UNIVERSITY

. The University will:
  1. Identify specific psychologists who, with the agreement of the Institution, will be assigned
part-time for training at the Institution in accord with a schedule agreed upon by the
University, Institution, and the psychologist
2. Require psychologists to conform the polices and procedures of the Institution, under the
direction of the Institution’s designated clinical supervisors
3. Assure that psychologists are duly licensed as psychologists by the New Mexico Board of
Psychologist Examiners

. Psychologists will meet all reasonable health standards imposed by applicable Laws and regulations
or imposed by the Institution.

. The University Program Training Director responsible for the psychologists’ rotation at the Institution
will send a letter to the Institution’s staff member responsible for the psychologists’ supervision at the
Institution that provides the following specific information:
1. The individual at the University who is designated to assume supervisor responsibilities for
the psychologist; and
2. The educational goals and objectives of the psychologist’s rotation at the Institution; and
3. The period of assignment of the psychologist at the Institution
4. The Institution’s responsibilities for supervision and evaluation of the psychologist’s
performance; and
5. The polices and procedures that govern the psychologist’s education while on rotation at the
Institution; and
6. An attestation by the program Training Director that the psychologist rotating at the
Institution is in good standing in the program; and
7. A delineation by the program Training Director of the minimum required level of
supervision of the psychologist

INSURANCE AND LIABILITY

. As between the parties, each party acknowledges that it will be responsible for claims or damages
arising from personal injury or damage to persons or property to the extent they result from
negligence of that party’s employees or (in the case of University) program director. The University
will provide professional liability insurance covering the program director and University employed
faculty members for their activities at the Institution, in accordance with the provisions of the New
Mexico Tort Claims Act, Sections 41-4-1 et. seq. NMSA 1978, as amended. The liability of the
faculty employed by the University will be subject in all cases to the limitations and immunities of the
New Mexico Tort Claims Act.

. If a complaint is made or otherwise involving a psychologist or University Employee, the Institution
will immediately provide written notice to the Counseling and Educational Psychology Department at
New Mexico State University. If a claim or suit is filed or initiated against the Institution, naming or
otherwise involving alleged actions or omissions of a psychologist, the University will manage and
control all aspects of the defense on behalf of the psychologist.

TERM AND TERMINATION
This agreement will become effective on ____________ and will continue through _________________
unless earlier terminated by their party by providing written notice of intent to terminate from the other
party at least 60 days prior to the proposed date.

REIMBURSEMENT
Unless otherwise specified, this relationship is based upon an exchange of services and not
reimbursement through funds.

HIPAA COMPLIANCE
. The parties will comply with the applicable provisions of HIPAA and any current future regulations
promulgated hereunder, including without limitation, the federal privacy regulations, the federal
security standards, and the federal standards for electronic transactions (collectively the “HIPAA
Requirements”). The parties will not use or further disclose any Protected Health Information or
Individually Identifiable Health Information (such as terms are defined in the HIPAA regulations),
Individually Identifiable Health Information (such as terms are defined in the HIPAA regulations),
other than as permitted by the HIPAA Requirements and the terms of this Agreement.
The University will ensure that psychologists have been provided training with regard to HIPAA
Requirements. Additionally, the Institution may require each psychologist to sign a Confidentiality
Agreement and an Acknowledgement that the psychologist has received Institution’s Notice of
Privacy Practices.

MISCELLANEOUS

Entire Agreement: This Agreement and the Program Letters references in Section III-C of this of this
Agreement represent the entire understanding between the parties and supersede any prior agreements
or understandings with respect to the subject matter of this Agreement.

Waiver of Breach. The waiver by either party of a breach or violation of any provision of this
Agreement will not operate as or be construed as a waiver of any subsequent breach of this
Agreement.

Modifications. No changes, amendments, of alterations to this Agreement will be effective unless in
writing and signed by both parties.

Non-Assignability. This Agreement will not be assigned by either party, nor will the duties imposed
upon either party by this Agreement be delegated, subcontracted, or transferred by either party, in
whole or in part, without the prior written consent of the other party.

Governing Law. This Agreement will be construed, interpreted, governed, and enforced in
accordance with the statutes, judicial decisions, and other laws of the State of New Mexico.

Severability. The invalidity or unenforceability of any term or provision of this Agreement will in no
way affect the validity or enforceability of any other term or provision to the extent permitted by Law.

Marketing Materials. Neither the University nor the Institution will use the other’s name in any
publicity or advertising materials without prior written consent of the other party; provided, however,
that either party may indicate to individual psychologists the existence and scope of the training
program available at the Institution.

Confidentially

1. Patient and Psychologist Records. The confidentiality of patients’ medical records and
psychologists’ academic records will be maintained by the parties in accordance with
applicable federal and state laws and regulations.

Retention of Records. The Institution and University will maintain detailed records associated with
the assignment of psychologists pursuant to this agreement for a period of five years.

Relationship of parties. Psychologists and employees of the University will not be considered
employees of the Institution for any purpose including, but not limited to, workers’ compensation,
insurance, bonding or any other benefits afforded to employees of the Institution.

Cooperation and Dispute Resolution. The parties agree that, to the extent and compatible with the
separate and independent management of each, they will maintain effective liaison and close
cooperation. If a dispute arises related to the obligations or performance of either party under this
Agreement, representatives of the parties will meet in good faith to attempt to resolve the dispute.

Third parties. Nothing in this Agreement, express or implied, is intended to confer any rights,
remedies, claims, or interests upon a person not a party to this agreement.

Eligibility for Participation in Government Programs. Each party represents that neither it, nor any of
its management or any other employees or independent contractors who will have any involvement in
the services or products supplied under this Agreement, have been excluded from participation in any
government healthcare program, debarred from or under any other federal program (including but not
limited to debarment under the Generic Drug Enforcement Act), or convicted of any offense defined
in 42 U.S.C. Section 1320a-7, and that it, its employees, and independent contractors are not
otherwise ineligible for participation in federal healthcare programs. Further, each party represents
that it is not aware of any such pending action(s) (including criminal actions) against it or its
employees or independent contractors. Each party shall notify the other party immediately upon
becoming aware of any pending or final action in any of these areas.

Notices. Any notice required to be given pursuant to terms and provisions of this Agreement will be
in writing and will be sent by certified mail, return receipt requested, postage prepaid, as follows:
To the University at: Department of Counseling and Educational Psychology
MSC 3AC
New Mexico State University
New Mexico State University
Insurance Plan for Students

The Southwestern Institute for the Advancement of Psychotherapy, LLC
1395 Missouri
Las Cruces, NM 88001
(575) 522-5466
Fax: (575) 521-8611

Letter from New Mexico State University
Director of Purchasing

March 2, 2004

RE: Professional Liability Insurance

TO WHOM IT MAY CONCERN:

New Mexico State University students who are participating in supervised practicum are covered by the State of New Mexico Risk Management Division for professional/medical liability up to the limits of the New Mexico Tort Claims Act. Coverage limits are:

- $300,000 Each Person for Bodily Injury
- $100,000 Property Damage
- $500,000 Aggregate
- $2,000,000 Excess Coverage (Out of State or Federal)
Sincerely,

Michael J. Abernethy
Director of Purchasing & Risk Management

WHAT YOU MUST REMEMBER WHEN SETTING UP YOUR 400-HOUR PRACTICUM IN WHICH YOU TREAT PATIENTS WITH PSYCHOTROPICS

The following steps are required by State Law and are being carefully monitored by the Application Committee (comprised, at the minimum, of one member of the Board of Psychologist Examiners, someone recommended by the Board of Medical Examiners, and a public member) when you apply for a conditional prescribing license. Later sections of this manual offer forms for completing each requirement. The forms created by the SIAP/NMSU Program may not exactly meet the needs of your Institution, and you may modify them as is appropriate. However, it is very important that if you modify the forms, you carefully study the Law and regulations to make sure that your forms will provide documentation of all factors that you need in order to apply for a prescribing license.

. You must develop a practicum plan and send a copy of that plan, signed by yourself and your primary supervisor, to the SIAP Training Director. A model plan is attached as SIAP FORM 400-1. Your plan should demonstrate that you will be working with:
  . A minimum of 100 separate patients
  . For at least 400 hours which are patient-only hours
  . For both evaluation and treatment with psychotropics
  . For a range of disorder, and a diversity of patients (including gender, ages throughout the lifecycle, various ethnicities, sociocultural background, various economic backgrounds) as much as possible within your area of expertise
  . A primary or secondary supervisor who is on site
  . And will obtain one hour of supervision from each eight hours of patient contact

. In addition to the practicum plan, you must also keep records that would document:
  . Dates and times of contact with patients and dates and times of supervision
  . SIAP FORM 400-3 and SIAP FORM 400-4 can be used for this purpose and will also serve to document requirements in the Law that: the practicum is completed in no less than six months and no more than three years; and that the practicum was completed within the last five years preceding the request from the Board for an application for a conditional prescribing license

. The Law and regulations require that you inform all patients of your training status. A copy of a form that can be used is included (SIAP FORM 400-5). Please feel free to modify this form if it does not fit your particular Institution. However, make sure that you do have a form you are using and send a copy of that to the Training Director of SIAP

. In addition to your regular case notes and the form to be used in that regard, you must keep a summary log with coded patient IDs which includes, for each of the 100 patients: (see SIAP FORM 400-6)
  . Birthdate/age
  . Gender
  . Diagnosis
  . Dates and time spent in pharmacotherapy

These logs must be submitted to the Training Director of the SIAP/NMSU Program upon completion of the 400-hour practicum. A copy of these logs may be requested by the Application Committee when you apply for your conditional prescribing license.
You must forward to the program written evaluations by your supervisor at least at the midpoint and at the end of completing your 400-hour practicum (SIAP FORMS 400-6).

In addition to this extensive evaluation requested by the law and by SIAP, the New Mexico Board of Psychologist Examiners requires a special form be completed by your physician at the end of the practicum. For your convenience is also included under (SIAP FORM 400-6) and additional form required by the New Mexico Board of Psychologist Examiners.

In addition, you must forward an evaluation completed at the end of practicum for every secondary supervisor (SIAP FORM 400-6).

The Law and the regulations also require you to keep very careful and extensive records of your work with each patient. These extensive case notes are in addition to the basic log mentioned in IV but are not submitted to the Training Director. Your extensive notes should be reviewed by your supervisors. It is also possible that the Board of Psychologist Examiners could request copies of these notes and look to see that they have all of the information listed in the Prescribing Psychologist Act and the regulations. SIAP has created forms to assist you in maintaining all required information. These forms include:

- 400-Hour Practicum initial intake forms for adults and children that include a review of symptoms
- 400-Hour Practicum for Prescribing Psychologists follow-up forms for adults and children
- Initial and follow-up symptom checklists to be completed by adults and parents/children

**ATTACHMENTS FOR THE 400-HOUR PRACTICUM**

The following attachments are forms and letters that you will need (as they are or modified according to your Institutional Directors), to meet the requirements of the Prescribing Psychologist Act.

**SIAP forms 400-1 through 400-5:** are developed as a part of your setting up your 400-hour practicum plan.

**SIAP form 400-6:** is an evaluation form that your practicum supervisor should fill out when you have worked with 50 patients and 100 patients.

**SIAP form 400-7 through 400-12:** are for your use while you are working with patients. Depending on the site where you are placed, you may be able to use these forms directly. You may modify them somewhat, or you may be in an institution where you need to use the institution’s forms. If you use these forms you can be assured that you will have documented with each patient all of the information that is required by the Prescribing Psychologists’ law. If you are not using these forms, you need to carefully look at the law to make sure that your forms include all of the information required by the Prescribing Psychologists’ law. You will see that included in this series are forms to be completed by the patient and forms to be completed by you.

**SIAP form 400-7 and 400-8:** are to be completed by the patient at the initial interview.

**SIAP form 400-11 and 400-12:** are to be completed by the patient before the beginning of each follow-up session. SIAP form 400-9 is one that you can use to record all pertinent information about a patient after your initial contact with them.

**SIAP form 400-10:** is a form to be used to record pertinent information on your follow-up sessions.

A summary of the forms is as follows:

1. SIAP FORM 400-1: 400-Hour Model Practicum Plan
2. SIAP FORM 400-2: Initial Evaluation Form
3. SIAP FORM 400-3: Follow-up Evaluation Form
4. SIAP FORM 400-4: Initial and Follow-up Symptom Checklists
5. SIAP FORM 400-5: Additional Supporting Information
6. SIAP FORM 400-6: Evaluation Form for Supervisors
7. SIAP FORM 400-7: Initial Intake Form for Adults
8. SIAP FORM 400-8: Initial Intake Form for Children
9. SIAP FORM 400-9: Patient Information Form
10. SIAP FORM 400-10: Follow-up Session Form
11. SIAP FORM 400-11: Prescribing Psychologist Follow-up Form for Adults
12. SIAP FORM 400-12: Prescribing Psychologist Follow-up Form for Children
SIAP FORM 400-1: 400-Hour Model Practicum Plan

2. SIAP FORM 400-2: Contract with Institution

3. SIAP FORM 400-3: 400-Hour Practicum form to log time spent with patient

4. SIAP FORM 400-4: 400-Hour Practicum form to log contact times with supervisor

5. SIAP FORM 400-5: 400-Hour Practicum Letter to patient Regarding Student Status

6. SIAP FORM 400-6:
   a&b: 400-Hour Performance Evaluation of Prescribing Psychologist (to be completed by supervisor at mid-point of practicum and form required by New Mexico Board of Psychologist Examiners) In addition to this extensive evaluation by the law and by SIAP.

7. SIAP FORM 400-7: 400-Hour Practicum Patient Intake Form to be completed by adult patients

8. SIAP FORM 400-8: 400-Hour Practicum Initial Patient Intake form to be completed by child patients

9. SIAP FORM 400-9: 400-Hour Practicum Initial Patient Chart form to be completed by prescribing psychologist intern

10. SIAP FORM 400-10: 400-Hour Practicum form for Patient follow-up sessions to be completed by prescribing psychologist intern

11. SIAP FORM 400-11: Symptom Checklist to be completed by adult patients at follow-up sessions

12. SIAP FORM 400-12: Symptom Checklist to be completed by child patients (with parent if help is necessary) at follow-up sessions

13. SIAP FORM 400-13: Everything You Need to Know Now that Your Coursework is Complete

14. SIAP FORM 400-14: Last, but not least, at the end of this manual is a checklist that describes all forms that you must send to the Training Director of the SIAP/NMSU Program before sending in your application for a conditional prescribing license to the New Mexico Board of Psychologist Examiners

SIAP FORM 400-1

400-hour Practicum Model Plan

The Southwestern Institute for the Advancement of Psychotherapy/New Mexico State University
1395 Missouri
Las Cruces, NM 88001
(575) 522-5466
Fax: (575) 521-8611

400-HOUR PRACTICUM PLAN

THIS PLAN IS TO BE SUBMITTED TO THE SIAP/NMSU TRAINING DIRECTOR BEFORE BEGINNING THE PRACTICUM.

1. Name of applicant: ________________________________________________________________

2. Date at which applicant will finish the 450 didactic hour training program of SIAP/NMSU __________________________________________________________________________

3. Information about the primary supervisor.

   Name of supervisor: ________________________________________________________________

   Summary of supervisor’s medical training:
Supervisor’s area of specialization:

4. Information about 1\textsuperscript{st} secondary supervisor

Name of supervisor:

Summary of supervisor’s medical training:

Supervisor’s area of specialization:

5. Information about 2\textsuperscript{nd} secondary supervisor

Name of supervisor:

Summary of supervisor’s medical training:

Supervisor’s area of specialization:

*Information on additional supervisors should be included on an attached sheet.*

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Time to be spent in facility</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Sites of practicum placement:

6. Explanation of how the supervisee will gain experience with a diverse patient population, including patients of different genders, ages, disorders, ethnicity, sociocultural, and economic background:
7. How much of the supervision will be face to face? _______________

8. How much time will be spent with the primary supervisor? __________

9. How much time will be spent with the secondary supervisor? __________

This plan has been reviewed and agreed upon by:

_________________________________                  ________________________
Applicant                                                                  Date

_________________________________                        ______________________
Supervisor                                                                 Date

Elaine S. LeVine, Ph.D., Training Director                                      Date
Southwestern Institute for the
Advancement of psychotherapy/New Mexico
State University/Program

SIAP FORM 400-2

Contract Between the Institution
SIAP/NMSU Program
The Regents of New Mexico State University for its operation of the postdoctoral prescribing psychologist program, specifically through its department of Counseling and Educational Psychology and the Southwestern Institute for the Advancement of Psychotherapy and the _____________________________ (the “Institution”), a health Institution, agree:

RECITALS

The purposes of this agreement are:

1. To establish a practicum training program for doctoral level psychologists who have completed postdoctoral academic coursework towards obtaining a license as a prescribing psychologist
2. To ensure a close working relationship between New Mexico State University and the Institution
3. To benefit the University by providing a quality practicum experience for these psychologists in training
4. To benefit the Institution in providing high quality psychological expertise in diagnosis, testing, and treatment of mental disorders
5. To enable the participating psychologists to become knowledgeable about operational aspects of various types of health delivery systems

RESPONSIBILITIES OF THE INSTITUTION

The Institution will:

1. Accept for training the number of psychologists to be determined jointly by the Institution and the University, but no more than three psychologists will be supervised by an individual staff member at the Institution.
2. Make available its clinical and related facilities and its personnel to provide quality learning experiences for the psychologists during their educational rotation at the Institution under the supervision of qualified Institutional personnel
3. Designate one or more clinical supervisors who will: (a) coordinate the psychologists’ clinical education experience with the appropriate university program director
4. Make patients aware that the psychologists from New Mexico State University are providing services to patients in the Institution’s facilities
5. Permit the University’s program director to work with the Institution’s clinical supervisors

RESPONSIBILITIES OF THE UNIVERSITY

The University will:

1. Identify specific psychologists who, with the agreement of the Institution, will be assigned part-time for training at the Institution in accord with a schedule agreed upon by the University, Institution, and the psychologist
2. Require psychologists to conform the polices and procedures of the Institution, under the direction of the Institution’s designated clinical supervisors
3. Assure that psychologists are duly licensed as psychologists by the New Mexico Board of Psychologist Examiners

Psychologists will meet all reasonable health standards imposed by applicable Laws and regulations or imposed by the Institution. Copies of Institutional standards will be provided by the Institution to the University and the House officers.
The University Program Director responsible for the psychologists’ rotation at the Institution will send a letter to the Institution’s staff member responsible for the psychologists’ supervision at the Institution that provides the following specific information:

1. The individual at the University who is designated to assume supervisor responsibilities for the psychologist; and
2. The educational goals and objectives of the psychologist’s rotation at the Institution; and
3. The period of assignment of the psychologist at the Institution
4. The Institution’s responsibilities for supervision and evaluation of the psychologist’s performance; and
5. The polices and procedures that govern the psychologist’s education while on rotation at the Institution; and
6. An attestation by the program director that the psychologist rotating at the Institution is in good standing in the program; and
7. A delineation by the program director of the minimum required level of supervision of the psychologist

INSURANCE AND LIABILITY

As between the parties, each party acknowledges that it will be responsible for claims or damages arising from personal injury or damage to persons or property to the extent they result from negligence of that party’s employees or (in the case of University) program director. The University will provide professional liability insurance covering the program director and University employed faculty members for their activities at the Institution, in accordance with the provisions of the New Mexico Tort Claims Act, Sections 41-4-1 et. seq. NMSA 1978, as amended. The liability of the faculty employed by the University will be subject in all cases to the limitations and immunities of the New Mexico Tort Claims Act.

If a complaint is made or otherwise involving a psychologist or University Employee, the Institution will immediately provide written notice to the Counseling and Educational Psychology Department at New Mexico State University. If a claim or suit is filed or initiated against the Institution, naming or otherwise involving alleged actions or omissions of a psychologist, the University will manage and control all aspects of the defense on behalf of the psychologist.

TERM AND TERMINATION

This agreement will become effective on ____________ and will continue through ______________ unless earlier terminated by their party by providing written notice of intent to terminate from the other party at least 60 days prior to the proposed date.

REIMBURSEMENT

Unless otherwise specified, this relationship is based upon an exchange of services and not reimbursement through funds.

HIPAA COMPLIANCE

The parties will comply with the applicable provisions of HIPAA and any current future regulations promulgated hereunder, including without limitation, the federal privacy regulations, the federal security standards, and the federal standards for electronic transactions (collectively the “HIPAA Requirements”). The parties will not use or further disclose any Protected Health Information or Individually Identifiable Health Information (such as terms are defined in the HIPAA regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement.

The University will ensure that psychologists have been provided training with regard to HIPAA Requirements. Additionally, the Institution may require each psychologist to sign a Confidentiality Agreement and an Acknowledgement that the psychologist has received Institution’s Notice of Privacy Practices.

MISCELLANEOUS
Entire Agreement: This Agreement and the Program Letters references in Section III-C of this of this Agreement represent the entire understanding between the parties and supersede any prior agreements or understandings with respect to the subject matter of this Agreement.

Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement will not operate as or be construed as a waiver of any subsequent breach of this Agreement.

Modifications. No changes, amendments, or alterations to this Agreement will be effective unless in writing and signed by both parties.

Non-Assignability. This Agreement will not be assigned by either party, nor will the duties imposed upon either party by this Agreement be delegated, subcontracted, or transferred by either party, in whole or in part, without the prior written consent of the other party.

Governing Law. This Agreement will be construed, interpreted, governed, and enforced in accordance with the statutes, judicial decisions, and other laws of the State of New Mexico.

Severability. The invalidity or unenforceability of any term or provision of this Agreement will in no way affect the validity or enforceability of any other term or provision to the extent permitted by Law.

Marketing Materials. Neither the University nor the Institution will use the other’s name in any publicity or advertising materials without prior written consent of the other party; provided, however, that either party may indicate to individual psychologists the existence and scope of the training program available at the Institution.

Confidentially

1. Patient and Psychologist Records. The confidentiality of patients’ medical records and psychologists’ academic records will be maintained by the parties in accordance with applicable federal and state laws and regulations.

Retention of Records. The Institution and University will maintain detailed records associated with the assignment of psychologists pursuant to this agreement for a period of five years.

Relationship of parties. Psychologists and employees of the University will not be considered employees of the Institution for any purpose including, but not limited to, workers’ compensation, insurance, bonding or any other benefits afforded to employees of the Institution.

Cooperation and Dispute Resolution. The parties agree that, to the extent and compatible with the separate and independent management of each, they will maintain effective liaison and close cooperation. If a dispute arises related to the obligations or performance of either party under this Agreement, representatives of the parties will meet in good faith to attempt to resolve the dispute.

Third parties. Nothing in this Agreement, express or implied, is intended to confer any rights, remedies, claims, or interests upon a person not a party to this agreement.

Eligibility for Participation in Government Programs. Each party represents that neither it, nor any of its management or any other employees or independent contractors who will have any involvement in the services or products supplied under this Agreement, have been excluded from participation in any government healthcare program, debarred from or under any other federal program (including but not limited to debarment under the Generic Drug Enforcement Act), or convicted of any offense defined in 42 U.S.C. Section 1320a-7, and that it, its employees, and independent contractors are not otherwise ineligible for participation in federal healthcare programs. Further, each party represents that it is not aware of any such pending action(s) (including criminal actions) against it or its employees or independent contractors. Each party shall notify the other party immediately upon becoming aware of any pending or final action in any of these areas.

Notices. Any notice required to be given pursuant to terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested, postage prepaid, as follows:

To the University at: Department of Counseling and Educational Psychology
MSC 3AC
New Mexico State University
Las Cruces, NM 88003

To the Institution: ______________________________
____________________________
Signed this _____ day of __________________, 20__.

An agent for the Institution:

By ______________________________________________

Signed this _____ day of __________________, 20__.

An agent for the Regents of New Mexico State University:

By _________________________________________________

Elaine S. LeVine, Ph.D., Training Director
Affiliate Associate Professor, New Mexico State University

SIAP FORM 400-3

Log of Contact Hours with the Patient
STUDENT LETTERHEAD

(Note: This will be easiest to follow if you keep a separate log sheet for each of the 100 patients)

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Working Diagnosis</th>
<th>Date(s)</th>
<th>Time(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthdate</td>
<td></td>
<td></td>
<td>Seen</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SIAP FORM 400-4

Log of Contact Times with Supervisor
STUDENT LETTERHEAD

400-Hour PRACTICUM FOR PRESCRIBING PSYCHOLOGISTS
SUPERVISORY LOG

Date       Name of Supervisor  Method of Supervision  Patients Reviewed  Hours

SIAP FORM 400-5

Letter to Patients
Dear Patient or Legal Guardian:

This letter is to inform you of my status as a doctor of psychology participating in a postdoctoral program training psychologists to prescribe psychotropic medications for their patients. My program, The Southwestern Institute for the Advancement of Psychotherapy/New Mexico State University Program, leads to professional development credit at New Mexico State University.

In order to obtain a license as a prescribing psychologist, I must complete 450 hours of postdoctoral coursework in basic biological sciences, pathophysiology, physical assessment, and advanced coursework in the treatment of medical and mental disorders. In addition, I must also complete an eighty-hour practicum with a primary care physician in which I have learned about medical illnesses, interpretation of lab tests, and appropriate drug treatment.

My work with you is part of a practicum in psychopharmacology in which I work with _______ (names of preceptors) to treat one hundred patients with psychotropic medication.

As a part of my ongoing learning experience, it is important that I keep very careful records of the medications prescribed, your progress in reaching your mental health goals, and your views of how your treatment is progressing. This may necessitate my requesting you to complete a number of forms as well as to sign off on some forms as we progress through your treatment. I believe that this monitoring will increase my effectiveness but also assures you the highest quality of care, and so I hope you will not feel encumbered by it. In signing this letter of which we will each keep a copy, you are indicating your understanding of the level of my training and the procedures involved.

________________________________________
RxP Student’s Signature

________________________________________
Patient’s Signature

____________________
Date

____________________
Date

SIAP FORM 400-6a

Performance Evaluation Form

The Southwestern Institute for the Advancement of Psychotherapy, LLC/New Mexico State University
1395 Missouri
Las Cruces, NM 88001
(575) 522-5466
Fax: (575) 521-8611
Date:___________________________

Psychologist’s name: ________________________________

Preceptor’s name: ________________________________

Midpoint and Final Evaluation - please indicate: 50 patients_____        100 patients_____        

Please use the following to guide your evaluation:

1. Has failed to demonstrate expected level of performance
2. Performs satisfactorily at times, has specific deficiencies
3. Meets expected level of performance
4. Exceeds expected level of performance
5. Exceptional performance

If a student receives a one or a two, please include any comments about what would improve his/her performance.

1) Obtains appropriate psychological and medical history:
   1   2   3   4   5

Comments: ____________________________________________________________________________________

2) Uses appropriate processes to establish diagnostic criteria to determine primary and alternate diagnoses:
   1   2   3   4   5

Comments: ____________________________________________________________________________________

3) Recommends referral for medical evaluation when necessary:
   1   2   3   4   5

Comments: ____________________________________________________________________________________

1) Initial goals are appropriate for patient’s diagnosis:
   1   2   3   4   5

Comments: ____________________________________________________________________________________

5) Is knowledgeable about when tests (laboratory, psychometric, and/or radiological) should be ordered:
   1   2   3   4   5
6) Demonstrates appropriate knowledge in interpreting tests (laboratory, psychometric, and/or radiological):

   1  2  3  4  5

Comments: ________________________________________________________________.

7) Demonstrates an ability to explain a drug’s benefits, side effect profile, and risk to patients in a thorough and clear manner:

   1  2  3  4  5

Comments: ________________________________________________________________.

8) Is responsible in monitoring psychotropic drug effectiveness and recommending appropriate changes:

   1  2  3  4  5

Comments: ________________________________________________________________.

9) Is systematic in checking for drug interactions:

   1  2  3  4  5

Comments: ________________________________________________________________.

10) Is systematic in assuring that drug selection is not contraindicated with patient’s medical condition or other medical treatment:

    1  2  3  4  5

Comments: ________________________________________________________________.

11) Gives patients written information when appropriate:

    1  2  3  4  5

Comments: ________________________________________________________________.

12) Using all available data, identifies the most appropriate treatment alternatives including medication, psychosocial, and combined treatments:
13) Sets appropriate long term goals:

| 1 | 2 | 3 | 4 | 5 |

Comments: ____________________________________________________________
______________________________________________________________________.

14) Keeps timely and thorough notes:

| 1 | 2 | 3 | 4 | 5 |

Comments: ____________________________________________________________
______________________________________________________________________.

15) Is an active participant in the learning process by asking appropriate questions, reading recommended material, etc.:

| 1 | 2 | 3 | 4 | 5 |

Comments: ____________________________________________________________
______________________________________________________________________.

16) Demonstrates proficiency in writing valid and complete prescriptions:

| 1 | 2 | 3 | 4 | 5 |

Comments: ____________________________________________________________
______________________________________________________________________.

17) Demonstrates and ability to work with others in an advisory fashion when appropriate:

| 1 | 2 | 3 | 4 | 5 |

Comments: ____________________________________________________________
______________________________________________________________________.

18) Demonstrates and ability to work with others in a collaborative manner when appropriate:

| 1 | 2 | 3 | 4 | 5 |

Comments: ____________________________________________________________
______________________________________________________________________.

19) In your professional opinion, this psychologist is ready to assume the responsibility for prescribing psychotropic medications for his/her patients in an independent manner?  ý yes  ý no
SIAP FORM 400-6b

Additional Form Required by the New Mexico Board of Psychologist Examiners

New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION
Board of Psychologist Examiners
Tower Annex Building • 3550 Cerrillos Road • Santa Fe, New Mexico 87506
(505) 476-4500 • Fax (505) 476-3865 • www.sld.state.nm.us/psychology

VERIFICATION BY PRIMARY SUPERVISOR OF 400-HOUR / 100 PATIENT PRACTICUM IN PRIMARY HEALTH CARE

Applicant Name: ________________________________
Mailing Address: ________________________________
City, State Zip: ________________________________
Telephone No: ________________________________

To be completed by the supervisor

SUPERVISOR
Name: ________________________________
Mailing Address: ________________________________
City, State Zip: ________________________________
Telephone No: ________________________________

Describe the area of practice in which you are formally trained and/or certified licensed: ________________________________

If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications: ________________________________

NEW MEXICO LICENSURE

Is your license current and unrestricted? ________________________________________________________________________________

Yes No

Date New Mexico medical license was issued: ________________________________
License Number and Type of License: ________________________________

If you hold any other professional licenses in this or any other jurisdiction list below:

<table>
<thead>
<tr>
<th>License No.</th>
<th>Type</th>
<th>State</th>
<th>Status (Active/Inactive)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name and Address of Applicant’s Training Director: ________________________________

Date Practicum Began: ________________________________ Date Practicum Ended: ________________________________

Revision date: 01/2008
Board of Psychologist Examiners
VERIFICATION OF 400-HOUR / 100 PATIENT PRACTICUM

To be completed by the secondary supervisor:

SECONDARY SUPERVISOR

Name: ________________________________
Mailing Address: ____________________________
City, State Zip: ____________________________
Telephone No. ____________________________

Describe the area of practice in which you are formally trained and/or certified/licensed:

______________________________________________________________________________

______________________________________________________________________________

If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medication:

______________________________________________________________________________

NEW MEXICO LICENSURE

Is your license current and unrestricted?

Yes  No

Date New Mexico medical license was issued:

License Number and Type of License:

______________________________________________________________________________

If you hold any other professional licenses in this or any other jurisdiction list below:

<table>
<thead>
<tr>
<th>License No.</th>
<th>Type</th>
<th>State</th>
<th>Status (Active/Inactive)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was the 400-hour Practicum part of the psychopharmacology training program from which the applicant obtained his/her certification or degree?

Yes  No

Did the practicum meet the following requirements?

- A minimum of 100 separate patients?
  
  Yes  No

- A range of disorders listed in the DSM?
  
  Yes  No

- Both acute and chronic conditions?
  
  Yes  No

Did the 400 hours include only time spent with patients to provide evaluation and psychopharmacotherapy and time spent in collaboration with treating healthcare providers?

Yes  No

Was there diversity including gender, age throughout the life-cycle, various ethnicities, socio-cultural backgrounds, and various economic backgrounds, as much as possible within the psychologist’s area of practice?

Yes  No

Was the primary or secondary supervisor on site?

Yes  No

New Mexico Regulation and Licensing Department
BOARDS AND COMMISSION DIVISION
### Intake Form (Adult)

**PLEASE USE INK**

**Today's Date**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Social Security#</th>
</tr>
</thead>
</table>

**Address:**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**Home telephone**

<table>
<thead>
<tr>
<th>Work Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
</table>

**Years of School Completed**

<table>
<thead>
<tr>
<th>Place of Employment</th>
</tr>
</thead>
</table>

**Type of Work**

<table>
<thead>
<tr>
<th>E-mail address</th>
</tr>
</thead>
</table>

**Marital Status**

<table>
<thead>
<tr>
<th>Number of Marriages</th>
<th>Religion</th>
</tr>
</thead>
</table>

1. **Information about Spouse/Partner:**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Social Security#</th>
</tr>
</thead>
</table>

**Address:**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**Home telephone**

<table>
<thead>
<tr>
<th>Work Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
</table>

**Years of School Completed**

<table>
<thead>
<tr>
<th>Place of Employment</th>
</tr>
</thead>
</table>

**Type of Work**

<table>
<thead>
<tr>
<th>E-mail address</th>
</tr>
</thead>
</table>

**Marital Status**

<table>
<thead>
<tr>
<th>Number of Marriages</th>
<th>Religion</th>
</tr>
</thead>
</table>

**OTHERS IN THE HOME:**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
</table>

**Ht:** _____   **Wt:** _____

(Note: Please check what applies to YOURSELF. If there is a family history of the condition, please check FAMILY HX, then specify who on the line provided, such as paternal uncle, maternal grandmother, etc.)

**Neurological**

<table>
<thead>
<tr>
<th>Headaches</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dizziness</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Fatigue</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Blackouts</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Head injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Condition</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Stroke</td>
</tr>
<tr>
<td>Convulsions/ seizures</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td><strong>ADDICTIONS</strong></td>
</tr>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Drugs</td>
</tr>
<tr>
<td>Nicotine</td>
</tr>
<tr>
<td>Caffeine</td>
</tr>
<tr>
<td>Dental/oral problem</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td><strong>PULMONARY/LUNGS</strong></td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Bronchitis</td>
</tr>
<tr>
<td>Emphysema</td>
</tr>
<tr>
<td>Pneumonia</td>
</tr>
<tr>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td><strong>DIGESTIVE (GI)</strong></td>
</tr>
<tr>
<td>Stomach/duodenal ulcer</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
</tr>
<tr>
<td>Weight loss and/or gain</td>
</tr>
<tr>
<td>Diverticulosis</td>
</tr>
<tr>
<td>Colitis</td>
</tr>
<tr>
<td>Blood in stools</td>
</tr>
<tr>
<td>Constipation or diarrhea</td>
</tr>
<tr>
<td>Hemorrhoids</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td><strong>CARDIOVASCULAR</strong></td>
</tr>
<tr>
<td>High or low blood pressure</td>
</tr>
<tr>
<td>High cholesterol</td>
</tr>
<tr>
<td>Arteriosclerosis</td>
</tr>
<tr>
<td>(hardening of arteries)</td>
</tr>
<tr>
<td>Heart attack</td>
</tr>
<tr>
<td>Chest pain</td>
</tr>
<tr>
<td>Irregular heartbeat</td>
</tr>
<tr>
<td>Heart murmur</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td><strong>Hepatitis</strong></td>
</tr>
<tr>
<td>Genital herpes</td>
</tr>
<tr>
<td>Liver problems</td>
</tr>
<tr>
<td>Gallbladder problems</td>
</tr>
<tr>
<td>Hernia</td>
</tr>
<tr>
<td><strong>Breast disease</strong></td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>
### EYE/EARS/NOSE/THROAT
- **Eye or eyelid infection**
- **Other eye problems**
- **Ear infection**
- **Deafness or decreased hearing**
- **Allergies or hay fever**
- **Frequent nosebleeds**

#### Other:

### KIDNEY/RENAL
- **Kidney or bladder disease**

### ENDOCRINE/METABOLIC
- **Thyroid problems**
- **Diabetes (Type I or Type II)**

### REPRODUCTIVE
- **Prostate problem (males)**
- **Gynecologic problem females**
- **Venereal disease**

### HEMATOLOGIC
- **Anemia**
- **Bleeding**
- **Other:**

### MUSCULOSKELETAL
- **Arthritis or other stiffness**
- **Gout**
- **Muscle weakness**
- **Muscle pain**
- **Bone fracture**
- **Other:**

### IMMUNE SYSTEM
- **Medication allergies**
- **Food allergies**
- **Other allergies, excluding ENT**
- **Tumor(s), cancerous or benign**
- **Other:**

### Other:
INFECTIONS
Measles
German measles/Rubella
Polio
Mumps
Scarlet fever
Chicken pox
Mononucleosis

DERMATOLOGIC/SKIN
Eczema
Psoriasis
Skin rash
Open wound(s)
Other: ____________________________

CURRENT HEALTH HABITS
Yes  No
Daily aerobic exercise•  •
Stable weight •  •
Stable sleep •  •
Coping skills for stress •  •
Wake up rested most mornings •  •
Have someone to turn to when troubled or upset•  •

Personal physician (Name, phone, address):

Date of last physical exam          Date of latest blood tests

Do you have any allergies to medications?  • Yes  • No
If so, to which ones?:
To Foods?  • Yes  • No  If so, to which ones?:

Have you ever been referred to a psychiatrist or your family doctor for an evaluation for psychiatric medication?  • Yes  • No

Please list all medications (include over-the-counter) and their doses that you are currently taking:

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>MEDICATION</th>
<th>DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>7.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>8.</td>
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<tr>
<td>4.</td>
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<td>9.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>10.</td>
<td></td>
</tr>
</tbody>
</table>

Have you ever been hospitalized for a psychiatric reason?  • Yes  • No
Please list all hospitalizations, medical and psychiatric:

<table>
<thead>
<tr>
<th>Dates of hospitalization</th>
<th>Psychiatric medications prescribed, if any</th>
</tr>
</thead>
</table>
hospitalization | Place | Reason
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tbody>
</table>

Do you have any children with chronic health problems?  ● Yes  ● No

Describe:

Your answers to this questionnaire can help me to quickly and accurately understand your concerns.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1.  Have you been consistently depressed or    ●    ●
down, most of the day, nearly every day, for the past two weeks, or longer? (If YES, continue with next question; if NO, skip to Question 5.)

2.  Have you become less interested in things    ●    ●
you used to enjoy most of the time?

3.  When something good happens, do you    ●    ●
feel better, even if only temporarily?

4.  Have you felt sad, low, or depressed most    ●    ●
of the time for the last two years?

5.  Other than when intoxicated on drugs or    ●    ●
alcohol, have you ever felt so “up” or “high” that other people thought you
were not your usual self?

6.  Have you ever gone for days at a time    ●    ●
without feeling the need for much sleep?

7.  Are you currently feeling “up,” “high,” or    ●    ●
full of energy?

8.  Have you been frequently irritable, over-
reacting to setbacks that you or others would consider relatively minor?

9.  Have you had anxiety attacks, i.e.,    ●    ●
become intensely frightened, uncomfortable, or uneasy, for no apparent reason?

10. Do you feel anxious or uneasy in particular    ●    ●
places or situations?

11. In the past month, have you been    ●    ●
repeatedly bothered by unwanted
thoughts or images?

12. In the past month, have you done some-
thing repeatedly without being able to resist doing it?
13. Have you ever experienced or witnessed serious injury or threat to yourself or another person, or an actual death?

14. Have you ever re-experienced a distressing event through dreams, flashbacks, or physical reactions?

   Yes  No

15. In the past 12 months, have you had three or more alcoholic drinks within a three hour period on more than three occasions?

16. In the past 12 months, did you drink alcohol or take a drug, more than once, to get high, feel better, or change your mood?

   If so, which of the following did you use?

   Stimulants, amphetamines, Speed, crystal meth, Dexedrine, Ritalin, diet pills.


   Narcotics, heroin, morphine, methadone, painkillers.

   Hallucinogens: LSD (“acid”), mescaline, peyote, PCP (“Angel dust,” “Peace Pill”), psilocybin, STP, mushrooms, Ecstasy, MDA, or MDMA.

   Inhalants: glue, ethyl chloride, nitrous oxide (“laughing gas”), amyl or butyl nitrate (“Poppers”).

   Marijuana: hashish, THC.

   Tranquilizers or downers.

   Miscellaneous: steroids, nonprescription sleep aids, diet pills, other

17. In the past three months, have you ever eaten a huge amount of food within a two-hour period?

18. Would people who know you well describe you as a worrier?

19. Have you ever felt that you should cut down on your drinking/drug use?

20. Has anyone annoyed you by telling you to cut down on your drinking/drug use?

21. Have you ever felt guilty or bad about your drinking/drug use?

22. Do you ever wake up in the morning...
Do you ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener)?

- Yes
- No

Has anyone ever criticized you or told you that you have a gambling problem?

- Yes
- No

Have you ever had to lie to family members, friends, or therapists about your gambling practices?

- Yes
- No

In the past month, have you wanted to harm yourself?

- Yes
- No

In the past month, did you have suicidal thoughts (e.g., wished you were dead or would be better off dead)?

- Yes
- No

Have you ever made a suicide plan?

- Yes
- No

Have you ever attempted suicide?

- Yes
- No

**FAMILY MENTAL HEALTH HISTORY**

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age, if still living</th>
<th>Mental health or substance abuse problems, if any*</th>
<th>If deceased, age at death</th>
<th>If deceased, cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister/Brother (circle one)</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<td></td>
</tr>
<tr>
<td>Sister/Brother (circle one)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Paternal Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Such as: alcoholism, drug addiction, depression, bipolar disorder, schizophrenia, ADHD, anxiety/panic, obsessive-compulsive disorder (OCD), learning disability, sleep disorder, violent tendencies.

**NAME:** ________________________________  **Visit Type:** Intake  Follow-up  Med Check  Other  **Date:** ____________

**DIAGNOSTIC INSTRUMENT**

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
<th>SD</th>
<th>IR</th>
<th>SR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I get along with others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I tire quickly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I feel no interest in things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I feel stressed at work/school/housework/volunteering.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I blame myself for things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I feel irritated.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I feel unhappy in my marriage/significant relationship.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I have thoughts of ending my life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>9. I feel weak.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10. I feel fearful.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. After heavy drinking, I need a drink the next morning to get</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12. I find my work/school/ housework/volunteering satisfying. 4 3 2 1 0 1 1 1
13. I am a happy person. 4 3 2 1 0 1 1 1
14. I work/study too much. 0 1 2 3 4 1 1 1
15. I feel worthless 0 1 2 3 4 1 1 1
16. I am concerned about family troubles. 0 1 2 3 4 1 1 1
17. I have an unfulfilling sex life. 0 1 2 3 4 1 1 1
18. I feel lonely. 0 1 2 3 4 1 1 1
19. I have frequent arguments. 0 1 2 3 4 1 1 1
20. I feel loved and wanted. 4 3 2 1 0 1 1 1
21. I enjoy my spare time. 4 3 2 1 0 1 1 1
22. I have difficulty concentrating. 0 1 2 3 4 1 1 1
23. I feel hopeless about the future. 0 1 2 3 4 1 1 1
24. I like myself. 4 3 2 1 0 1 1 1
25. Disturbing thoughts come into my mind that I can’t get rid of. 0 1 2 3 4 1 1 1
26. I feel annoyed by people who criticize my drinking (or frequent drug use). (If not applicable, mark “never”) 0 1 2 3 4 1 1 1
27. I have an upset stomach. 0 1 2 3 4 1 1 1
28. I am not working/studying housework/volunteering as well as I used to. 0 1 2 3 4 1 1 1
29. My heart pounds too much. 0 1 2 3 4 1 1 1
30. I have trouble getting along with my friends and close acquaintances. 0 1 2 3 4 1 1 1
31. I am satisfied with my life. 4 3 2 1 0 1 1 1
32. I have trouble at work/school housework/volunteering because of drinking or drug use. (If not applicable, mark “never”) 0 1 2 3 4 1 1 1
33. I feel that something bad is going to happen. 0 1 2 3 4 1 1 1
34. I have sore muscles. 0 1 2 3 4 1 1 1
35. I feel afraid of open spaces, or driving, or being on buses, subways, and so forth. 0 1 2 3 4 1 1 1
36. I feel nervous. 0 1 2 3 4 1 1 1
37. I feel my love relationships are full and complete. 4 3 2 1 0 1 1 1
38. I feel that I am not doing well at work/school. 0 1 2 3 4 1 1 1
39. I have too many disagreements at work/school. 0 1 2 3 4 1 1 1
40. I feel something is wrong with my mind. 0 1 2 3 4 1 1 1
41. I have trouble falling asleep or staying asleep. 0 1 2 3 4 1 1 1
42. I feel blue. 0 1 2 3 4 1 1 1
43. I am satisfied with my relationships with others. 4 3 2 1 0 1 1 1
44. I feel angry enough at work/school housework/volunteering to do something I may regret. 0 1 2 3 4 1 1 1
45. I have headaches. 0 1 2 3 4 1 1 1
46. I feel restless & can’t sit still. 0 1 2 3 4 1 1 1
47. I hear or see things that may not be there. 0 1 2 3 4 1 1 1
48. I do impulsive things (spending/gambling/dangerous driving) 0 1 2 3 4 1 1 1
49. My thoughts race. 0 1 2 3 4 1 1 1

TOTAL:
Even though we will ask to make a copy of your insurance card, we would appreciate if you would fill in the following information:

**PRIMARY INSURANCE COMPANY**

Name of Insurance Company  
Policy#  
Group#

Authorization or Referral Number

Name of Insured Person  
DOB  
Social Security#

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:
City  
State  
Zip Code

Home telephone  
Cell Phone
SECONDARY INSURANCE COMPANY

Name of Insurance Company       Policy#       Group#

Authorization or Referral Number

Name of Insured Person       DOB       Social Security#

Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:       City       State       Zip Code
Home telephone       Cell Phone
Place of Employment       Work Phone

Name of person who referred you to this office

Why are you seeking treatment now?
Have you ever seen a therapist or counselor before?  Yes  No
If yes, what was the name of therapist?
Dates and reason for therapy

PATIENT OR AUTHORIZED PERSON’S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims:
Yes  No
I authorize payment of medical benefits to _____________ for services rendered:
Yes  No
SIGNED: _________________________ DATE: _________________________

Has a referral been made to a psychiatrist/family doctor for medication evaluation?
Yes  No

For each item, below, please indicate your preference, provide your initials on the line to the left, and then sign below:

- Yes  No  I grant permission for _____________ to speak with my primary care physician about my psychological and medical status.

- Yes  No  I grant permission for _____________ to speak with (other healthcare provider’s name, address, and phone number):

  about my psychological and/or medical status.

- Yes  No

I authorize the release of any medical or other information necessary to process insurance claims:
Yes  No

I authorize payment of medical benefits _____________, for services rendered:
Yes  No

I have read _____________’s practice and privacy policies, and the HIPPA information, and consent to this patient-psychologist agreement.
All questions on your account should be directed to the Business Manager

INTAKE FORM (Adolescent 12-17)

Name        Sex:  ● Male  ● Female  DOB___
Age         Social Security#  ____________________________
Address     City     State     Zip Code
Home telephone
Emergency contact  Relationship  Telephone
School     Grade     Teacher’s Name     Telephone

Information about Mother:
Name        DOB        Age        SS#
Address:     City     State     Zip Code
Home telephone  Work Phone  Cell Phone
Years of School Completed   Place of Employment
Type of Work     E-mail address
Marital Status   Number of Marriages   Religion

Information about Father:
Name        DOB        Age        SS#
Address:     City     State     Zip Code
Home telephone  Work Phone  Cell Phone
Years of School Completed   Place of Employment
Type of Work     E-mail address
Marital Status   Number of Marriages   Religion

OTHERS IN THE HOME:
Name        DOB        Age        Relationship

Ht:  Wt:  
(Note: Please check what applies to YOURSELF. If there is a family history of the condition, please check FAMILY HX, then specify who on the line provided, such as paternal uncle, maternal grandmother, etc.)

NEUROLOGICAL
Headaches   £ £ £ £ £ ___
Dizziness    £ £ £ £ £ ___
Fatigue      £ £ £ £ £ ___
Blackouts    £ £ £ £ £ ___


<table>
<thead>
<tr>
<th>Section</th>
<th>Conditions</th>
<th>£££££</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convulsions/seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADICTIONS</td>
<td></td>
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</tr>
<tr>
<td>Alcohol</td>
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</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicotine</td>
<td></td>
<td></td>
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<tr>
<td>Caffeine</td>
<td></td>
<td></td>
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<tr>
<td>Dental/oral problem</td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
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<tr>
<td>PULMONARY/LUNGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
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<tr>
<td>Bronchitis</td>
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<td>Emphysema</td>
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<td>Pneumonia</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIGESTIVE (GI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach/duodenal ulcer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss and/or gain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diverticulosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood in stools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation or diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>REPRODUCTIVE</td>
<td></td>
<td></td>
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<tr>
<td>Hemorrhoids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital herpes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallbladder problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARDIOVASCULAR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## CARDIOVASCULAR
- High or low blood pressure
- High cholesterol
- Arteriosclerosis
- Heart attack
- Chest pain
- Irregular heartbeat
- Heart murmur
- Other:

## EYE/EARS/NOSE/THROAT
- Eye or eyelid infection
- Other eye problems
- Ear infection
- Deafness or decreased hearing
- Allergies or hay fever
- Frequent nosebleeds
- Difficulty swallowing
- Strep throat

## KIDNEY/RENAL
- Kidney or bladder disease

## ENDOCRINE/METABOLIC
- Thyroid problems
- Diabetes (Type I or Type II)
- Prostate problem (males)
- Gynecologic problem (females)
- Venereal disease

## HEMATOLOGIC
- Anemia
- Bleeding
- Other:

## MUSCUL
<table>
<thead>
<tr>
<th>Condition</th>
<th>Options</th>
<th>Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis or other stiffness</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Gout</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Muscle weakness</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Muscle pain</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Bone fracture</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Other:</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
</tbody>
</table>

**IMMUNE SYSTEM**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Options</th>
<th>Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication allergies</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Food allergies</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Other allergies, excluding ENT</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Tumor(s), cancerous or benign</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Other:</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
</tbody>
</table>

**INFECTIONS**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Options</th>
<th>Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>German measles/Rubella</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Polio</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Mumps</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Chicken pox</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Mononucleosis</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Other:</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
</tbody>
</table>

**DERMATOLOGIC/SKIN**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Options</th>
<th>Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eczema</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Skin rash</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Open wound(s)</td>
<td>£ £ £ £ £</td>
<td>_____</td>
</tr>
<tr>
<td>Other:</td>
<td>£ £ £ £ £</td>
<td>_____</td>
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</table>

**CURRENT HEALTH HABITS**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Options</th>
<th>Marks</th>
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</thead>
<tbody>
<tr>
<td>Daily aerobic exercise</td>
<td>£ £</td>
<td></td>
</tr>
<tr>
<td>Stable weight</td>
<td>£ £</td>
<td></td>
</tr>
<tr>
<td>Stable sleep</td>
<td>£ £</td>
<td></td>
</tr>
<tr>
<td>Coping skills for stress</td>
<td>£ £</td>
<td></td>
</tr>
<tr>
<td>Wake up rested most mornings</td>
<td>£ £</td>
<td></td>
</tr>
<tr>
<td>Have someone to turn to when troubled or upset</td>
<td>£ £</td>
<td></td>
</tr>
</tbody>
</table>

Personal physician (Name, phone, address):

Date of last physical exam
Date of latest blood tests

Do you have any allergies to medications? • Yes • No
If so, to which ones?
If so, to which ones?:

To Foods? • Yes • No If so, to which ones?:

Have you ever been referred to a psychiatrist or your family doctor for an evaluation for psychiatric medication? • Yes • No

Please list all medications (include over-the-counter) and their doses that you are currently taking:

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>MEDICATION</th>
<th>DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>7.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>8.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>9.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>10.</td>
<td></td>
</tr>
</tbody>
</table>

Have you ever been hospitalized for a psychiatric reason? • Yes • No

Please list all hospitalizations, medical and psychiatric:

<table>
<thead>
<tr>
<th>Dates of hospitalization</th>
<th>Place</th>
<th>Reason</th>
<th>Psychiatric medications prescribed, if any</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospital</th>
<th>Reason</th>
<th>Medications</th>
</tr>
</thead>
</table>

Do you have any children with chronic health problems? • Yes • No

Describe:

Your answers to this questionnaire can help me to quickly and accurately understand your concerns.

29. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks, or longer? (If YES, continue with next question; if NO, skip to Question 5.)

30. Have you become less interested in things you used to enjoy most of the time?

31. When something good happens, do you feel better, even if only temporarily?

32. Have you felt sad, low, or depressed most of the time for the last two years?

33. Other than when intoxicated on drugs or alcohol, have you ever felt so “up” or “high” that other people thought you were not your usual self?

34. Have you ever gone for days at a time without feeling the need for much sleep?
35. Are you currently feeling “up,” “high,” or £ £ full of energy?

36. Have you been frequently irritable, over- £ £ reacting to setbacks that you or others would consider relatively minor?

37. Have you had anxiety attacks, i.e., £ £ become intensely frightened, uncomfortable, or uneasy, for no apparent reason?

38. Do you feel anxious or uneasy in particular £ £ places or situations?

39. In the past month, have you been £ £ repeatedly bothered by unwanted thoughts or images?

40. In the past month, have you done some- £ £ thing repeatedly without being able to resist doing it?

41. Have you ever experienced or witnessed £ £ serious injury or threat to yourself or another person, or an actual death?

42. Have you ever re-experienced a distress- £ £ ing event through dreams, flashbacks, or physical reactions?

43. In the past 12 months, have you had £ £ three or more alcoholic drinks within a three hour period on more than three occasions?

44. In the past 12 months, did you drink £ £ alcohol or take a drug, more than once, to get high, feel better, or change your mood?

If so, which of the following did you use?

Stimulants, amphetamines, Speed, crystal meth, Dexamphetamine, Ritalin, diet pills.


Narcotics, heroin, morphine, methadone, £ £ painkillers.

Yes No
Hallucinogens: LSD (“acid”), mescaline, £ £ peyote, PCP (“Angel dust,” “Peace Pill”), psilocybin, STP, mushrooms, Ecstasy, MDA, or MDMA.

Inhalants: glue, ethyl chloride, nitrous £ £
Inhalants: glue, ethyl chloride, nitrous oxide ("laughing gas"), amyl or butyl nitrate ("Poppers").

Marijuana: hashish, THC.

Tranquilizers or downers.

Miscellaneous: steroids, nonprescription sleep aids, diet pills, other

45. In the past three months, have you ever eaten a huge amount of food within a two-hour period?

46. Would people who know you well describe you as a worrier?

47. Have you ever felt that you should cut down on your drinking/drug use?

48. Has anyone annoyed you by telling you to cut down on your drinking/drug use?

49. Have you ever felt guilty or bad about your drinking/drug use?

50. Do you ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener)?

51. Has anyone ever criticized you or told you that you have a gambling problem?

52. Have you ever had to lie to family members, friends, or therapists about your gambling practices?

53. In the past month, have you wanted to harm yourself?

54. In the past month, did you have suicidal thoughts (e.g., wished you were dead or would be better off dead)?

55. Have you ever made a suicide plan?

56. Have you ever attempted suicide?

FAMILY MENTAL HEALTH HISTORY

45.
46.
47.
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56.
**FAMILY MENTAL HEALTH HISTORY**

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age, if still living</th>
<th>Mental health or substance abuse problems, if any*</th>
<th>If deceased, age at death</th>
<th>If deceased, cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
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<tr>
<td>Father</td>
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<td>Sister/Brother (circle one)</td>
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<tr>
<td>Maternal Grandmother</td>
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<td>Maternal Grandfather</td>
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<tr>
<td>Paternal Grandfather</td>
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</tr>
</tbody>
</table>

*Such as: alcoholism, drug addiction, depression, bipolar disorder, schizophrenia, ADHD, anxiety/panic, obsessive-compulsive disorder (OCD), learning disability, sleep disorder, violent tendencies.

Please check the current statements about the past week that are applicable to you.

<table>
<thead>
<tr>
<th></th>
<th>Satisfactory</th>
<th>Major Problem</th>
<th>Minor Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crying</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Appetite</td>
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<td></td>
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<tr>
<td>Weight</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Binging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of laxatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guilt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal Thoughts</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Homicidal Thoughts</td>
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<td></td>
<td></td>
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<tr>
<td>Concentration</td>
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<td></td>
<td></td>
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<tr>
<td>Feeling bored</td>
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<td></td>
<td></td>
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<tr>
<td>Pleasure</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Energy</td>
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<td></td>
<td></td>
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<tr>
<td>Assertiveness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Feeling defensive</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hearing voices</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Feeling that people talk about you</td>
<td></td>
<td></td>
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<tr>
<td>Frustration</td>
<td></td>
<td></td>
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<tr>
<td>Explosiveness</td>
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<td></td>
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<tr>
<td>Physical Aggression</td>
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<td></td>
<td></td>
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<tr>
<td>Mood swings</td>
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<td></td>
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<tr>
<td>Anxiety</td>
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<td></td>
<td></td>
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<tr>
<td>Anxiety</td>
<td>Palpitations</td>
<td>Shortness of breath</td>
<td>Panic Attacks</td>
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<table>
<thead>
<tr>
<th><strong>Satisfactory</strong></th>
<th><strong>Major Problem</strong></th>
<th><strong>Minor Problem</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance to AA/NA meetings</td>
<td></td>
<td></td>
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<tr>
<td>Reoccurring thoughts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need to check and recheck (doors, stove, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>Headaches</td>
<td></td>
<td></td>
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<tr>
<td>Pain (other than headaches)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with medication</td>
<td></td>
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</tr>
</tbody>
</table>

Even though we will ask to make a copy of your insurance card, we would appreciate if you would fill in the following information:

**PRIMARY INSURANCE COMPANY**
Name of Insurance Company Policy# Group#
Authorization or Referral Number
Name of Insured Person DOB Social Security#
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address: City State Zip Code
Home telephone Cell Phone
Place of Employment Work Phone

**SECONDARY INSURANCE COMPANY**
Name of Insurance Company   Policy#   Group#
Authorization or Referral Number_________________________
Name of Insured Person   DOB   Social Security#
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:   City   State   Zip Code
Home telephone   Cell Phone__________
Place of Employment   Work Phone

Name of person who referred you to this office

Why are you seeking treatment now?
Have you ever seen a therapist or counselor before? ● Yes ● No
If yes, what was the name of therapist?
Dates and reason for therapy

PATIENT OR AUTHORIZED PERSON’S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims: p Yes p No
I authorize payment of medical benefits to ____________ for services rendered: p Yes p No

SIGNED: _________________________DATE:__________________________________
Has a referral been made to a psychiatrist/family doctor for medication evaluation?
● Yes ● No

For each item, below, please check your preference and provide your initials; then sign below:

● Yes ● No I grant permission for ____________ to speak with my child’s primary care physician about my child’s psychological and medical status.

● Yes ● No I grant permission for ____________ to speak about my child’s psychological and/or medical status with (other healthcare provider’s name, address, and phone number):

● Yes ● No I grant permission for ____________ to speak with my child’s teacher and other school personnel at (name of school) about how my child is doing in school.

● Yes ● No I grant permission for ____________ to release medical or other information about my child’s care to my child’s insurance company, in order to process insurance claims.

● Yes ● No I authorize payment of medical benefits to ____________, for services rendered.

All questions on your account should be directed to the Business Manager,
I have read ______________’s practice and privacy policies, and the HIPPA information, and consent to this patient-psychologist agreement.

___________________________  ______________________
Parent or Guardian’s Signature  Patient’s Signature

________________________
Date

15

SIAP FORM 400-8

400-hour Practicum Initial Patient Intake Form
To Be Completed by Child Patients
(with parental assistance)
(Student Letterhead)
INTAKE FORM
(Child)

Today's Date

Information about Child:
Name  Sex:  ● Male  ● Female  DOB
Age  Social Security#
Address  City  State  Zip Code
Height  Weight
Home telephone
Emergency contact  Relationship  Telephone
School  Grade  Teacher’s Name  Telephone

Information about Mother:
Name  DOB  Age  SS#
Address:  City  State  Zip Code
Home telephone  Work Phone  Cell Phone
Years of School Completed  Place of Employment
Type of Work  E-mail address
Marital Status  Number of Marriages  Religion
**Information about Father:**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>SS#</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Address:</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<table>
<thead>
<tr>
<th>Home telephone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
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<table>
<thead>
<tr>
<th>Years of School Completed</th>
<th>Place of Employment</th>
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<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>E-mail address</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Marriages</th>
<th>Religion</th>
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</table>

**OTHERS IN THE HOME:**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Relationship</th>
</tr>
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<tbody>
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</table>

Your child’s primary care physician (name, phone, address):

Does your child have any allergies to medications?  ● Yes  ● No

If so, to which ones?:

To Foods?  ● Yes  ● No  If so, to which ones?:

Has your child ever had any of the following medical problems?:

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Heart disease</th>
<th>Kidney disease</th>
<th>Liver disease</th>
<th>Diabetes</th>
<th>Thyroid problem</th>
<th>Endocrine disorder</th>
<th>Seizures or other neurological disorder</th>
<th>Substance abuse</th>
<th>Chemical sensitivities</th>
<th>Frequent infections</th>
<th>Frequent nausea and vomiting</th>
<th>Frequent constipation or diarrhea</th>
<th>Vision problems</th>
<th>Hearing problems</th>
<th>Unexplained, severe pains</th>
<th>Other unusual sensations</th>
<th>Muscle weakness or fatigue</th>
<th>Other medical illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Headaches</th>
<th>Dizziness</th>
<th>Asthma</th>
<th>Bronchitis</th>
<th>Tuberculosis</th>
<th>Colitis</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Chest pain
Frequent nosebleeds
Strep throat
Kidney/bladder disease
Diabetes (Type I or Type II)
Venereal Disease
Anemia
Bleeding
Tumor(s), cancerous or benign
Measles
German Measles/Rubella
Polio
Mumps
Scarlet Fever
Chicken Pox
Mononucleosis
Muscle pain
Bone fracture
Eczema
Skin rash

Has your child ever been referred to a psychiatrist or other prescriber for an evaluation for psychiatric medication?  ● Yes  ● No

Please list all medications and their doses (medical, psychiatric, non-prescription, herbal) that your child is currently taking:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Medication</th>
<th>Dose</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>5.</td>
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<td>3.</td>
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<td>6.</td>
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</tbody>
</table>

Has your child ever been hospitalized for a psychiatric reason?  ● Yes  ● No

Please list all hospitalizations, medical and psychiatric:

<table>
<thead>
<tr>
<th>Dates of hospitalization</th>
<th>Place</th>
<th>Reason</th>
<th>Psychiatric medications prescribed, if any</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Has your child ever had any of the following problems?

Sleep problems: i.e., resists going to bed, interferes with parents’ sleep, has trouble getting up in the morning
Easily irritated or frustrated
<table>
<thead>
<tr>
<th>Sleep problems</th>
<th>Behavior problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep, has trouble getting up in the morning</td>
<td>Argues or becomes aggressive</td>
</tr>
<tr>
<td>Nightmares, night terrors, or sleep walking</td>
<td>Has voiced thoughts of harming someone else</td>
</tr>
<tr>
<td>Finicky eating</td>
<td>Physically assaulted someone</td>
</tr>
<tr>
<td>Eating too much</td>
<td>Risky behavior __________</td>
</tr>
<tr>
<td>Eating too little</td>
<td>Dramatic changes in energy</td>
</tr>
<tr>
<td></td>
<td>Behavior problems at school</td>
</tr>
<tr>
<td>Up or Down?</td>
<td>Academic problems</td>
</tr>
<tr>
<td>Frequent crying spells</td>
<td>Smokes cigarettes</td>
</tr>
<tr>
<td>Anxiety, panic, nervousness</td>
<td>Acts without thinking</td>
</tr>
<tr>
<td>Worry, intense shyness</td>
<td>Cannot stay focused</td>
</tr>
<tr>
<td>Depressed, sad, or hopeless</td>
<td>Restless, fidgety, or hyper</td>
</tr>
<tr>
<td>Voiced thoughts of harming self</td>
<td>Breaks family or school rules</td>
</tr>
<tr>
<td>Engaged in self-injury</td>
<td>Lies or steals</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>Involvement in correctional system</td>
</tr>
<tr>
<td>Concerns about personal appearance</td>
<td>Alcohol problems</td>
</tr>
<tr>
<td>Does purposeless things over and over</td>
<td>Drug problems</td>
</tr>
<tr>
<td>Cannot get certain thoughts out of his/her head</td>
<td>Past/present drug or alcohol problems?</td>
</tr>
<tr>
<td>Unusual behavior or beliefs that seem strange to others</td>
<td>Other: ________________</td>
</tr>
</tbody>
</table>

Your answers to this questionnaire can help me to quickly and accurately understand your concerns. If adolescent, please complete. If parent, complete with child.

1.) Has your child been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks or longer? (If YES, continue with the next question; if NO, skip to Question 5)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

12.) In the past month, has your child done something repeatedly without being able to resist doing it?

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<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
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13.) Has your child ever experienced or witnessed serious injury or threat to yourself or another person, or an actual death?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

14.) Has your child ever re-experienced a distressing event through dreams, flashbacks, or physical reactions?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>
4.) Has your child felt sad, low, or depressed most of the time for the last 2 years? Yes

5.) Other than when intoxicated on drugs or alcohol, has your child ever felt so “up” or “high” that other people thought you were not your usual self? Yes

6.) Has your child ever gone for days at a time without feeling the need for much sleep? Yes

7.) Is your child currently feeling “up” “high”, or “full of energy”? Yes

8.) Has your child been frequently irritable, over-reacting to setbacks that you or others would consider relatively minor? Yes

9.) Has your child had anxiety attacks, i.e. become intensely frightened, uncomfortable, or uneasy, for no apparent reason? Yes

10.) Does your child feel anxious or uneasy in particular places or situations? Yes

11.) In the past month, have you been repeatedly bothered by unwanted thoughts or images? Yes

15.) In the past 12 months, has your child had 3 or more alcoholic drinks within a 3 hour period on more than 3 occasions? Yes

16.) In the past 12 months, did your child drink alcohol or take a drug, more than once, to get high, feel better, or change your mood? Yes

If so, which of the following did your child use? (below)

17.) In the past 3 months, has your child ever eaten a huge amount of food within a 2-hr period? Yes

18.) Would people who know your child well describe him/her as a worrier? Yes

19.) Has your child ever felt that he/she should cut down on drinking or drug use? Yes

20.) Has anyone annoyed your child by telling him/her to cut down on drinking or drug use? Yes

21.) Has your child ever felt guilty or bad about drinking or drug use? Yes

22.) Does your child ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener)? Yes

23.) Has anyone ever criticized your child or told him/her that he/she has a gambling problem? Yes

24.) Has your child ever had to lie to family members, friends, or therapists about his/her gambling practices? Yes

25.) In the past month, has your child wanted to harm himself/herself? Yes

26.) In the past month, did your child have suicidal thoughts (i.e., wished he/she were dead or would be better off dead?) Yes

27.) Has your child ever made a suicide plan? Yes

28.) Has your child ever attempted suicide? Yes
**FAMILY MENTAL HEALTH HISTORY**

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age, if still living</th>
<th>Mental health or substance abuse problems, if any*</th>
<th>If deceased, age at death</th>
<th>If deceased, cause of death</th>
</tr>
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<tbody>
<tr>
<td>Mother</td>
<td></td>
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<tr>
<td>Father</td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<td>Sister/Brother (circle one)</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Paternal Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Such as: alcoholism, drug addiction, depression, bipolar disorder, schizophrenia, ADHD, anxiety/panic, obsessive-compulsive disorder (OCD), learning disability, sleep disorder, violent tendencies.

Even though we will ask to make a copy of your child’s insurance card, we would appreciate if you would fill in the following information:

**PRIMARY INSURANCE COMPANY**

Name of Insurance Company    Policy#    Group#

Authorization or Referral Number

Name of Insured Person    DOB    SS#

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:    City    State    Zip Code

Home telephone _ Cell Phone

Place of Employment    Work Phone

**SECONDARY INSURANCE COMPANY**

Name of Insurance Company    Policy#    Group#

Authorization or Referral Number

Name of Insured Person    DOB    SS#

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:    City    State    Zip Code

Home telephone _ Cell Phone

Place of Employment    Work Phone
PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other
information necessary to process insurance claims:
£ Yes  £ No
I authorize payment of medical benefits to ______________________ for services rendered:
£ Yes  £ No

SIGNED: _________________________ DATE: ______________________________
Name of person who referred you to this office
Why are you seeking treatment for your child now?

Has your child ever seen a therapist or counselor before?  • Yes  • No
If yes, what was the name of therapist?
Dates and reason for therapy

For each item, below, please check your preference and provide your initials; then sign below:

• Yes  • No  I grant permission for Dr. ____________ to speak with my child’s primary care
  physician about my child’s psychological and medical status.

• Yes  • No  I grant permission for Dr. ____________ to speak about my child’s psychological
  and/or medical status with (other healthcare provider’s name, address, and phone
  number):

• Yes  • No  I grant permission for Dr. ____________ to speak with my child’s teacher and other
  school personnel at (name of school)
  about how my child is doing in school.

• Yes  • No  I grant permission for Dr. ____________ to release medical or other information
  about my child’s care to my child’s insurance company, in order to process
  insurance claims.
  • Yes  • No  I authorize payment of medical benefits to _______________________, for services rendered.

I have read ________________’s practice and privacy policies, and the HIPPA information, and consent to
this patient-psychologist agreement.

____________________  _________________________  ________________
Parent/Guardian Name (printed)  Parent/Guardian Signature  Date

SIAP FORM 400-9
400-hour Practicum Initial Patient Chart Form
To Be Completed by the Psychologist

Student Letterhead or Your Institution’s Letterhead

400-Hour PRACTICUM FOR PRESCRIBING PSYCHOLOGISTS

INITIAL PATIENT DATA

Supervisee: ____________________________
Patient Name: __________________________
Patient Date of Birth: ____________
Date: ____________
Gender: __________________
Height: ____________
Weight: ____________
Ethnic and Relevant Cultural Background: ____________
Medical History Form Completed Yes ___  No___

Presenting Symptoms and History of Symptoms:
_____________________________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________________________

Review of Systems:

<table>
<thead>
<tr>
<th>CONST:</th>
<th>Fever</th>
<th>Chills</th>
<th>Fatigue</th>
<th>Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT:</td>
<td>Sore Throat</td>
<td>Nasal Drainage</td>
<td>Nasal Congestion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cough</td>
<td>Sputum</td>
<td>Trouble Breathing</td>
<td>Chest Pain</td>
</tr>
<tr>
<td>PULMONARY:</td>
<td>Asthma</td>
<td>Bronchitis</td>
<td>Emphysema</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>CVS:</td>
<td>High Blood Pressure</td>
<td>Irregular Heartbeat</td>
<td>Foot Swelling</td>
<td>Anemia</td>
</tr>
<tr>
<td>MUS/SKEL:</td>
<td>Arthritis</td>
<td>Muscle Pain</td>
<td>Leg Pain</td>
<td>Fracture</td>
</tr>
<tr>
<td></td>
<td>Back Pain</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSTEO:</td>
<td>Arthritis</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GI:</td>
<td>Constipation</td>
<td>Black/Bloody Stools</td>
<td>Liver Problems</td>
<td>Hemorrhoids</td>
</tr>
<tr>
<td></td>
<td>Hemia</td>
<td>Hepatitis Ulcer</td>
<td>Kidney Disease</td>
<td>Bladder Disease</td>
</tr>
<tr>
<td>GU:</td>
<td>Problems Urinating</td>
<td>Frequent Urination</td>
<td>Hemorrhoids</td>
<td></td>
</tr>
<tr>
<td>SKIN:</td>
<td>Skin Rash</td>
<td>Eczema</td>
<td>Psoriasis</td>
<td>Open Wounds</td>
</tr>
<tr>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEURO/EYES:</td>
<td>Double Vision</td>
<td>Stroke</td>
<td>Head Injury</td>
<td>Seizures/Convulsions</td>
</tr>
<tr>
<td></td>
<td>Eye Infections</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Hospitalizations and Surgeries:**

**Use of Alcohol, Drugs, Caffeine and Tobacco:**

**Significant Family History Including Medical and Mental Conditions:**

**Mental Status:**

<table>
<thead>
<tr>
<th>APPEARANCE</th>
<th>Appropriate</th>
<th>Unclean</th>
<th>Disheveled</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEHAVIOR</td>
<td>Appropriate</td>
<td>Poor Eye Contact</td>
<td>Restless</td>
<td>Lethargic</td>
</tr>
<tr>
<td>ORIENTATION</td>
<td>Time</td>
<td>Person</td>
<td>Place</td>
<td>Situation</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
<td>Bronchitis</td>
<td>Emphysema</td>
<td>Pneumonia</td>
</tr>
<tr>
<td></td>
<td>Allergies</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPEECH/LANGUAGE</td>
<td>Organized</td>
<td>Disorganized</td>
<td>Rate NL</td>
<td>Slow</td>
</tr>
<tr>
<td></td>
<td>Soft</td>
<td>Loud</td>
<td>Tone NL</td>
<td>Monotone</td>
</tr>
<tr>
<td></td>
<td>Sparse</td>
<td>Verbose</td>
<td>Nonverbal</td>
<td></td>
</tr>
<tr>
<td>MOOD/AFFECT</td>
<td>Euthymic</td>
<td>Depressed</td>
<td>Irritable</td>
<td>Tearful</td>
</tr>
<tr>
<td>THOUGHT PROCESS</td>
<td>Hypervigilant</td>
<td>Linear</td>
<td>Tangential</td>
<td>Loose</td>
</tr>
<tr>
<td></td>
<td>Inattentive</td>
<td>Circumstantial</td>
<td>Coherent</td>
<td>Trouble Concentrating</td>
</tr>
<tr>
<td>THOUGHT CONTENT</td>
<td>Obsessional</td>
<td>Grandiosity</td>
<td>Hallucinations</td>
<td>Delusions</td>
</tr>
<tr>
<td></td>
<td>Worries</td>
<td>Self-Criticism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUICIDE:</td>
<td>Ideation</td>
<td>Plan</td>
<td>IS w/o Means</td>
<td>Prior SA</td>
</tr>
<tr>
<td></td>
<td>Discuss/Thought/Plan:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOMICIDE:</td>
<td>Ideation</td>
<td>Plan</td>
<td>HI w/o Means</td>
<td>HI w/Means</td>
</tr>
<tr>
<td></td>
<td>Discuss/Thought/Plan:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Vegetative Symptoms:**

<table>
<thead>
<tr>
<th>S - SLEEP:</th>
<th>Nightmares</th>
<th>Insomnia</th>
<th>Flashbacks</th>
<th>Hypersomnia</th>
<th>Hypnopompic Hallucinations</th>
<th>Hrs of Sleep ___</th>
<th>Hyperarousal</th>
<th>Hypnagogic Hallucinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - APPETITE CHANGE:</td>
<td>None</td>
<td>Decrease</td>
<td>Increase</td>
<td>Severe</td>
<td>Weight Change Loss ____</td>
<td>Gain ____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M - MEMORY:</td>
<td>Intact</td>
<td>Poor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C - CONCENTRATION:</td>
<td>High</td>
<td>Decrease</td>
<td>Low</td>
<td>Intact</td>
<td>Slight Impairment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E - ENERGY:</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L - LIBIDO:</td>
<td>Increase</td>
<td>Decrease</td>
<td>Same</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diagnosis:**

<table>
<thead>
<tr>
<th>AXIS I:</th>
<th>Present</th>
<th>AXIS V:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AXIS II:</td>
<td>Past</td>
<td>GAF Score: ____</td>
</tr>
<tr>
<td>AXIS III:</td>
<td>Uncertain</td>
<td>Initial: ____ Current: ____</td>
</tr>
<tr>
<td>AXIS IV – Psychosocial and Environmental Problems (check all that apply)</td>
<td></td>
<td>Highest in Last Yr ____</td>
</tr>
<tr>
<td>Family hx</td>
<td>Housing</td>
<td>Educational</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient’s motivation for treatment: ___ low ___ moderate ___ high

Patient’s strength:

Patient’s obstacles to recovery:

Food allergies:

Drug allergies:

Conditions for which psychotropic drugs are contraindicated:

Primary symptoms to be targeted by the psychotropic medication:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed Mood</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Decreased Energy</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Grief</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Valueslessness</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Guilt</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Panic Attacks</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Obsessions/Compulsions</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Elevated Mood</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Irritability</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Disruption of Thought-Process/Content</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Delusions</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Paranoia</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
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<tr>
<td>Dissociative State</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
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<td>Oppositionalism</td>
<td>1.</td>
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<td>3.</td>
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<tr>
<td>Somatic Complaints</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
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<tr>
<td>Impulsiveness</td>
<td>1.</td>
<td>2.</td>
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<tr>
<td>PTSD Symptomatology</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
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<td>Sexual Trauma Perpetrator Symptomology</td>
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<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Substance Use</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Other</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td>Other</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
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</tbody>
</table>

Relevant Findings from lab tests:

Discussion with PCP:

Discharge Criteria:

For Medical Conditions (prescription and over-the-counter):

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Dosage</th>
<th>Prescribed By</th>
<th>Taken For</th>
<th>Date Started</th>
<th>Date Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Psychotropic Medications:

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Dosage</th>
<th>Prescribed By</th>
<th>Taken For</th>
<th>Date Started</th>
<th>Date Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

PSYCHOTHERAPY PLAN:

Data –

Assessment –

Plan –

Or

Subjective –

Past

Uncertain

None

Objective –

Family Hx

Who

Assessment –

Plan –

Present

Past

Uncertain

None

Family Hx

Who

Directions for Scoring the Outcome Questionnaire

This description of the Outcome Questionnaire 45 is written by John Drozd. Ph.D., who recently completed the Masters Degree in Psychopharmacology.

Purpose: Global outcome measure that assesses patient progress in therapy (not a diagnostic instrument). Assesses patient progress along 3 dimensions:

(Please note that this form is identical to the form included in the initial intake form so that you can measure the changes)
Overall Description: The OQ45.2 is a brief 45 item self-report outcome/tracking instrument designed for repeated measurement of client progress throughout the course of therapy and at termination. The OQ45.2 is the result of a unique partnership between behavioral health care administrators, practitioners, and academic researchers in response to the changing mental health arena and the accompanying demands for cost containment, quality care, reliable monitoring, and accountability for services provided. As continuous monitoring of outcome may be achieved by standardized data, Dr. Burlingame, Lambert, and Reisinger et al, set out to design an instrument that would meet the needs of both providers and payers.

Normative Sample: Normative data from community mental health and private freestanding outpatient clinics, EAP participants, and asymptomatic community and undergraduate populations are available. These normative samples (N=1,000+) were collected from sites in seven different states and reflect both gender (female = 60%) and age (from 17-80 years of age) diversity. Current analyses do not reflect any reliable normative differences by gender and age.

Psychometric Properties: The OQ45.2 is a standardized instrument with empirical support. It is based on normative data. Validity and reliability exceed industry standards.

Scoring and Interpretation: Total score is sum of 3 subscale scores (i.e. all 45 items) and yields a total score range from 0 – 180. The higher the score the more disturbed the individual.

Risk Assessment:
- Item 8 is a suicide potential screening item
- Items 11, 26, and 32 are substance abuse screening items
- Item 44 screens for violence at work.

Any rating on above Items other than 0 should be investigated further

Cutoff Score: When a patient scores a total score of 63 or higher, it is more likely that they are part of the clinical rather than the non-clinical (“normal”) standardization sample.

Cutoff scores for subscales are:

- Symptom Distress – 36,
- Interpersonal Relations – 15,
- Social Role – 12

Reliable Change Index: Total score changes of 14 points or more in either direction suggest reliable change (i.e., not due merely to measurement error)

FOR FURTHER INFORMATION

Burlingame, et. al. (1995). “Pragmatics of Tracking Mental Health Outcomes in a Managed Care Setting.” Journal of Mental Health Administration, Summer, pp.226-236.


<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
<th>SD</th>
<th>IR</th>
<th>SR</th>
<th>SRSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I get along with others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I tire quickly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I feel no interest in things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I feel stressed at work/school/housework/volunteering.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I blame myself for things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I feel irritated.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I feel unhappy in my marriage/significant relationship.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I have thoughts of ending my life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I feel weak.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I feel fearful.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. After heavy drinking, I need a drink the next morning to get going.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
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<td>(If you do not drink, mark “never”)</td>
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<td>12. I find my work/school/housework/volunteering satisfying.</td>
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<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<tr>
<td>13. I am a happy person.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<td>14. I work/study too much.</td>
<td>0</td>
<td>1</td>
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<td>15. I feel worthless</td>
<td>0</td>
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<td>16. I am concerned about family troubles.</td>
<td>0</td>
<td>1</td>
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<td>3</td>
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<td>17. I have an unfulfilling sex life.</td>
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<td>18. I feel lonely.</td>
<td>0</td>
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<td>19. I have frequent arguments.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<tr>
<td>20. I feel loved and wanted.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<tr>
<td>21. I enjoy my spare time.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<td>22. I have difficulty concentrating.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>23. I feel hopeless about the future.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>24. I like myself.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<td>25. Disturbing thoughts come into my mind that I can’t get rid of.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>(If not applicable, mark “never”)</td>
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<td>26. I feel annoyed by people who criticize my drinking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
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<td>(or frequent drug use).</td>
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<td>27. I have an upset stomach.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>28. I am not working/studying/housework/volunteering as well as</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>I used to.</td>
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<td>29. My heart pounds too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
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<tr>
<td>30. I have trouble getting along with my friends and close</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
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<tr>
<td>acquaintances.</td>
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<tr>
<td>31. I am satisfied with my life.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
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<tr>
<td>32. I have trouble at work/school/housework/volunteering because</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>of drinking or drug use.</td>
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<td>33. I feel that something bad is going to happen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
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<tr>
<td>34. I have sore muscles.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>35. I feel afraid of open spaces, or driving, or being on buses,</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<td>subways, and so forth.</td>
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<tr>
<td>36. I feel nervous.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td></td>
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<tr>
<td>37. I feel my love relationships are full and complete.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
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<tr>
<td>38. I feel that I am not doing well at work/school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>39. I have too many disagreements at work/school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
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<tr>
<td>40. I feel something is wrong with my mind.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>41. I have trouble falling asleep or staying asleep.</td>
<td>0</td>
<td>1</td>
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<td>3</td>
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<td>42. I feel blue.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>43. I am satisfied with my relationships with others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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</tbody>
</table>
44. I feel angry enough at work/school/housework/volunteering to do something I may regret.

45. I have headaches.

46. I feel restless & can't sit still.

47. I hear or see things that may not be there.

48. I do impulsive things (spending/gambling/dangerous driving).

49. My thoughts race.

TOTAL:

PAIN SURVEY (1-10)

Directions: On the diagram below, please mark the areas where you are experiencing pain.

1. Headache
2. Neck pain
3. Shoulder pain
4. Upper back pain
5. Lower back pain
6. Hip pain
7. Knee pain
8. Foot pain

TOTAL:

WELL-BEING QUESTIONNAIRE

Directions: Please circle any of the following that apply to you:

1. Not at all
2. A little
3. Moderate
4. Very

TOTAL:
SIAP FORM 400-11

400-hour Practicum Symptom Checklist
To Be Completed by Adult Patient Before Each Follow-up Session

SIAP FORM 400-12

400-hour Practicum Symptom Checklist To Be Completed by Child Patient (with parent’s assistance if needed) Before Each Follow-up Session

CHILD FOLLOW-UP CHECKLIST

Name: _______________________________ Date:________________

Please rate the degree to which you experienced each of the following since the last session:

- Sleep problems: i.e., resists going to bed, interferes with parents’ sleep, has trouble getting up in the morning
- Nightmares, night terrors, or sleep walking
- Finicky eating
- Eating too much
- Eating too little
- Dramatic changes in energy
- Up or Down?
- Frequent crying spells
- Easily irritated or frustrated
- Argues or becomes aggressive
- Has voiced thoughts of harming someone else
- Physically assaulted someone
- Risky behavior ________
- Behavior problems at school
- Academic problems
- Smokes cigarettes
Anxiety, panic, nervousness
Worry, intense shyness
Depressed, sad, or hopeless
Voiced thoughts of harming himself/herself
Engaged in self-injury
Attempted suicide
Concerns about personal appearance
Does purposeless things over and over
Cannot get certain thoughts out of his/her head
Unusual behavior or beliefs that seem strange to others
Acts without thinking
Cannot stay focused
Restless, fidgety, or hyper
Breaks family or school rules
Lies or steals
Involvement in correctional system
Alcohol problems
Drug problems
Past/present drug or alcohol problems?
Other: ________________

Since the last session has your child…

…had any new medical problems? Yes No. If Yes, explain:

These SIDE EFFECTS are sometimes experienced by a patient on medication. Has your child experienced any of these since being on MEDICATION?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Severe Problem</th>
<th>Moderate Problem</th>
<th>Minor Problem</th>
<th>Medication</th>
<th>Approximate Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty Falling asleep</td>
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<tr>
<td>Difficulty waking up</td>
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<tr>
<td>Interrupted sleep</td>
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<tr>
<td>Extreme tiredness</td>
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<tr>
<td>Trouble concentrating</td>
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<tr>
<td>Loss of memory</td>
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<tr>
<td>Headaches</td>
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<tr>
<td>Shaking/Tics/twitches</td>
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<tr>
<td>Odd muscle movements</td>
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<td>Blurred vision</td>
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<tr>
<td>Stomach distress</td>
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<tr>
<td>Diarrhea</td>
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<tr>
<td>Difficulty urinating</td>
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<td>Dry mouth</td>
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<tr>
<td>Difficulty swallowing</td>
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<tr>
<td>Inability to sit still</td>
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</table>


Racing mind

…visited a health care provider?  Yes  No.  If Yes, explain:

…started, stopped, or changed the dosage of any medication, herb, supplement, caffeine, or nicotine?  Yes  No.  If Yes, explain:

…experienced stressful events at home, school, or work?  Yes  No

If Yes, explain:

Does your child need a refill on any of his/her medications?  Yes  No.  If Yes, please list with current dosage:


SIAP FORM 400-13

Everything You Need to Know
Now That Your Coursework is Complete

EVERYTHING YOU NEED TO KNOW
NOW THAT YOUR RXP COURSEWORK IS COMPLETE

Regarding the 80-hour Practicum

• You must complete an 80-hour practicum with a primary care physician.

• This Supervisor must sign an evaluation form. The evaluation form is on the www.siaprxp.com website in the handbook.

• You can have more than one supervisor; there has to be a primary supervisor who is an MD (not a nurse) who signs off on the form.

• Send a copy of the evaluation form to SIAP in care of me. Keep the original of that evaluation form for yourself; you will have to submit it to the board to get your license.

• Must be completed in time frame from two weeks to thirty weeks.

You also need to complete a 100 patient/400 hour practicum in which you evaluate and treat patients for psychotropic intervention.

• You need to submit a practicum plan with your signature and the supervisor’s signature to SIAP/NMSU. I will sign it and return the original to you, and keep a copy in your student file.

• You must have one hour of supervision for each eight hours of clinical experience. If you are doing joint work with your supervisor, that qualifies as supervision time, as well as does the time talking about cases in between patient sessions.

• Writing case notes does not count. It has to be direct clinical time.
- You can have more than one Supervisor. The primary supervisor is responsible for getting feedback from the secondary supervisor at the midpoint and end of your program.

- You need to have an evaluation form completed after the first 50 patients and at end when you have seen 100 patients for 400 hours. That evaluation form is also in the practicum manual on the SIAP website.

- Send copies of those evaluation forms to SIAP in care of Elaine LeVine. Keep the original of it for yourself; you will need to send it to the Board in order to get your license.

- According to the law, there are records of the Practicum that you must keep:
  - A list of the dates and times you are with your supervisor.
  - A list of patients (using a code for their names to protect their identity) which describes the basic facts of each case.
  - Forms to use for those lists can be found on the website.
  - You must also keep a copy of your case notes. You do not need to send those case notes to me to get your degree, but you must send a copy of your case notes to me before applying for your conditional license. The law requires that I look at your case notes.

- Must be completed in time frame of six months to three years

To remain eligible and apply for the Masters degree:

- You must register for two sections of the practicum with CEP 811 and 812 the semester after completing the coursework. If you are not finished with your practicum at that time, these will carry forward as an “I” until you are done.

- The semester you plan to graduate, you need to register for one credit of CEP 698.

- The semester you intend to graduate, please notify the director of SIAP, Elaine LeVine, as early as possible.

- When you register for the final semester:
  - Make sure that your program of study that has been filed
  - You must complete a form online stating your intention to graduate
    Go to your MYNMSU and find the link for application to graduate
    Follow the instructions for the interdisciplinary Masters (IMAS)

- There is a “Capstone Experience” that needs to be completed for any Masters degree. The Capstone Experience is to be taken the semester you plan to graduate. The Capstone is a short essay exam for you to complete which asks you to evaluate one of the cases of your practicum. The test has been written in a way that will, hopefully, give you the opportunity to think through some interesting matters.

- When you are ready to take the exam, contact Elaine LeVine. It will be emailed to you. However, it is important that you ask for the exam at the beginning of the semester you plan to graduate, which
is important that you ask for the exam at the beginning of the semester you plan to graduate, which will give you time to do it. The Capstone must be completed about six weeks before the semester ends.

**Taking the PEP**

- You are eligible to take the PEP as soon as you complete the coursework, even before you complete the Practicum.

- To get the official PEP application you need to email Jan Ciuccio (jciuccio@apa.org) at the American Psychological Association.

- You need to submit an official transcript from NMSU and a certificate of coursework completion with the application. You can request an official copy of your transcript by calling the Office of the Registrar at 575-646-3411 or online at [http://www.nmsu.edu/~registra/transcripts/index.html](http://www.nmsu.edu/~registra/transcripts/index.html).

- The pass rate for the exam is set somewhere around 71-72% of the items. It is hard to know exactly what the rate is until you have taken the test.

**Applying for you conditional license to prescribe**

- The information for applying for your conditional license is on the Board of Psychologist Examiners webpage. That information, as well as the forms for the application, can be downloaded from there.

- You will be asked to fill out an application form and send to the Board copies of your evaluation of each practicum. They may also ask for the documentation of the number of hours of supervision and basic data about your patients. You will also need to provide evidence that you passed the PEP.

- They will ask me to fill out a form about you. In order for me to do that, I must have the following:
  - Copies of your evaluation forms.
  - Copies of your case notes of your 100-hour practicum without the names (using a code to protect their identity) OR completion of the form titled Verification of Specifics of 100 Patients/400 hour Practicum (that form is attached.)
  - Two short forms which indicate your hours of supervision and basic data about the patients.

**Moving from a conditional to an unconditional license to prescribe:**

- During the two years of a conditional license, you must see 50 patients and you must be supervised for four hours a month.

- There is no formal interaction with the SIAP program necessary at this point. SIAP does not keep records of your work as a conditional prescribing psychologist.

- You can obtain the application forms on the Board of Psychologist Examiners website.

- After you apply, you will be contacted by the Board about how they will review your cases.

**Getting an ABMP designation**

- The American Board of Medical Psychology offers a Diplomate that allows you to put the initials ABMP after your name.
You can then call yourself a “medical psychologist.”

They had an earlier grandfathering period which is now over. You now must complete an exam as well as document experience.

Their requirements are online (www.abmp.org)

Remember, it is your responsibility that you progress smoothly through these steps.

- Please read New Mexico State University regulations regarding graduate school and a Masters degree.
- Please be familiar with the law for prescriptive authority.
- Please carefully read the regulations for prescriptive authority.
- I have tried to make these notes as inclusive as possible, but there are so many steps and so many specific items, it really is important for you to become familiar with the regulations for yourself.

SOUTHWESTERN INSTITUTE FOR THE ADVANCEMENT OF PSYCHOTHERAPY / NEW MEXICO STATE UNIVERSITY

Verification of Specifics of 100 Patients/400 Hour Practicum

1. Attached to this form, have you included a coded log, which includes patient ID, age, gender, diagnosis, and time spent in treatment?
   _____YES       _____NO

2. Have you also included with the form a log of the dates and times of Supervision?
   _____YES       _____NO

3. Have you included a copy of the form you used to indicate to patients that you were under supervision?
   _____YES _____NO

4. Have you submitted to the Training Director two formal written evaluations completed by the primary supervisor?
   _____YES _____NO

5. Please describe the population parameters with whom you hope to practice with your conditional prescribing license (for example, only adults, only children, severely mentally ill, etc).

   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

6. Please describe the range of disorders treated during your practicum experience.
7. How many of these were seen for acute conditions and chronic conditions.
   Acute ________  Chronic________

8. In general terms, please provide evidence that you have seen a diverse set of patients throughout the lifecycle of various ethnicity and social/cultural backgrounds.

9. Do you attest that the primary or secondary supervisor was on site?
   _____YES _____NO

10. Did your primary or secondary supervisor review charts and records?
    _____YES _____NO

11. Will you attest that there was at least one hour of supervision for every eight hours or direct service?
    _____YES _____NO

12. What was the date you began your practicum and completed your practicum?
    Begin_____________  Ended_____________

13. In evaluating your application, the Board of Psychologist Examiners reserves the right to request clinical records from the applicant or the Training Director. Do you certify, that if requested by the Board of Psychologist Examiners, you can and will make available to the Training Director of SIAP/NMSU or the Board of Psychologist Examiners clinical records that support all of the experiences described above?
    _____YES  _____NO

I, _________________________, swear or affirm under penalty of perjury under the laws of the State of New
I, _______________________, swear or affirm under penalty of perjury under the laws of the State of New Mexico, that all forms requested are attached and that everything written above is complete and true.

Sworn this _____________ day of ______________________________, 20_____, at ______________________________, City and State

_________________________________
Signature

STATE OF __________

COUNTY OF ________________

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____________ DAY OF ______________________________, 20_____

SEAL

Signature of Notary Public: ____________________________________
My Commission expires on: _________________________________

SIAP FORM 400-14

Last But Not Least!

The Southwestern Institute for the Advancement of Psychotherapy/New Mexico State University
1395 Missouri
Las Cruces, NM  88001
(575) 522-5466
Fax: (575) 521-8611

CHECKLIST OF MATERIAL TO BE SENT TO SIAP BEFORE APPLYING FOR YOUR CONDITIONAL PRESCRIBING LICENSE

- Copy of 80-Hour Practicum in Primary Care dated and signed by your supervising physician
- Copy of 100 patients/400 hours Practicum Plan
- Copy of form given to patients that they sign that explains you are a student in training
- Copy of your log for each of 100 patients seen in you 400-hour practicum
- Copy of your log which lists dates and times of supervision
- Copy of evaluations completed by your primary supervisor at the midpoint and end of practicum
- Copy of evaluation form completed by your secondary supervisor(s) of your practicum
- Copy of all your case notes with the identity and date blacked out or a notarized copy of the verification form that follows.
- It is also important for you to assure that your insurance carrier will cover you as a prescribing psychologist. The APA Insurance Trust has given their commitment to do so. If you have insurance coverage with a different carrier, it is strongly recommended that you write to them early on in your practicum to determine if they will cover you or if you need to seek another company
5. Attached to this form, have you included a coded log, which includes patient ID, age, gender, diagnosis, and time spent in treatment?

6. Have you also included with the form a log of the dates and times of Supervision?
   ____YES  ____NO

7. Have you included a copy of the form you used to indicate to patients that you were under supervision?
   ____YES  ____NO

8. Have you submitted to the Training Director two formal written evaluations completed by the primary supervisor?
   ____YES  ____NO

9. Please describe the population parameters with whom you hope to practice with your conditional prescribing license (for example, only adults, only children, severely mentally ill, etc).
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

10. Please describe the range of disorders treated during your practicum experience.
    ______________________________________________________________________________________
    ______________________________________________________________________________________
    ______________________________________________________________________________________

11. How many of these were seen for acute conditions and chronic conditions.
    Acute ________  Chronic ________

12. In general terms, please provide evidence that you have seen a diverse set of patients throughout the lifecycle of various ethnicity and social/cultural backgrounds.
    ______________________________________________________________________________________
    ______________________________________________________________________________________
    ______________________________________________________________________________________

13. Do you attest that the primary or secondary supervisor was on site?
    ____YES  ____NO

14. Did your primary or secondary supervisor review charts and records?
    ____YES  ____NO

15. Will you attest that there was at least one hour of supervision for every eight hours or direct service?
    ____YES  ____NO

16. What was the date you began your practicum and completed your practicum?
    Begin__________     Ended__________

17. In evaluating your application, the Board of Psychologist Examiners reserves the right to request clinical records from the applicant or the Training Director. Do you certify, that if requested by the Board of Psychologist Examiners, you can and will make available to the Training Director of SIAP/NMSU or the Board of Psychologist Examiners clinical records that support all of the experiences described above?
    ____YES  ____NO
I, _________________________, swear or affirm under penalty of perjury under the laws of the State of New Mexico, that all forms requested are attached and that everything written above is complete and true.

Sworn this _____________ day of ______________________________, 20_____, at ______________________________.
City and State

____________________________________
Signature

STATE OF ________

COUNTY OF ________________

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____________ DAY OF ________________, 20________

SEAL

Signature of Notary Public:_______________________________
My Commission expires on:_______________________________