oasis
counseling for
women & children

Client Name: ________________________

INFORMED CONSENT FOR TREATMENT

Welcome to Oasis. This document ("the Consent") contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). Although these documents are long and sometimes complex, it is very important that you read them carefully before your first session. Your counselor will go over the main points on this document with you and can answer any questions you may have at that time. You may revoke this Consent in writing at any time. That revocation will be binding unless we have already taken action; if there are obligations imposed on us by your health insurer in order to substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

The Counseling Process: Counseling is a cooperative learning process that offers opportunities for personal growth through insight, behavior change, problem solving, and better coping with stressors. This process requires a commitment to explore the problems that brought you to counseling, and the more you invest of yourself, the more you will gain from the process. During the course of counseling, you may experience distressing memories, feelings, and thoughts; similarly, the insights you gain may change aspects of your life, including personal relationships. You have the right to refuse to participate in any area of therapy and to limit your level of personal exploration. To maximize the benefits of counseling, it is best to promptly communicate your questions, concerns, needs, and/or plans for treatment to your counselor.

Confidentiality: Under the code of ethics for Licensed Professional Counselors, Licensed Marriage and Family Therapists, Licensed Clinical Social Workers, and Psychologists, your personal health information, particularly information shared in the counseling session, is strictly confidential and will not be disclosed without your prior written authorization except in these situations:

1) When there is clear and immediate danger to you, other individuals, or society, we are required to intervene. If we believe you pose a life-threatening risk to yourself or to others, we may need to notify responsible individuals for your protection. In this case, we may call your emergency contact person, a friend or relative, or summon the police to take you to a hospital for psychiatric evaluation or observation.
2) Child abuse reporting laws in the State of Alabama require counselors to report suspected cases of child abuse to the Department of Human Resources. Child abuse and neglect may include physical, emotional or sexual abuse of children and the abandonment of children.
3) If we know that an elderly or disabled adult has been abused, neglected, and/or exploited, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.
4) If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, we will not disclose information without your (or your legal representative's) written authorization, a subpoena, or a court order.
5) In order to receive payment from insurance companies or other agencies, we may be asked to release details about your treatment with us. When disclosing information we will make reasonable efforts to limit the information to the minimum necessary to accomplish the intended purpose of the disclosure.
6) At times, we may consult with a professional outside of the agency if we feel it is needed to offer the best possible service for you. During such consultations we make every effort to avoid revealing the identity of the client. Consultations with other professionals specific to your case are documented in your file, thus becoming part of your Clinical Record. Members of the agency's clinical team (i.e. therapists and case managers) routinely consult with each other about all cases. This is done to ensure the most effective treatment for you, the client.
7) Children under the age of 14 (and who have not been emancipated) will need their parents' or legal guardians' consent for

treatment. Adolescents who are 14 years of age or older, can give legal consent for treatment in the state of Alabama, and will need to sign authorizations for their parents or guardians to access their treatment records. Although parents or guardians may have legal rights to access the treatment records of minors under 14, the confidential nature of the therapeutic relationship with children is to be respected. Children need to know that they can trust their counselor and feel safe and secure in their counseling sessions. Because privacy in counseling is crucial to successful progress, particularly with adolescents, we request that parents agree to respect the child's privacy by only accessing their treatment records when there is a clear need (such as for ensuring continuation of care, advocating for child's interests on their behalf, etc). We will provide parents and guardians with general information regarding the child's progress in treatment. Furthermore, we will promptly notify parents or guardians of any and all safety concerns that may arise. As much as possible, we will attempt to discuss the matter with the child and gain their permission for sharing the information before we do so.

8) We reserve the right to use the information you share to evaluate our services. No identifying information will be used in conjunction with such evaluation.

HIPAA and Client's Rights: The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights related to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices ("the Notice") detailing the use and disclosure of your PHI for treatment, payment, and health care operations. The Notice, which is attached to this Consent (or available for download next to this document), explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Furthermore, HIPAA provides you with privacy protections and rights with regard to your Clinical Record. These rights include: requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which protected disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a copy of this Agreement and the document entitled Notice of Privacy Practices.

Alabama Medicaid Coverage: Medicaid requires that information about your treatment be shared with your referring physician. If you have any concerns related to your care, you may speak with your counselor. **By initialing this section of the Informed Consent, you are agreeing to the disclosure of your PHI to your referring physician. Initials__________**

Appointments: Appointments last **fifty minutes**. Counseling is a time-sensitive activity and your appointment is reserved specifically for you. Please make every effort to arrive a few minutes early to your appointment so as to allow enough time for check in. If you know you are going to be late to an appointment, please call the office and let us know. A pattern of tardiness to appointments may result in appointment cancellations. If you must cancel or reschedule an appointment, please call **24 hours** before the appointment time. **If you cancel in less than 24 hours of the appointment time, you will be charged one-half of the regular session fee. If you fail to show for your scheduled appointment without calling, you will be charged your regular fee for the missed appointment.** If there is a consistent pattern of failed or cancelled appointments, you will need to speak with your counselor before any further appointments can be scheduled. You may be referred to another agency as a result of appointment non-compliance. Adults accompanying children under 14 years of age must remain in the agency premises during the entire appointment, even if the child is meeting with the counselor alone.

Length and Termination of Counseling Sessions: The number and frequency of counseling sessions may vary depending on the type and severity of problems. Your counselor will take into account individual factors and discuss a time frame that meets your needs. You may terminate therapy at any time, at your discretion. We encourage clients to discuss thoughts or plans to terminate therapy with counselors. Your therapist, as a representative of Oasis, may also terminate services and refer you to other providers or agencies in the community for continued treatment. Reasons for termination include, but are not limited

to: successful achievement of treatment goals; lack of payment (high unpaid balances); failure to comply with treatment recommendations; conflicts of interest; client's failure to participate in therapy; therapeutic needs that are outside of our scope of services or competence; client failure to follow the terms established in this consent document; or conflict between client and counselor that cannot be resolved and leads to an ineffective therapeutic relationship. Because of the importance of the therapeutic relationship between client and counselor, we generally recommend clients come in for one or more sessions to discuss what was accomplished in treatment and possible transition to other providers. This is particularly important if the therapy involves children. These sessions are intended to facilitate a positive termination experience and treatment continuity if necessary. We will attempt to ensure a smooth transition by offering information on community resources if requested.

Fees and Payment: Your fee is based on your annual income and number of dependents. We ask that you provide accurate information concerning your income and inform us if there are any changes while receiving counseling at Oasis. Payment is expected at the time of treatment. Appointment scheduling will be interrupted if payment is not received for two appointments. If you have concerns regarding the amount of your fee or payment of your fee please discuss with your counselor and/or the Office Manager.

Electronic Communication: Oasis Counseling seeks at all times to maintain and respect the confidentiality of each client, including not only the details of any services rendered but also the fact that an individual may have contacted us. Please note that electronic communication such as email, and texting, is not a secure form of communication and confidentiality cannot be guaranteed. The use of electronic communication to communicate with Oasis is discouraged; however, with your express permission, electronic communication may be used for scheduling and confirmation of appointments but should not be used for communicating information regarding the nature or content of the counseling process.

Business Hours: Our business hours are from 8:30 a.m. to 5:00 p.m. Monday through Friday. Early morning appointments may be arranged at your counselor's discretion. If you leave a voicemail message after hours, we will return your call as soon as possible, usually within 24 business hours. However, if you feel that you need immediate assistance after-hours, you should contact the 24-hour Crisis Center at (205) 323-7777, or go to the nearest emergency room.

Legal Proceedings: If you are involved in a legal matter, your attorney may request copies of your records or that your counselor testify in court. There are additional charges for provision of records and/or time needed by the counselor to prepare for court and/or testify. These need to be discussed with your counselor if such services are requested. A subpoena is required for any release of records for court proceedings.

Client Grievance: Although it is unlikely, conflict may arise between you and your counselor or another staff member. These are the steps we will take to resolve such conflicts:

1) In the event a client has a problem or concern related to their treatment at Oasis, the client should first attempt to resolve the problem with the counselor.
2) If no satisfactory solution is achieved, or if the client is uncomfortable discussing the situation with the counselor, the client may bring the matter to the Clinical Director. The Clinical Director will keep a written record of the problem and the subsequent resolution.
3) If again, no satisfactory solution is achieved, or if the situation involves the Clinical Director, the client may bring the matter to the Executive Director. The Executive Director will keep a written record of the problem and the subsequent resolution.
4) If a problem or concern involves administrative staff, these issues should be reported in writing or by email by the counselor to the Executive Director.

Client Name: ______________________

Couples or Family Therapy: Oasis offers couples and family therapy by specifically licensed and/or certified clinicians. When clients receive individual counseling at Oasis in addition to couples or family therapy, the couples/family therapist will only consult with the individual therapist when permission is granted from all parties participating in couples/family therapy. As explained above, if you are involved in a legal matter, the courts may order counselors to testify about confidential matters if you raise the issue of your or your partner's mental health status. If you request records to be released and/or a court order is received, all couple therapy records (i.e. information about both parties) are therefore released. The couples therapist will contact both partners to notify them that such an order was received. Oasis highly recommends scheduling a consultation with your couples/family clinician prior to signing any authorization for release of records. If you are engaging in couple or family counseling all parties' signatures are required to authorize the release of couple/family therapy record information to anyone requesting such information, including any individuals involved in the couple/family therapy itself. Likewise, the therapist working with the couple or family will attempt to notify all parties involved in therapy of any inquiries or requests for medical records.

Case Management: Oasis offers case management services by a licensed social worker. These services are offered as needed, at the referral of counselors in the course of counseling treatment. All policies and procedures outlined in this document also apply to case management services. If you'd like to request or find out more about case management at Oasis, please talk to your counselor. This consent document also serves as consent for case management services, including appropriate referral(s) to the agency's case manager.

Acknowledgement and Consent: By signing below, I (the Client) acknowledge that I have reviewed and fully understand the terms and conditions of this Consent. I have discussed such terms and conditions with my counselor and have had any questions with regard to its terms and conditions answered. I agree to abide by the terms and conditions outlined in this document and consent to counseling and mental health treatment at Oasis. I also acknowledge that I have read and received a copy of the 'Notice of Privacy Practices'.

______________________	___/___/___	______________________
Client/Parent or Guardian Signature	Date	Printed Name/Relationship to client
______________________	___/___/___	______________________
Client/Parent or Guardian Signature	Date	Printed Name/Relationship to client
______________________	___/___/___	______________________
Client/Parent or Guardian Signature	Date	Printed Name/Relationship to client
______________________	___/___/___	______________________
Agency Representative	Date	Printed Name

WELCOME TO OASIS!

WE HOPE YOU HAVE A MEANINGFUL AND SUCCESSFUL COUNSELING EXPERIENCE.

1900 14th Avenue South Birmingham, AL 35205
P: 205-933-0338 f: 205-933-0343 oasiscounseling.org

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Client Name: ____________________

INFORMED CONSENT ADDENDUM FOR DISTANCE COUNSELING/TELETHERAPY

Purpose and Service Description

This form is designed to allow you to give informed consent for the use of telecommunications technology for distance counseling or teletherapy (the terms are interchangeable in this document). Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This document is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

Teletherapy is defined as the use of technology to have a therapy session. We will use doxy.me, a HIPAA compliant platform that uses video and audio technology through a webcam and microphone on your device and my device to connect us securely. At times, we may also use telephone calls from our agency landlines to whatever phone number you provide us.

Doxy.me uses point-to-point NIST-approved AES 128 bit encryption for all video & audio communication; full volume encryption and 256-bit AES encryption; and HIPAA and HITECH compliant servers. No data is stored on the doxy.me platform (such as documents, messages, progress notes, or recordings of video meetings). Your counselor will complete progress notes on each telehealth session--just like she does after each in-person session--and store it in your electronic health chart in Welligent, the agency's electronic health record platform, which is also HIPAA compliant and secure.

Benefits of Distance Counseling

The benefits of teletherapy include the convenience of location, scheduling, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations. Research shows that teletherapy is just as effective as in-person therapy for clients whose presenting problems are deemed appropriate for this kind of service.

At the beginning of your treatment—or before starting distance counseling sessions--your counselor will conduct a brief screening with you to ensure that teletherapy is appropriate for your needs. In case you or your counselor conclude that telehealth is not appropriate for you at this time, your counselor will talk to you about other options for care, including but not limited to, in-person sessions and referrals to other services or providers.

Limitations of Distance Counseling

Distance counseling should not be viewed as a substitute for face-to-face counseling or medication by a physician. It is an alternative form of counseling with some differences from traditional counseling.

Telecommunication may lack some visual or audio cues that on occasion may result in misunderstanding. Should this ever happen, it is important to assume that your counselor has positive regard for you, and to check out your assumptions with your counselor. This will reduce any unnecessary feelings of discomfort.

All technology has some limitations. Technology may occasionally fail before or during our session, posing the risk of service disruption and lower service quality. The problems may be related to internet connectivity, difficulties with

hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session. The therapist will make every effort to help get the session back on track if there is a disruption due to technology, but if this is not possible *due to technical problems on the part of the therapist*, you will not be charged for the session.

If you are having a crisis, acute psychosis, or suicidal or homicidal thoughts, video counseling might not be appropriate for you needs. Please promptly inform your counselor of your needs and discuss alternative services and modalities that can better meet them.

Emergency Management for Distance Counseling

So that Oasis is able to get you help in the case of an emergency and for your safety, the following measures are important and necessary:

• Your Oasis counselor will need to know the location/address in which you will consistently be during counseling sessions, and will need to know if this location changes. Please be advised that pertinent mental health laws limit licensed therapists in Alabama to provide teletherapy only within the state, to clients who reside and are located in Alabama.

Physical address of where you will be during sessions:

____

Nearest Emergency Room/Hospital: ______________________________

• Your counselor will request that you identify a person, whom you trust, who your counselor will contact should a situation occur that requires that immediate assistance be sent to your location. You, and/or your counselor, will verify that this emergency contact person is able and willing to go to your location in the event of an emergency, and if your counselor deems necessary, call 911 and/or transport you to a hospital.

Name of Emergency Contact: ______________________________

Relationship to you (client): ____________ **Phone Number(s):** ____________

• You will receive a flyer containing important information for you to know as you engage in telehealth. This flyer will contain some phone numbers and websites you can use in case of an emergency. Please keep this flyer somewhere you can easily retrieve it. Please consider sharing it with your emergency contact as well.

If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911. Your initials: ________

Client Name: ______________________

Client Responsibilities and Agreements

Maintaining the highest level of online security to your Protected Health Information (PHI) is both yours and your health provider's responsibility. In order to do all you can to protect your PHI, we ask you to agree to (please initial next to each item):

• Use a secure internet connection to access doxy.me (e.g. a password-protected network, not public wi-fi);
Your Initials: ___________

• Participate in telehealth sessions from a private location that allows for confidentiality (i.e. where no one will hear your conversation or interrupt your session);
Your initials: _________

• Have an initial session in-person or via video conferencing in order to verify your identity (e.g. by showing your photo ID and/or setting a password only you and the counselor know);
Your initials: _________ **Password for audio-only sessions:** ______________________________

• Not allowing another person to use my links, e-mail, ID, or passwords associated with computer log-ins and other telecommunication services.
Your initials: _________

Agreement and Consent to Treatment

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.

I understand that should we not be able to connect during a telehealth session for any reason, and I'm experiencing an immediate crisis or life-threatening situation, I will call 911 or go to the nearest emergency room.

I understand that although email is not a completely secure form of communication, my therapist may need to reach me through the e-mail address I provide on my record if they cannot reach me on the phone or through secure audioconferencing technology. I give permission for my therapist to e-mail me at the e-mail address provided in my record if needed.

I, voluntarily agree to receive distance counseling services for an assessment, continued care, treatment, or other services and authorize Oasis Conseling for Women and Children to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment,

or services and that I may withdraw consent for such care, treatment, or services that I receive through Oasis Counseling for Women and Children at any time. I understand Oasis Counseling for Women and Children will determine on an ongoing basis whether the condition being assessed and/or treated is appropriate for online therapy.

I agree to be contacted for the purposes of distance counseling in the following ways:

Phone number: ______________________ **Alternate Phone number:** __________________

E-mail address: ____

I consent to receiving messages with basic information about rescheduling at the phone numbers and e-mail address listed. **Your initials:** ____________

My verbal consent to this document will serve as informed consent for teletherapy services until I can provide the agency/my therapist with a signed copy of this document. Likewise, by accepting the 'terms of service' on oasiscouseling.doxy.me, I indicate my agreement and consent to the information outlined in this document.

By signing this informed consent and providing my contact information here, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____________________________ _________________________ ____________________

Client Name Client Signature Date

____ ____________________

Parent, Guardian or Legal Representative Name and Signature Date
(if minor or needed otherwise)

____ ____________________

Agency Representative Date

INTAKE INFORMATION – FOR ADULTS

Today's Date: ___________

GENERAL INFORMATION

Preferred Name ________________________________ DOB ___________ SSN ____________________

Legal Name (if different from preferred name): ____

Address _______________________________________ Home Phone _________________________

City/State/Zip ____ County _________________________

Cell Phone_______________________________________ OK to receive messages? [ ] No [ ] Yes

Work Phone ____

May we contact you at this number if we cannot reach you on your personal numbers? [ ] No [ ] Yes

Marital Status ___________________________________ Your Gender __________________________

Sexual Orientation ______________________________ Preferred Pronouns ______________________

Emergency Contact_________________________________ Emerg. Phone 1_________________________

Relationship _____________________________________ Emerg. Phone 2 _________________________

Address ____________________________________ City ______________State ____Zip _________

FINANCIAL INFORMATION

Gross Annual Family Income:______________________ Number of IRS dependents: ___________________

Health Insurance Carrier:______________________________ Policy Number: ______________________

If you must CANCEL or reschedule an appointment, please **call 24 hours before the appointment time.** You will be charged one-half of your regular fee if an appointment is cancelled **with less** than 24 hours notice. If you fail to come for your scheduled appointment **without calling**, you will be charged your full fee. **Please Initial**______

If no payment has been made for more than two sessions, we will not schedule another session until some payment has been made. **Please Initial**______

I HAVE REPORTED ALL INCOME/ASSESTS FOR MY WHOLE HOUSEHOLD, AS NOTED ABOVE. I understand that I must notify the Business Office in the event that this information changes. I understand that I am responsible for all charges incurred while I am a client at Oasis Counseling, unless I have indicated another responsible party to the Oasis Office Manager. I understand that session fee will be: $_______ (To be completed by Oasis)
I will notify Oasis of any changes in my financial status.

______________________________ ______________________
CLIENT SIGNATURE DATE

______________________________ ______________________
AGENCY REPRESENTATIVE DATE

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PRESENT CONCERNS/CIRCUMSTANCES

Reason for seeking counseling: ____

____

Please check all events that have occurred within the past 12 months:

[ ] Significant marital conflicts
[ ] Separation
[ ] Divorce
[ ] Spouse with emotional difficulties
[ ] Death of spouse
[ ] Death of close family member
[ ] Death of close friend
[ ] Personal injury or illness
[ ] Change in financial status
[ ] Change in residence
[ ] Physical assault
[ ] Other stressors__________________

[ ] Marriage
[ ] Pregnancy
[ ] Birth of child
[ ] Gain of new family member
[ ] Child leaving home
[ ] Significant conflicts at work
[ ] Losing job
[ ] Change in job
[ ] Legal problems
[ ] Natural Disaster (flood, tornado)
[ ] Sexual assault

Are you interested in case management? [ ] No [ ] Yes

If so, what would you like the case manager's help with? ______________________________

____

Please indicate if you have any notable changes or concerns with the following:

____ Sleep: Please describe ____

____ Eating Habits: Please describe ______________________________________

____ Exercise: Please describe ____

____ Other: Please describe ____

HEALTH INFORMATION

Primary Physician ____

Medical Problems ____

Current Medications ____

____

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History of hospitalizations? [ ] No [ ] Yes

If yes, please list years and reasons of past hospitalizations: ______________________________

____

____

Do you use alcohol? [ ] No [ ] Yes How much/How often: ______________________

Do you use drugs? [ ] No [ ] Yes What/How often: ______________________

Substance Abuse Treatment History: Dates: ______________________________

Location: ____

Have you ever been physically, sexually, or emotionally abused? ☐ Yes ☐ No

Past experience in counseling/therapy:

Counselor Name ______________________________ When ______________

Reason for counseling at the time ______________________________________

Risk Assessment: Have you ever...

...Thought about suicide? (when)______________________________________

...Attempted suicide? (when)______________________________________

...Thought about killing someone else? (who, when) ______________________

...Tried to kill someone else? (who, when) ______________________________

PROFESSIONAL INFORMATION

Education Level ____

Current Employer______________________ Occupation ______________________

FAMILY INFORMATION

Family History

____ Suicide attempts, please identify family member ______________________

____ Death by suicide, please identify family member ______________________

____ Alcohol abuse, please identify family member ______________________

____ Other Substance abuse, please identify family member ______________________

____ Mental Illness, please identify family member ______________________

Please briefly describe your relationship with the following family members:

Mother______________________

Father______________________

Siblings (please list siblings)______________________

____

Partner(s) (please include name and age)______________________

Children/step-children (please list names and ages, and describe relationship) ______________________

____

Who lives in the household with you?______________________

Describe your primary support system ______________________

SOCIAL INFORMATION

Leisure and recreation activities/hobbies:______________________

Religious affiliation ______________________

Other community involvement: ______________________

LEGAL INFORMATION

Any legal problems or history of arrests? [ ] No [ ] Yes Explain ______________________

____

Please add any additional information that you wish:______________________

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Client Name: ______________________ **Date:** ______________

PATIENT QUESTIONNAIRE – PRIME-MD

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems?**

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

Total Score: ____________

United Way
of Central Alabama, Inc.

1900 14th Avenue South · Birmingham, AL 35205-4906
Telephone 205 933 · 0338 or Fax 205 933 · 0343
www.oasiscounseling.org

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Client Name: ______________________________ Date: __________

ANXIETY SCREEN

	Yes	No
1. Most days I feel very nervous	☐	☐
2. Most days I worry about lots of things.	☐	☐
3. Most days I cannot stop worrying.	☐	☐
4. Most days my worry is hard to control.	☐	☐
5. I feel restless, keyed up or on edge.	☐	☐
6. I get tired easily.	☐	☐
7. I have trouble concentrating.	☐	☐
8. I am easily annoyed or irritated.	☐	☐
9. My muscles are tense and tight.	☐	☐
10. I have trouble sleeping.	☐	☐
11. Did the things you noted above affect your daily life (home life, or work, or leisure) or cause you a lot of distress?	☐	☐
12. Were the things you noted above bad enough that you thought about getting help for them?	☐	☐

Total Score ________

Client Name: ______________________ **Date:** ____________

WHO-Five Well-being Index (WHO-Five)

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3 in the upper right corner.

	Over the last two weeks	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	I have felt cheerful and in good spirits	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2	I have felt calm and relaxed	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3	I have felt active and vigorous	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	I woke up feeling fresh and rested	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5	My daily life has been filled with things that interest me	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Total Score: ______