Stewart Behavioral Health, LLC

Has client been seen at Stewart Behavioral Health before? Yes No Date: _____

Client's Legal Name/Nickname: _____

Sex: ___ Age: _____ Race: _____ Birthday: _____ Social Security #: _____

Employment Status (circle one): Full-time Student Part-time Student Employed Unemployed/Other

Marital Status (circle one): Single Married Divorced Other

Address: _____

City: _____ State: _____ Zip: _____

Parent/Caretaker (If Applicable): _____

Primary Phone #: _____ Alternative Phone#: _____

Email: _____

Do you accept messages via: Voice messages: Yes No

Text: Yes No

Email: Yes No

Relation to client of person filling out this packet:

Self Parent Stepparent Grandparent Foster Parent Legal Guardian Other: _____

Emergency Contacts:

Name: _____ Phone: _____

Relationship to Client: _____

Name: _____ Phone: _____

Relationship to Client: _____

PLEASE FILL OUT THE FOLLOWING

Client's Insurance Provider: _____ **Name on Insurance Card:** _____

ID #: _____ **Insured's Birthday:** _____

Please continue to next page.

Client Name: _____ **Date:** _____

Please read each section carefully and sign or initial as indicated:

Thank you for choosing Stewart Behavioral Health, LLC. This document is intended to inform you of our policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and we will do our best to provide you with information you need. **In signing the following agreement, I am consenting to participate in counseling services. I agree to attend scheduled counseling appointments. I understand that counseling appointments are dependent on a case by case basis, sometimes ranging from 30 minutes to 90 minutes.**

Mission Statement

At Stewart Behavioral Health (hereinafter may be referred to as SBH), we are dedicated professionals committed to providing quality counseling services. It is our overall goal to enhance the quality of life for individuals and families at all stages of life. Our belief is that all people are valuable and unique and should be treated with dignity and respect. We strive to uphold a caring, confidential and professional environment to support clients throughout the counseling process.

Scheduling and Appointments:

Office hours may vary depending on the provider that you work with. We have several providers that provide services and with that we typically can offer times that may accommodate most clients. We cannot guarantee that the available schedule may accommodate all clients but, in the event, that this occurs we will support the client by providing alternative options.

Administrative staff is available 9 A.M. - 7 P.M. Mondays through Thursday.

Throughout the day, we check our messages regularly, and whenever possible we try to return calls the same day. If we have not returned your call within 24 hours, please try again. We strive to meet all our clients' needs within our scope of practice and your communications are important and valued.

Missed Appointments:

All appointments should be cancelled at least 24 hours in advance. In the event an appointment is not cancelled within the allowable time, you will be charged $50.00 for the missed appointment. If you miss a scheduled visit, and you do not call our office within seven days to reschedule, your counselor will accept that as your notice that you have terminated this agreement and that you wish to discontinue counseling with our office.

Initials indicate that you have read and agree: _____

Management Contact Information:

Clinical Director: Martha Stewart, mstewart@stewartbehavioralhealth.com.
Office manager: Randa Abbott, rabbott@stewartbehavioralhealth.com.

Fees:

It is customary to pay for professional services at the time they are rendered. We accept various forms of insurance, cash, checks and credit cards and will provide a receipt upon request. You are responsible for any fees that may be incurred as a result of participating in counseling services.

Associated fees may vary dependent on the type of service rendered. A schedule of fees is available upon request. If you fail to pay or are unable to pay, we may refer you to another provider.

Initials indicate that you have read and agree: _____

Please continue to next page.

**EMERGENCY PROCEDURES:

If an emergency occurs while you are not at SBH, please call emergency services (911). If you would like to contact your counselor regarding your situation, you may call the office at 843-407-5419 at your convenience. SBH will follow those emergency services with standard counseling and support to the client and/or to the family of the client. If an emergency occurs while you are at SBH, we will call emergency services (911).

Crisis prevention intervention is verbal and/or physical de-escalation. If something occurs during a session involving a client becoming agitated/aggressive/violent, our first attempt will be to verbally de-escalate the situation. If that fails, the counselor or front office staff will contact emergency services (911) to diffuse the situation. If you want more information on our procedures, please ask to see our "Policies and Procedures Manual."

Initials indicate that you have read and agree: _____

In the event of an emergency, I agree to call 911 or report to the nearest emergency room for treatment. I will notify my counselor of any emergencies.

_____ _____

Signature (Client/Parent/Guardian/Legal Representative) Date

Confidentiality:

The information you share in psychotherapy is protected health information (PHI) and is considered confidential by both South Carolina statute law and federal regulations. Exceptions to confidentiality include:

1. **Revealing intent to harm self or others.**
2. **Abuse of a child, the elderly or medically vulnerable.**
3. **Intent to commit a crime.**
4. **If my counselor is provided with a court order.**
5. **For billing purposes if a release of information is granted by client or guardian.**
6. **If a Release of Confidential Information is endorsed by client or caregiver.**
6. **If information is necessary for supervision or consultation.**

Also, there may be times that an intern will be asked to observe and/or participate in session for the purposes of enhancing your treatment and the profession. Please be aware that you may refuse to have an intern in your session at any time.

Please note that a specific Consent for the Release of Information may be revoked by writing to our privacy officer. You may ask any staff member for assistance in this area. However, please be aware that information may have been shared prior to the date of revocation, and this cannot be changed.

Additionally, SBH may need to disclose PHI for purposes of treatment such as coordination and consultation or for general healthcare operations. This may a requirement for some certification, compliance and licensing procedures. Information may also be shared with law enforcement, should a crime be committed on our premises or against our staff.

Initials indicate that you have read and agree: _____

Please continue to next page.

Ethics:

SBH follows the Code of Ethics of the South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists.

Some ethical considerations are:

- At SBH, we dedicate ourselves to serving the best interests of each client.
- At SBH, we will not discriminate against clients or professionals based upon age, race, creed, disabilities, handicaps, preferences or other personal concerns.
- At SBH, we are committed to maintaining an objective and professional relationship with each client. Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned.
- At SBH, we respect the rights and views of other mental health professionals.
- At SBH, we will appropriately end services or refer clients to other programs when necessary or in the best interest of the client.
- At SBH, we will evaluate our personal limitations, strengths, biases and effectiveness on an ongoing basis for the purposes of quality treatment for our clients and self-improvement as professionals. We will continually attain further education and training.
- At SBH, we respect various institutional and managerial policies but are committed to assisting in improving such policies if this is in the best interests of the client.
- **Please note that if you believe that any of your rights have been violated, we will gladly direct you to the necessary agency to address your concerns.**

Initials indicate that you have read and agree: _____

Please continue to next page.

****IF SERVICES ARE FOR YOURSELF AND NOT YOUR CHILD, skip to Emergency Procedures Section****

Consent for Treatment of Minors:

If you are requesting services for a child as the guardian or parent, it will be critical that the child trust the therapist. With your understanding in advance, we shall keep what your child says/does confidential.

If we think it would be helpful to share a specific detail with you, we shall first ask the child's permission to do so, or we shall encourage the child to do so. It is important to the therapy process that he/she does not think the parent and the therapist are conspiring against him/her in any way. You have the right and responsibility to question the therapy process, to understand the nature of activities with the child, and to be informed of the child's progress. We have the right to use our clinical discretion as to what is appropriate disclosure. We shall review the child's progress in therapy with you, and we want to obtain feedback from you regarding your interactions with the child and observations of the child in various settings. In this way, we shall work as a team. We value your consultations with us and your involvement. We shall discuss with you how you can participate effectively in the child's treatment and progress outside of therapy.

I consent that _____ may be treated as a client by _____.
Child/Adolescent Counselor

_____ _____
Parent/Guardian Signature Date

Consent for Treatment of Minor

The minor named below lives in my home. **Yes** **No**

Name of Child: _____ Child's Date of Birth: _____

Your Name (please print): _____

Your relationship to child: Parent Stepparent Guardian Grandparent Other

- I hereby swear that I have the following **legal custody** (circle appropriate): **Joint** **Sole** **None**
- I hereby swear that I have a legal right to obtain treatment for the above-named child: **Yes** **No**
- In instances of divorce, it is essential that the legal custodian of the child grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order which names you the legal custodian of the above child. Are you willing to do so? **Yes** **No**

If the answer to any of the above questions is "No," counseling services cannot be provided to the above-named child until a copy of the court order which names you the legal custodian is provided to this office.

In the event of your counselor's death or disability, SBH may designate a proper custodian to be responsible for the care of your records.

Initials indicate that you have read and agree: _____

Please continue to next page.

Informed Consent:

Your signature verifies you have been offered a copy of this document and the HIPAA document.

Further you need to be aware:

- Treatment is not always successful and may open unexpected emotionally sensitive areas.
- Counselors with SBH are not physicians and cannot prescribe medications.
- Counselors with SBH may need to consult with your physician, attorney, or other counselor.
- Counselors with SBH are not available 24 hours a day.
- Counselors with SBH are licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists; this Board is located in The Synergy Center (Kingstree Building) in Columbia, South Carolina at 803-896-4652 (mailing address is P.O. Box 11329, Columbia, SC 29211-1329).

Initials indicate that you have read and agree: _____

I further acknowledge that I seek and consent to treatment for (please circle): **myself** **my child**

with Stewart Behavioral Health. My signature below confirms that I understand and accept all the information contained in the ***Stewart Behavioral Health Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights***.

My signature verifies that:

- I have read, understand, and agree to ***the Stewart Behavioral Health Professional Disclosure Statement and Informed Consent for Treatment and the HIPAA Client's Rights***.
- I am aware of its content and policies and understand that a copy of this Signature Statement will be a part of my case record.
- I have read it and if necessary, I have discussed and clarified my understanding of it with a representative of Stewart Behavioral Health.
- I agree to abide by the terms/policies set forth in this document.
- I consent to have the above-named minor(s) receive therapeutic services provided through Stewart Behavioral Health, LLC (SBH) without a parent or guardian present.

_____

Client name (please print)

_____ _____

Client/Guardian Signature Date

_____

Witness Signature

****The majority of this document is mandated by both South Carolina State law and Public Law 104-191.**

Please continue to next page.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request. All information revealed by you in counseling or therapy session and most information placed in your counseling file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA. ***As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization.*** The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in your therapist's Professional Disclosure Statement and Consent for Treatment.

1. Use or disclosure of the following protected health information does not require your consent or authorization:
2. Uses and disclosures required by law *-like files court-ordered by a Judge*
3. Uses and disclosures about victims of abuse, neglect, or domestic violence *-like the Duties to Warn explained in your therapist's/counselor's Disclosure Statement*
4. Uses and disclosures for health and oversight activities *-like correcting records or correcting records already disclosed*
5. Uses and disclosures for judicial and administrative proceedings *-like a case where you are claiming malpractice or breech of ethics*
6. Uses and disclosures for law enforcement purposes *-like if you intend to harm someone else (see Duties to Warn in your therapist's/counselor's Disclosure Statement)*
7. Uses and disclosures for research purposes *-like using client information in research; always maintaining client confidentiality*
8. Uses and disclosures to avert a serious threat to health or safety *-like calling Probate Court for a commitment hearing.*
9. Uses and disclosures for Workers' Compensation *-like the basic information obtained in counseling as a result of your Worker's Compensation claim*

YOUR RIGHTS AS A COUNSELING CLIENT UNDER HIPAA

- As a client, you have the right to see your counseling file. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.
- As a client, you have the right to receive a copy of your counseling file. This file copy will consist of only documents generated by us. You will be charged copying fees @ $.20/page. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.
- As a client, you have the right to request amendments to your counseling file.
- As a client, you have the right to receive a history of all disclosures of protected health information. You will be charged copying fees @ $.20/page.
- As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
- As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.
- A copy of this notice is available upon request

_____ _____

Client name (please print) Date

_____

Client/Guardian Signature

Please continue to next page.

Appointment Cancellation Policy

Patient Name _____ Date of Birth _____

In order to maximize the benefits of therapy, it is very important that all scheduled appointments are attended. The consistency of attending therapy sessions assures that you and/or your child will obtain maximum treatment benefit and assist in meeting your goals. A missed or late appointment disrupts therapy schedules that impact both you and other patients.

Stewart Behavioral Health, LLC strives to provide professional and quality services to all individuals, children, couples and families that we serve. We will do our best to accommodate scheduling requests for every client and build a schedule that meets your needs. Please understand that in working to meet your needs we must ask that our clients adhere to our attendance policy.

We anticipate that you will adhere to the following:

1. I understand that missing three scheduled therapy appointments in a six-month period is grounds for discharge from therapy. If I must cancel the appointment due to an illness or emergency, I will contact the office as soon as possible. Family emergencies will be taken into consideration.
2. I understand that if two consecutive appointments are missed, then I may only reschedule at the discretion of my counselor. If my counselor does not allow me to reschedule a new appointment, I will not be seen at Stewart Behavioral Health for six months.
3. I agree to call to cancel my appointments at least 24 hours in advance. If I do not call to cancel and do not attend therapy, this will be considered a "no-show."
4. I understand that two "no-shows", within a six-month period, are grounds for discharge from therapy.
5. I understand that if my appointment is missed and I do not call the office within 7 days to reschedule, my counselor will accept that as notice that this agreement has been terminated and that I do not wish to continue counseling services.
6. I understand that if I arrive fifteen minutes late, I may not receive therapy that day, depending on what the therapist had planned for that session.
7. I understand that two times tardy for therapy equals an absence.
8. I agree to notify the therapist at least one week in advance of vacations or extended leave of absence for the duration of my scheduled treatment sessions.
9. I may be charged a cancellation fee of $50 when appointments are not attended nor cancelled appropriately.

In signing this form, you are indicating that you understand the attendance policy and the consequences of not keeping your appointments. Following these guidelines will greatly facilitate quality of treatment. Thank you for your cooperation.

_____

Client/Guardian Signature Date

_____

Staff Signature Date

Please continue to next page.

Client Electronic Messaging Usage Consent

Your therapist will use reasonable means to protect the security and confidentiality of information sent and received through electronic means (i.e. email, text messages, etc.). However, because of the risks identified below, your therapist cannot guarantee the security of email communication, and is not liable for improper disclosure of confidential information that is not caused by the therapist's intentional misuse.

RISKS OF USING ELECTRONIC MESSAGING TO COMMUNICATE WITH YOUR THERAPIST

Transmitting client information electronically has a number of risks that clients should consider before using electronic communication methods to communicate with your therapist. These include, but are not limited to, the following risks:

- Electronic messaging can be circulated, forwarded and stored in numerous paper and electronic files.
- Electronic messaging can be immediately broadcast worldwide and be received by unintended recipients.
- Electronic messaging senders can easily type in the wrong email address.
- Electronic messaging is easier to falsify than handwritten or signed documents.
- Backup copies or electronic messaging may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect Electronic messaging transmitted through their systems.
- Electronic messaging can be intercepted, altered, forwarded, or used without authorization or detection.
- Electronic messaging can be used to introduce viruses into computer systems.
- Electronic messaging can be used as evidence in court.

CLIENT OBLIGATIONS WHEN CONSENTING TO ELECTRONIC MESSAGING

- Use electronic messaging for general client information only. Do not use electronic messaging for medical emergencies, other time sensitive matters, or for non-general medical information. Include your name in the body of the message and identify the category of question in the subject line. Include a phone number where you can be reached. Please review your electronic messaging to make sure your question is as clear as possible.
- Follow-up with your therapist if you have not received a response to your electronic messaging within 5 business days.
- Take precautions to preserve the confidentiality of electronic messaging. Use screen savers and safeguard your computer password.
- Inform your therapist of any changes to your e-mail address, phone number or any other communication methods. .
- Withdraw consent to electronic messaging client information through hard copy written communication to your therapist.

ALTERNATE FORMS OF COMMUNICATION

I understand that I may also communicate with the therapist via telephone or during a scheduled appointment and that the electronic messaging is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive information.

TYPES OF ELECTRONIC MESSAGING TRANSMISSIONS THAT CLIENT AGREES TO SEND AND/OR RECEIVE

The types of information that can be communicated via Electronic messaging with your therapist includes: appointment scheduling requests, billing and insurance questions and patient education. Your therapist will not engage in email communication that is unlawful, such as unlawfully practicing therapy across state lines. If you are not sure if the issue you wish to discuss should be included in an Electronic messaging, you should call your therapist's office to schedule an appointment.

HOLD HARMLESS

I agree to indemnify and hold harmless the therapist, his/her therapy practice, Stewart Behavioral Health, LLC and staff/contractors, website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the therapist's web-site, any arrangements you make based on information obtained by the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The therapist does not warrant that the functions contained in any materials provided will be interrupted or error-free, that defects will be corrected, or that the therapist's website or server that makes such site available is free of viruses or other harmful components.

Please continue to next page.

TERMINATION OF THE ELECTRONIC MESSAGING RELATIONSHIP

The therapist shall have the right to immediately terminate the electronic messaging relationship with you if he/she determines, in his/her sole discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engage in conduct which the therapist determines, in his/her sole discretion to be unacceptable. The electronic messaging relationship between the therapist and the client will terminate in the event the therapist, in his/her sole discretion, no longer wishes to utilize the electronic messaging to communicate with all his/her patients.

FORWARDING ELECTRONIC MESSAGES

I understand that there may be times in which the therapist must forward the information I have provided via electronic messaging to a third party for treatment, billing and payment purposes. I expressly provide my consent to allow the therapist to forward these Electronic messaging to a third party under these conditions and evidence my consent by placing my initials below:

Initials indicate that you have read and agree: _____

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the therapist and acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of electronic messaging between the therapist and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the therapist may impose to communicate with patients by electronic messaging. Any questions I may have had were answered.

Client name (Print): _____ Date: _____

Client/Guardian Signature: _____ Date: _____

Client E-mail Address: _____

Please continue to next page.

Consent for the Release of Confidential Information: Insurance

Client Name (Last, First, MI)	DOB

I, _____,

(name of client/guardian)

authorize Stewart Behavioral Health to disclose to

Insurance Provider/Payer:

(person or organization to whom the disclosure is to be made)

The following information: Identifying information, dates attended, diagnosis, treatment plan, billing information,

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cannot be disclosed without my written consent unless otherwise provided for in the regulations, such as revealing intent to harm myself or others; abuse of a child, the elderly, or medically vulnerable, if I reveal intent to commit a crime, or if it is court ordered. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

1 year following case closure or upon last payment.

(specification of the date, event or condition upon which this consent expires)

I understand that generally, Stewart Behavioral Health, may not condition my treatment on whether I sign a consent form, but that, in certain limited circumstances, I may be denied treatment if I do not sign a consent form.

Client Name	Date
Client/Guardian Signature	Date
Witness Signature	Date

Please continue to next page.

Consent for the Release of Confidential Information: Primary Care Physician

Client Name (Last, First, MI)	DOB

I, _____,

(name of client/guardian)

authorize Stewart Behavioral Health to disclose to

Primary Care Physician/Practice:

(person or organization to whom the disclosure is to be made)

The following information: Identifying information, attendance, diagnosis, treatment plan, behavioral observations, evaluations, assessments, recommendations, impressions, consultation,

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cannot be disclosed without my written consent unless otherwise provided for in the regulations, such as revealing intent to harm myself or others; abuse of a child, the elderly, or medically vulnerable, if I reveal intent to commit a crime, or if court ordered. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

1 year following case closure or upon last payment

(specification of the date, event or condition upon which this consent expires)

I understand that generally Stewart Behavioral Health may not condition my treatment on whether I sign a consent form, but that, in certain limited circumstances, I may be denied treatment if I do not sign a consent form.

Client Name	Date
Client/Guardian Signature	Date
Witness Signature	Date

Please continue to next page.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	