BRIGHTER DAYS COUNSELING SERVICES, LLC
www.brighter-days.net

P.O. BOX 7974
LAKE CHARLES, LA 70606
748 E. BAYOU PINES, SUITE B
LAKE CHARLES, LA 70601
Phone: (337) 515-5654
Fax: (337) 214-1836
karensteenlpc@brighter-days.net

CHILD INTAKE FORM

Child Information:

Name: _____ Today's Date: _____ Sex: *M* __ *F*__

Age: _____ Birth Date: _____ Grade: _____ School: _____

Parent/Caregiver Information:

Name: _____ Relationship to child: _____

Relationship Status: *Single* __ *Married* __ *Separated*__ *Divorced*__ *Widowed*__ *Long-term Relation*__

Custody/Court Papers: *Y*__ *N*__ Right to seek counseling services? *Y*__ *N*__ Sex: *M*__ *F*__

Employer: _____ Birth Date: _____

Mailing Address: _____

Physical Address:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____ May we confirm appointments by *email*___ or *text*___

Are you remarried? *Y*__ *N*__ Name of Spouse: _____

Other Parent:

Name: _____ Relationship to child: _____

Relationship Status: *Single* __ *Married* __ *Separated*__ *Divorced*__ *Widowed*__ *Long-term Relation*__

Sex: *M*__ *F*__ Employer:_____ Birth Date: _____

Mailing Address: _____

Physical Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ May we confirm appointments by *email*___ or *text*___

Are you remarried? *Y*__ *N*__ Name of Spouse: _____

In the event of an emergency, whom should we contact?
Name: _____Relationship: _____
Cell Phone: _____Email: _____
Which number may we leave a message? ____ *Home* ____ *Cell* ____ *Other*: _____

Please provide a copy of both sides of your insurance card and driver's license for verification of benefits & identity. Thank you.

If there has been psychological testing completed for this child, please provide a copy of the reports with this form.

Have you ever sought counseling for child before? Yes ___ No___

If yes, name of professional: _____ Duration of counseling: _____

Who referred you to this counselor?

_____Self/Former Client
_____Family/Friend
_____School
_____Courts/Judicial System
_____Managed Care
_____Employee Assistance Program
_____Insurance Carrier
_____Other _____

I may not be able to see your child until you supply a copy of all appropriate papers related to the custody of your child including the most recent legal custody arrangements.

Please initial in blank provided indicating you understand the above statement. _____

Problem Description:

Please list the main reason for seeking counseling at this time _____

_____

Under what conditions does the problem or pattern seem to get worse? _____

_____

Under what conditions does the problem or pattern usually improve? _____

_____

How long has the problem or pattern existed? _____

What would you like to get out of counseling at this time? _____

_____

Family/Home Information:

List all persons living in the home: (*please add any additional names on back of form)*

NAME (first, last)	**Relationship**	**Age**	**Birth Date**

List any immediate family members not living with you due to some type of separation.

Is there a family history of any of the following: (please check all that apply)

____ ADD/ADHD ____ Alcohol Abuse ____Anxiety ____ Arrests ____ Bipolar Disorder
____ Depression ____ Domestic Violence ____ Drug Abuse ____ Dyslexia ____ Learning Disabilities
____ Oppositional Behavior ____ Physical Abuse ____ Postpartum Depression ____ Schizophrenia
____ Seizures ____ Sexual Abuse ____ Tics or Tourettes

Family Atmosphere (circle the number that best describes how you view your current family)											
Very Lenient	1	2	3	4	5	6	7	8	9	10	Very Strict
Very Relaxed Environment	1	2	3	4	5	6	7	8	9	10	Very Tense Environment
Very Unstructured	1	2	3	4	5	6	7	8	9	10	Very Structured
Few Expectations	1	2	3	4	5	6	7	8	9	10	High Expectations
Consistent	1	2	3	4	5	6	7	8	9	10	Inconsistent

Parent Assessment of Child:

List the child's strengths:

1. _____
2. _____
3. _____

List the child's areas needing improvement:

1. _____
2. _____
3. _____

List the child's main difficulties in school and/or daycare:

1. _____
2. _____
3. _____

List the child's main difficulties at home:

1. _____
2. _____
3. _____

Briefly describe the child's friendships: _____

_____

Briefly describe the child's hobbies and interests: _____

_____

Describe how the child is disciplined: _____

_____

For what reasons is the child disciplined: _____

_____

Briefly describe the child's way of expressing the following emotions or behaviors:

Anger: _____

Happiness: _____

Sadness: _____

Anxiety: _____

Developmental History:

Pregnancy, Labor and Delivery

Duration of Pregnancy _____ Did the mother smoke? ***Y***___ ***N***___ (if yes, how many packs per day?)_____

Was there any drinking or drug use by mother during this time? ***Y***___ ***N***___

How far along was the mother when she ceased drinking or drug use? _____

Please describe fully: _____

Were there any complications during pregnancy (i.e., illness, injuries, hospitalization, etc.)? ***Y*** ___ ***N*** ___

Please describe: _____

Any complications during labor/delivery (i.e., premature, lack of oxygen, injuries to mother or child, incubator care, infections, etc.)? ***Y***___ ***N***___ Please explain: _____

During the following periods did your child experience problems with any of these?

Infancy through First Year

Primary caregiver(s) during this time _____

Any changes in, or separation from, primary caregiver lasting more than 2 weeks: ***Y***___ ***N***___ How long? _____

Did not enjoy cuddling	Y N	Excessive irritability	Y N
Was not calmed by being held or stroked	Y N	Diminished sleep	Y N
Difficult to comfort	Y N	Frequent head banging	Y N
Colic	Y N	Problems with nursing or taking bottle	Y N
Excessive restlessness	Y N	Constantly into everything	Y N

Other concerns:

Toddler (Second to Third Year)

Primary caregiver(s) during this time _____

Any changes in, or separation from, primary caregiver lasting more than 2 weeks: ***Y***___ ***N***___ How long? _____

Excessively active	Y N	Irregular patterns of sleep, appetite, habits	Y N
Cranky/irritable	Y N	Discomfort with any auditory, tactile, visual stimulation	Y N
Withdrawn/fearful	Y N		

Was your child on time, early, or late in reaching developmental milestones? Please explain.

_____

Has your child ever experienced traumatic experiences (such as changes, deaths in family, divorce, etc.)?
Please explain: _____

_____

Symptom	Frequently	Sometimes	Rarely	Never

Fails to give close attention to details or makes careless mistakes				
Has difficulty sustaining attention in tasks or play activities				
Doesn't seem to listen when spoken to directly				
Doesn't follow through on instructions and fails to finish tasks				
Has difficulty organizing tasks and activities				
Avoids or is reluctant to engage in tasks that require sustained effort				
Loses things necessary for tasks or activities				
Is easily distracted by external stimuli				
Is forgetful in daily activities				
Fidgets with hands or feet or squirms in seat				
Leaves seat in situations in which remaining seated is expected				
Runs about or climbs excessively in situations in which it is inappropriate				
Has difficulty playing or engaging in leisure activities quietly				
Is "on the go" or acts as if "driven by a motor"				
Talks excessively				
Blurts out answers before the questions have been completed				
Has difficulty awaiting turn				
Interrupts or intrudes on others (butts into conversations or games)				
Loses temper				
Argues with adults				
Actively defies or refuses to comply with adults' requests or rules				
Social problems (difficulty making friends)				
Deliberately annoys people				
Blames others for his or her mistakes or misbehavior				
Is touchy or easily annoyed by others				
Negative/Pessimistic outlook				
Restricted range of affect (i.e., unable to have loving feelings)				
Sense of foreshortened future				
Loss of interest in typical likes or hobbies				
Difficulty falling or staying asleep				
Trouble relaxing				
Irritability or outbursts of anger				
Difficulty concentrating				
Hypervigilance				
Exaggerated startle response				
Excessive distress when separation from home or loved ones is anticipated				
Excessive worry about losing, or harm happening to, a loved one				
Excessive worry that some bad event will lead to separation from loved ones				
Depression				
Lonely				
Shy				
Tearful				
Reluctance of refusal to go to school or elsewhere because of fear				
Excessive fear to be alone at home or elsewhere without loved ones				
Reluctance or refusal to go to sleep without being near loved ones				
Nightmares or night terrors				
Complaints of physical symptoms when separation occurs or is anticipated				
Frequent headaches or stomachaches				
Symptom	Frequently	Sometimes	Rarely	Never

Substance use resulting in a failure to fulfill major obligations at school				
Substance use in situations in which it is physically hazardous (i.e., driving)				
Substance use related to legal problems				
Substance use despite recurring social or interpersonal problems				
Urges to hurt others				
Thoughts of suicide or hurting self				

Parent Information:

Please describe your relationship (both positive and negative) with your child.

_____

Please describe the other parent's relationship with your child.

_____

Please describe your communication with your child.

_____

Please rate and describe your stress level with your child. (1=low to 10=high)

_____

Please list any parenting challenges (anxiety, work stress, depression, single parent, etc.)

_____

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Insurance Information

*Please provide a copy of both sides of your insurance card and driver's license for verification of benefits and identity. You can either scan and email these to karensteenlpc@yahoo.com or take a picture and text it to 337-515-5654 if you would like your benefits verified prior to your appointment. You can bring these with you on the day of your appointment if you would like it to be verified at that time.

RESPONSIBLE PARTY

Name: _____ Birth Date: _____
Address: _____
Drivers License #: _____ SS#_____ Phone: _____
Prefer billing and correspondence: _____ *Email* _____ *Physical Address* _____ *Mailing Address*

INSURANCE INFORMATION

Who is the insured? _____ SS # _____
Birth Date: _____ Relationship to Client: _____
Cell Phone: _____ Work Phone: _____
Employer of Insured: _____
Insurance Company Name: _____
Insurance Phone # for Mental Health _____ Member ID#: _____
Group ID#: _____

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that Brighter Days Counseling Services, LLC will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold Brighter Days Counseling Services, LLC liable for insurance nonpayment due to misquoted benefits. I will not hold Brighter Days Counseling Services, LLC responsible to know and understand my benefits plan. Brighter Days Counseling Services, LLC will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request benefits be paid to Brighter Days Counseling Services, LLC.

Signature of Client and/or Responsible Party: _____
Date: _____

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Court / Report Policy

This policy needs to be signed by each client receiving services in order to provide for any potential future needs from this office involving the described services below

I, _____, understand that fees for Karen Steen, MA, LPC-S, to appear in court are as follows:

Appearance fees are billed at the court rate of **$250.00** an hour with a 2 hour minimum with a deposit of **$750.00** required before the scheduled court date. If the counselor does not appear in court and all matters have been completely settled the deposit will be refunded, minus a **$100.00** court preparation fee and any outstanding balance for appointments and requested reports. Depositions are billed at **$150.00** per hour due upon completion of interview.

As a general rule, progress notes are not released without a judge's order. In lieu of progress notes, a written report and case summary can be provided with signed releases. Report fees are billed at a rate of **$150.00** per hour. If you, the Client, chooses to not release your file or records to the court, you will be responsible for all attorney fees, court fees, and filing fees associated with your decision to not release your information. Brighter Days Counseling Services, LLC or Karen Steen, MA, LPC-S will not be responsible for any legal fees accrued by the client.

Services involving mental health assessments of any kind require a **$500.00** deposit prior to making any appointments and are billed as follows: **$150.00** per 1 hour session, **$150.00** per hour for reports, and **$150.00** per hour for phone consultations between assessed parties and/or their attorneys which will be prorated accordingly. Any balance that remains beyond the deposit must be paid in full prior to the release of the reports. An extensive assessment report involving your individual therapy that does not require the assessment of other parties is also billed at the rate of **$150.00** per hour paid in full prior to the release of the report.

All of the above services cannot be billed through your insurance carrier, therefore are your full responsibility.

If you do not understand any of the information contained in this policy or have any questions concerning this policy, please do not hesitate to bring your concerns to your counselor.

_____

CLIENT **DATE**

_____

COUNSELOR **DATE**

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Request / Authorization for Releasing / Obtaining Information

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Parent/Guardian Name (if minor)_____

I, _____, hereby authorize Brighter Days Counseling Services, LLC and Karen L. Steen, MA, LPC-S (118 State St, Lake Charles, LA 70605) to exchange information with _____ (name of individual or organization). This information will be shared for the following purpose(s):

☐ Assist with treatment planning for the continuity of care

☐ Document a need for services

☐ Other: _____

Individual or Organization Information

Name: _____ Contact Person: _____

Address: _____ Phone: _____

_____ Fax: _____

I understand that I may revoke this consent at any time. I further understand that this consent may not be renewed without my written consent. This consent will expire in one year from the signature date.

_____ _____ _____

Client Signature or Parent/Guardian/ Representative | Printed Name | Date

DECLARATION OF PRACTICE AND PROCEDURES

KAREN L. STEEN, MA, LPC-S
748 Bayou Pines East, Suite B
Lake Charles, LA 70601
Phone: (337) 515-5654
Fax: (337) 214-1836
karensteenlpc@brighter-days.net

QUALIFICATIONS: I hold a Master of Arts in Clinical/Counseling Psychology from McNeese State University. I am licensed as a Licensed Professional Counselor (#3088) with the LPC Board of Examiners, which is located at 11410 Lake Sherwood Avenue North, Suite A, Baton Rouge, LA 70816, phone: (225) 295-8444 & fax: (225) 295-8448. I am an LPC-S, certified to supervise Provisional Licensed Professional Counselors working towards their licensure in the State of Louisiana.

AREAS OF EXPERTISE: I have training and experience working with individuals, adults, adolescents, children, families, couples and groups on a variety of issues such as depression, anxiety, interpersonal relationships and other mental health concerns. I have training in the field of Infant Mental Health and have done dyadic work with mothers and infants and have provided mental health consultation to childcare centers in the five parish area. I have training in and work with clients using Eye Movement Desensitization Reprocessing (EMDR) therapy which is aimed at giving relief to individuals suffering symptoms related to trauma. I am currently working towards certification for this specialized therapy. I also have training in and practice Anthetics Therapy involving inner figure work with individuals to relieve their suffering from a variety of mental health issues.

THERAPEUTIC RELATIONSHIP: I view the counseling relationship as one built on trust, where teamwork is a must. We will work to develop and implement goals to improve your quality of life. While it is not possible or realistic to guarantee certain results, together you and I can work to achieve positive results for you.

I see a variety of people and use a variety of formats including individual, dyadic, couples, families and group settings. I choose techniques that fit each client's beliefs and needs individually and techniques that will be the most beneficial to them. While I typically prefer to use EMDR, Anthetics Therapy or the cognitive- behavioral approach, I often integrate other theoretical approaches into the sessions.

CODE OF CONDUCT: It is important for you to realize that we are entering a professional relationship and that you are experiencing me in my professional role. I am best able to serve you if our relationship stays strictly professional and if our sessions focus only on your concerns. Additionally, while I can assist in understanding the consequences of making certain decisions, my professional code of conduct prohibits me to advise you how to make decisions. I am required by state law to adhere to the Code of Conduct for practice that has been adopted by the Louisiana Licensed Professional Counselors' Board of Examiners. A copy of the code of Conduct is available upon request.

PRIVILEGED COMMUNICATION: I am required to abide by the professional practice standards for Licensed Professional Counselors and Louisiana law. Information shared during sessions will be kept confidential, with certain exceptions, such as a client's written consent authorizing the sharing of information or when I am mandated or permitted by law to disclose information.

State law mandates that I report to the appropriate authorities suspected cases of child abuse/neglect, elder abuse/neglect (60 or older), or abuse/neglect of a disabled person, and instances in which you are believed to be a danger to yourself or someone else. Certain types of litigation may result in a court-order to release information without your consent.

In family counseling situations, information obtained from an individual adult client may be shared with the client's family members only with the written consent of the client, with the exception of marriage counseling situations. Material which is discussed with a minor client may be shared with the client's parent or legal guardian.

In marriage counseling situations, I do not withhold information from one spouse/partner which is provided to me by another spouse/partner. This includes any and all information provided to me through individual counseling sessions with a spouse/partner or through any type of electronic communication such as email, phone calls, texts, etc. Should you desire such confidentiality, I can assist you with a referral to a therapist who can provide marriage counseling where such information is shared only with your written consent or I can assist you with a referral to a therapist who can provide you with individual counseling that can occur in conjunction with the marriage counseling I provide to you and your spouse/partner.

FEE SCALES: The cash/self pay fee for an initial 45-50 minute individual or family session is $120.00. The cash/self pay fee for additional 45-50 minute sessions is $75.00. If insurance is being used, client is responsible for any copay or deductible required by their insurance company. Fees can either be paid at the end of the session with cash, check, debit or credit card, or client can choose to receive email invoices to be paid upon receipt. As a courtesy, I will submit claims to insurance companies for you. Any portion not paid by your insurance company will be your responsibility. Except in the event of an emergency, any cancellation or rescheduling of appointments made with less than 24 hours notice will result in your being charged the full session fee. Arriving late does not extend the counseling hour. All sessions will end at the scheduled time regardless of the time at which you arrive for the appointment. This is a courtesy to other clients who may be scheduled after your appointment.

CLIENT RESPONSIBILITIES: As a client, your honesty and participation are necessary if progress and success are the desired results. During this process, should questions or concerns arise regarding the services received, I would hope that you would share those with me so that we can address those issues. If you should feel you would be better served by another mental health provider, I will assist you with a referral. If you are currently seeing another mental health professional, I ask that you inform me of this and grant me permission to share information with them so that we may coordinate our efforts to better serve you.

In the counseling relationship, clients are primarily responsible for following appointment scheduling procedures, making a committed effort in the counseling process, and terminating one counseling relationship before beginning another.

POTENTIAL COUNSELING RISK: The client should be aware of the possibility that counseling could result in having underlying issues brought to the surface which you may not have been aware of prior to the onset of the counseling relationship.

PHYSICAL HEALTH: Physical health can be an important factor in an individual's emotional well being. If you have not had a physical examination within the past year, it is recommended that you do so and that you provide me with a list of any medications which you are currently taking, in an effort to help me better serve you.

AFTER HOURS AND EMERGENCY SITUATIONS: If a crisis or emergency should arise, you may seek assistance through hospital emergency room facilities or by calling 911.

_____

Client Signature Date

_____

Karen L. Steen, MA, LPC-S Date

I, (parent or guardian) _____, give permission

for Karen L. Steen, MA, LPC-S to conduct counseling with my (relationship)

_____ (name of minor) _____ .

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Notice of HIPAA Practices

Information such as the content of the message, email addresses, etc.

- Email providers (Gmail, Yahoo, etc) keep a copy of each email on their servers, where it might be accessible to their employees or other company individuals

Karen Steen takes precautions to help minimize the chance of a compromise in your Personal Health Information

- Cell phones and lap top contains password protection
- When electronic devices such as cell phone or laptop is retired, it is first "wiped" of all information before it is either recycled or destroyed
- If there is a breach of your Personal Health Information, I will personally contact you to inform you of the extent of the breach and the plan to contain the situation
- I will not sell any of your Personal Health Information for marketing purposes
- I follow all Ethical Codes which help in securing your information. You may obtain a copy of the Codes on the Louisiana LPC Board's Official Website.
- All HIPAA documentation will be kept on file for a minimum of 6 years

Storage of Client Files

Your client file containing your Personal Health Information as well as any and all information concerning treatment are stored in a locked file cabinet for 5 years after the date of the last session. If something should happen to me, the LPC Board has a designated counselor on record who is responsible for taking possession of my files. They will store them under the same guidelines to protect your confidentiality. When a file is ready to be destroyed, it is shredded.

CLIENT PRIVACY

Private Health Information may be used and/or disclosed in the following situations:

- Information that is necessary in order to file insurance claims and complete billing and collection procedures
- When required for workman's compensation
- When required by any state or federal law, such as in cases of abuse or neglect
- When required by any specialized government or military functions
- When required in cases of an individual who is confined to a correctional

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institution or under any type of law enforcement supervision
- When used for any clerical purposes and necessary file audits by managed care companies

As a client, you have the following rights with regard to your Personal Health Information:

- The right to review or receive a copy of your records by signing and providing a written request. Under rare circumstances, a request may be denied. In such cases, you may choose to receive a summary of progress instead which will include information about symptoms and treatment plans. Requests for records will receive a response or will be completed within 15 days
- The right to request information on any party that has requested information pertaining to your Private Health Information from me
- The right to receive confidential information about your Private Health Information
- The right to revoke this consent in writing. However, please be aware that it will not affect any information already disclosed
- The right to request a copy of this notice at any time

As a mental health professional, I have the responsibility to:

- Make each client aware of the Privacy Notice and any changes made to it
- Make necessary changes to the Privacy Notice as required by law

The protection and security of your Personal Health Information is very important to me. If you have questions or comments about this Privacy Notice, please let me know. If you as the client feel your privacy has been violated, you have the right to contact the U.S. Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/ . Any and all complaints filed against me will be recorded on this company's Complaints Form and provided to any and all of Karen's clients with the intake paperwork.

By signing below, I acknowledge that I have read and understand this document.

_____ _____
Client Signature Date

_____ _____
Karen L. Steen. MA. LPC-S Date

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Notice of HIPAA Practices

Please take a moment to review the following notice carefully as it describes my duty to protect your Personal Health Information. Protecting the privacy and security of my client's Personal Health Information is important to me. This notice describes how I may use your information or disclose it, what your privacy rights are and how you may gain access to your own Personal Health Information.

PRIVACY PRACTICES

Designated Security and Privacy Officer for Brighter Days Counseling Services, LLC

Karen L. Steen, MA, LPC-S is the designated Security Officer and Privacy Officer and all privacy and security questions, concerns or requests should be directed to me as I will be responsible for handling them.

How Karen Steen Uses and/or Discloses Your Personal Health Information

Abuse, Neglect or Domestic Violence – As a mandated reporter in the State of Louisiana, if I believe you or your child/children may be victims of abuse, neglect or domestic violence I may disclose health information about you or your child/children to the appropriate agency which requires me to disclose this information.

Serious Threat to Safety or Health – I may use or disclose information about you or your child/children if I believe that there is a serious and immediate threat and that it is needed in order to protect the safety of you, your child/children, a person, or the public.

Judicial Proceedings – I may use or disclose you or your child/children's health information in any judicial proceeding if I receive a court ordered subpoena that requires me to disclose it.

Privacy and Security Policies

All reasonable measures have been taken to ensure confidentiality of any and all electronic information sent and received (i.e. emails, texts). It is important for you to be aware of the risks taken when information is shared in this format. Some possible risks of sharing personal or confidential information in this way:

- Accidental delivery of an email or text to an incorrectly typed address or phone number
- Email accounts may be "hacked" giving a 3rd party access to sensitive

DES

Eve Bernstein Carlson, PhD **Frank W Putnam, MD**

Directions

this questionnaire consists of 28 questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

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

(never) (always)

Date_____ Age_____ Gender M__ F__

1. Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle the number to show what percentage of the time this happens to you.

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

2. Some people find that sometimes they are listening to someone talk and they suddenly realized that they did not hear part or all of what was said. Circle the number to show the percentage of the time this happens to you.

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

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle the number to show what percentage of the time this happens to you.

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

4. Some people have the experience of finding themselves dressed in close that they don't remember putting on. Circle the number to show what percentage of the time this happens to you.

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

5. Some people have the experience of finding new things among the belongings that they do not remember buying. Circle the number to show the percentage of the time this happens to you.

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

6. Some people sometimes find that they are approached by people that they do not know or who call them by another name or insist that they have met them before. Circle the number to show the percentage of the time this happens to you.

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

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle the number to show what percentage of the time this happens to you.

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

8. Some people are told that they sometimes do not recognize friends or family members. Circle the number to show what percentage of the time this happens to you.

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

9. Some people find that they have no memory for something or the events in their lives (for example, a wedding or graduation). Circle the number to show what percentage of the time this happens to you.

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

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle the number to show what percentage of the time this happens to you.

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

11. Some people have the experience of looking in the mirror and not recognizing themselves. Circlet the number to show the percentage of the time this happens to you.

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

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle the number to show what percentage of the time this happens to you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were 2 different people. Circle the number to show what percentage of the time this happened to you.

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

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

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

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

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

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

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

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

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

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

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

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

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