Tandra T. Baker, Tapestry of Wellness, LLC
LPC-MH, LAC, QMHP & Linehan Board Certified DBT Clinician
6810 S Lyncrest Avenue, Suite 201, Sioux Falls, SD 57108
Tel: (605) 530-2968 Fax: 605-215-0405

PATIENT REGISTRATION SHEET

Today's Date:	**Please Print**	

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address:	City:	State:	ZIP Code:		
Home phone #: ( )	Cell/Other contact #: ( )	Social Security #:	Birth Date: / /	Sex: ❑ M ❑ F	
Email:					
Employer:	Occupation:	Work phone #: ( )			
Street Address:	City:	State:	ZIP Code:		
Notify Primary Care Physician? ❑ YES ❑ NO	Name of Primary Care Physician	Contact #: ( )			

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone #: ( )	Cell phone #: ( )

INSURANCE INFORMATION

Insured's Last Name **(if different):**	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone #: **(if different)** ( )	Cell/Other contact #: ( )	Social Security #:	Birth Date: / /	Sex: ❑ M ❑ F	
Insurance Company:	Insurance Billing Address:	Insurance phone #: ( )			
Policy #:	Group #:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company:	Insurance Billing Address:	Insurance phone #: ( )			
Policy #:	Group #:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. *I understand that I am financially responsible for any balance.* I also authorize Tandra T. Baker, Tapestry of Wellness, LLC & those acting on her behalf, and my insurance company to release any information required to process my claims.

Right to Refuse Treatment: I understand that I have the right to refuse any treatment.
Confidentiality: I understand that all information concerning me is held in confidence and can only be released with my written permission, with the following exceptions: my therapist is legally required to report to designated authorities when it is believed someone is a danger to themselves or others, including child/elder abuse/neglect, or as required by federal or state law. Your therapist may be involved in case consultation within DBT Teams and Midwest Health Management Services as needed.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

Patient/Guardian signature *Date*

*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations.***
*** Otherwise, your account will be charged the full fee for the session time. Thank you for your cooperation. ***

Release Authorization Form

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I, _____, whose Date of Birth is _____, authorize *Tandra T. Baker, Tapestry of Wellness, LLC, LPC-MH, QMHP, LAC* to disclose to and/or obtain the following information from:

Name: _____ **Phone:** _____

Address: _____

Fax: _____ **Email:** _____

Describe the purpose of this authorization:

_____

_____

Description of Information to be Disclosed:

_____ Assessment	_____ Psychological Evaluation	_____ Diagnosis
_____ Psychosocial Evaluation	_____ Continuing Care Plan	_____ Billing Records
_____ Treatment Plan/Summary	_____ Alcohol & Drug Use Evaluation	_____Educational
_____ Presence/Participation in Treatment	_____ Progress in Treatment	_____ Other _____
_____ Demographic Information	_____ Mutually Unrestricted	

I understand the following:

1. This authorization is voluntary and I may refuse to sign this authorization without it affecting my health care or the payment for my health care

2. that I may revoke this authorization, in writing, at any time by sending written notification to Tandra T. Baker, Tapestry of Wellness, LLC. I further understand that a revocation of the authorization is not effective on any actions that were taken prior to the revocation or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law that provides the insurer with the right to contest a claim under that policy.

3. that this authorization will expire one year from the date of signing unless revoked in writing.

4. I further understand that *Tandra T. Baker, Tapestry of Wellness, LLC,* will not condition my treatment on whether I give authorization for the requested disclosure and that it has been explained to me that failure to sign this authorization may have consequences.

5. That unless you have specifically requested in writing that the disclosure be made in certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

6. That Federal law prohibits this person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

7. That *Tandra T. Baker, Tapestry of Wellness, LLC* agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health care plan, health care clearinghouse or health care provider federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by the HIPAA rules.

_____ _____

Signature of Patient/Client/Guardian **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual) power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

_____ _____

Tandra T Baker, MA, LPC-MH, LAC, QMHP **Date**

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Intake Information

Client Name: _____ Date: _____

Check which of the following you have had in the past 6 months:

___ Anxiety	___ Increased appetite	___ Panic Attacks
___ Decreased appetite	___ Depressed Mood	___ Suicidal thoughts
___ Suicide attempt	___ Fear	___ Decreased Sleep
___ Increased Sleep	___ Relationship concerns	___ Anger
___ Increased alcohol consumption	___ Racing thoughts	___ Delusions
___ Hallucinations	___ Hopelessness	___ Increased energy
___ Trauma	___ Loss	___ Inability to focus
___ Medical concerns	___ Self-harming	___ Tearfulness
___ Legal problems	___ Other _____	

Briefly describe why you are seeking help at this time?

_____
_____
_____

Have you had any previous counseling? Y ____ N _____
If yes, who?

_____
Name **Phone Number**

May we contact them? Y _____ N _____ (additional Release of Information needed to contact)

Describe any current or recurrent health problems you or your family may have?

_____
_____

List all medications in use (name, dosage, frequency, who prescribes them):

_____
_____

Any other information you would like the therapist to know:

_____
_____
_____

What is your general goal for counseling?

_____
_____
_____
_____

Who referred you?

_____

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Informed Consent & Service Agreement

Client Counselor Service Agreement:
This document contains important information about the professional services and business policies offered by Tandra T. Baker, Tapestry of Wellness, LLC. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between you, the Client, and Tandra T. Baker, LPC-MH, LAC, QMHP, BC-TMH, the
Mental Health Provider, for therapeutic services to be provided and accepted. Any questions that arise can be discussed when you sign this form or at any time in the future. Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your Mental Health Provider, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Counseling:
There can be many goals for the counseling relationship. Some of these will be long-term goals such as improving the quality of your life, learning to live with mindfulness, etc. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for counseling, they will be set by the Client according to what they want to work on in counseling. The Mental Health Provider may make suggestions on how to reach that goal, but the Client decides where they want to go.

Risks/Benefits of Counseling:
Counseling is an intensely personal process, which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a
very active effort on your part. To be most successful, you will have to work on things that are discussed outside of sessions. However, there are many benefits to counseling. Counseling can help a person develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

Emergencies:
If you are experiencing a mental health emergency or severe crisis, such as thoughts of self-harm or ending your life, please call or text:

Avera Behavioral Health 1-800-691-4336

Suicide Prevention Lifeline1-800-273-8255

Crisis Text Lifeline Text “HOME” to 741741

Local Emergency Response Services Dial 9-1-1

Eligibility for TeleMental Health Services:
Participants participating in TeleMental Health must first consult with Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC to discuss eligibility and well as the terms and conditions that apply to said services. All participants must be at least 18 years old. Prior to joining the telehealth session you can schedule an online interview and orientation session. You will need to have all agreements and consents signed and returned prior to being allowed into the telehealth session time.

If it is determined at any point that telehealth is not likely to or not meeting your needs Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC reserves the right to refuse and/or make appropriate treatment recommendations.

TeleMental Health does not provide crisis counseling. It is not appropriate for participants who are:

- suicidal
- homicidal
- engaging in violent behavior
- have a recent history (within last 12 months) of:
    - a major psychiatric episode
    - hospitalizations due to an overdose, suicide attempt, psychiatric episode or eating disorder
    - actively participating in addiction behaviors.

Failure to disclose this information or knowingly mislead excludes Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC from any legal obligations or liability related to said participant.

Nature of Online Support Meetings and What you can expect:
The duration of individual sessions vary from 30-58 minutes and groups from 60-90 minutes. The number of groups and individual sessions are determined by both yourself and your counselor.

You as the participant understands that TeleMental Health have limitations (as well as benefits) compared to in-person meetings. At times there may be internet limitations and connection. If a life threatening crisis should occur, you agree to contact a crisis hotline in your area, call 911, or go to a hospital emergency room. You also agree to use DBT phone coaching as agreed upon between you and your therapist. You also understand that I follow the professional laws and regulations put in place by the Counselor Licensing Board of the State of South Dakota (USA) as well as the American Counseling Association. The groups and sessons will be considered to take place in the state of South Dakota (USA).

Expectations of TeleMental Health:

- You agree to fully participate in the sessions, both offering and receiving communication
- You agree to attend all scheduled sessions, to arrive on time and stay the full allotted time

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- You agree to sitting in one place, not walking away from your device for the duration of the session
- You agree to do everything that you can to maintain confidentiality of all those involved by doing the following
    - Use a pair of headphones
    - Joining in a private room and not allowing others in the room with you
    - Making sure others are not able to see your screen
    - Making sure that others are not able to hear the session
    - Signing out fully from the platform after each session
    - Do not record sessions
    - Use a secure internet connection rather than a free/
- You agree to practice effectively utilizing your skills while in groups and individual sessions to help you achieve your wise mind goals
- You understand there are no guarantees of what you will experience, and that you enter this Agreement and at your own risk
- You agree that you understand the possible advantages and disadvantages of TeleMental Health and shall not hold accountable Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC for any information or insight distributed here
- If you are not feeling satisfied with your support for any reason, you are asked to discuss this directly with me and I will work with you to uncover what might be preventing the most effective support
- If you are unable to attend a meeting you must notify your therapist 24-hours in advance. If you do not give 24 hour notice you will be charged for the session
- You agree to confirm with your insurance company that they cover telemental health video sessions. If they do not you are responsible for the full fee of your session
- You agree to keep all payment arrangements and understand that insurance coverage is not guaranteed

Privacy Policy:
According to mental health licensing statutes, the law protects the privacy of all communications between a participant and practitioner. Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC is in compliance with the requirements of HIPPA. Confidentiality is taken seriously and discussing or releasing your information to any individual, agency, or corporation except if such release is requested by a signed authorization form (see below); or if a participant indicates intent to do harm to her/himself or others.

Confidentiality Policy and Limits of Confidentiality:
TeleMental Health groups and individual sessions are strictly confidential and may not be revealed to anyone without your written permission. There are exceptions to confidentiality where disclosure is required by law (see below). Additionally, there may be times that I need to consult with a colleague in order to discuss aspects of our work together. The Notice of Privacy Practices provides detailed information about how private information about your health care is protected and under what circumstances it may be shared. Confidentiality of cell phones, text messages, and e-mail are generally considered unsecured ways of communication. If you choose to participate in these types of communication you do so being fully aware of these limitations. At the same time understand that Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC will attempt to make it as secure as she can and asks the same of you. You will not be connected to from any form of social media and ask that you do not try to connect through any social media platforms. You understand that there are limitations to confidentiality with all these things and agree to not hold Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC liable for any breech in this way.

Every effort to keep information confidential is made. Likewise, it is asked that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends. It is encouraged for you to only communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured. Be sure to fully exit all online platforms and password protect your computer, email, phone and text messages.

If we are unable to connect or are disconnected during a group or induvial session due to a technological breakdown, please restart your computer and log back in. If reconnection is not possible please communicate that with your therapist.

Legal Exemptions to Confidentiality:
Legal exceptions to confidentiality are in place to protect your safety and the safety of others. This includes when there is reasonable suspicion of child abuse (physical, sexual, emotional, neglect), adult dependent care abuse, elder abuse/neglect, and when a participant threatens to harm or kill others, or intent to damage another person's property. Legally, I am a mandated reporter of abuse or intent to harm another. If you're homicidal and make a serious threat to hurt another person or persons I will contact 911 and make every attempt to inform the intended victim or victims. Additionally, if I am court ordered to release records, I must abide by the court order. I may be compelled by court order to testify and must answer all questions honestly.

Telephone and Emergency Procedures:
If you need to speak with me between sessions, please call 605-530-2968. Your call will be returned as soon as possible. Messages are checked less frequently on weekends and holidays. If an emergency situation arises that requires immediate attention, you may call the emergency National Suicide Hotline at 800-784-2433 or dial 911. If a life-threatening crisis should occur, you agree to contact a crisis hotline, call 911 or go to a hospital emergency room.

Payment for Services:
The TeleMental Health Groups and Individual Sessions will be submitted to your health insurance plan. You are responsible to know what your coverage is and you are responsible to pay all co-pays deductibles, co-insurance and denials. You agree to pay at the time of service. If you have other payment arrangements those will continue to apply.

Cancellation Policy:
Cell phones cannot guarantee confidentiality, however, if for any reason you are not able to attend the meeting please call or send a text message to 605-530-2968. If the meeting is cancelled due to Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC not being able to attend I will do my best to contact you to inform you of this prior to the meeting time.

No-Show and Missed Meetings:
If you do not show up for a scheduled session or have not notified your therapist 24-hours before your session time you will be charged the full session fee. You are responsible for keeping track of and attending the scheduled sessions.

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Internet Access:
The sessions are held through a HIPAA compliant platform. The sessions are in Central Standard Time (CST). You will need to have access to a secure computer that allows both video and audio communication.

By signing this form I understand that TeleMental Health sessions are technical in nature and that there may be problems with internet connectivity, which is the fault of neither Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC and yourself. Internet availability may be limited or disrupted by things such as server maintenance, upgrades, or other problems (such as software or hardware malfunction) or natural or man-made disasters (such as internet viruses and so forth). These types of problems are beyond all of our control.

Although Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC have taken a significant number of steps to ensure the confidentiality and privacy of online communication(s), these actions, in whole or in part, cannot guarantee the security of internet transmissions. I permanently agree to release and indemnify Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC from all suits, claims, formal complaints and other actions originating from services provided.

Release of Information:
By signing this agreement you are providing unrestricted consent for Tandra T. Baker, LPC-MH, LAC, QHMP, BC-TMH/Tapestry of Wellness, LLC to seek consultation with other professionals if/when necessary.

_____

Client Signature *Date*

_____

Therapist *Date*

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Name: _____ Date: _____

The Michigan Alcohol Screening Test (MAST)

Directions: read read each question carefully and answer yes or no to the following questions:

		Yes	No
1.	Do you feel you are a normal drinker? ("normal" is defined as drinking as much or less than most other people)		
2.	Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?		
3.	Does any near relative or close friend ever worry or complain about your drinking?		
4.	Can you stop drinking without difficulty after one or two drinks?		
5.	Do you ever feel guilty about your drinking?		
6.	Have you ever attended a meeting of Alcoholics Anonymous (AA)?		
7.	Have you ever gotten into physical fights when drinking?		
8.	Has drinking ever created problems between you and a near relative or close friend?		
9.	Has any family member or close friend gone to anyone for help about your drinking?		
10.	Have you ever lost friends because of your drinking?		
11.	Have you ever gotten into trouble at work because of drinking?		
12.	Have you ever lost a job because of drinking?		
13.	Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking?		
14.	Do you drink before noon fairly often?		

		Yes	No
15.	Have you ever been told you have liver trouble, such as cirrhosis?		
16.	After heavy drinking, have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?		
17.	Have you ever gone to anyone for help about your drinking?		
18.	Have you ever been hospitalized because of drinking?		
19.	Has your drinking ever resulted in your being hospitalized in a psychiatric ward?		
20.	Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem?		
21.	Have you been arrested more than once for driving under the influence of alcohol?		
22.	Have you ever been arrested, or detained by an official for a few hours, because of other behavior while drinking?		

For Office Use Only: Code: _____

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Name: _____ **Date:** _____

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question

		Yes	No
1.	Have you used drugs other than those required for medical reasons?		
2.	Have you abused prescription drugs?		
3.	Do you abuse more than one drug at a time?		
4.	Can you get through the week without using drugs (other than those required for medical reasons)?		
5.	Are you always able to stop using drugs when you want to?		
6.	Do you abuse drugs on a continuous basis?		
7.	Do you try to limit your drug use to certain situations?		
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?		
9.	Do you ever feel bad about your drug abuse?		
10.	Does your spouse (or parents) ever complain about your involvement with drugs?		
11.	Do your friends or relatives know or suspect you abuse drugs?		
12.	Has drug abuse ever created problems between you and your spouse?		
13.	Has any family member ever sought help for problems related to your drug use?		
14.	Have you ever lost friends because of your use of drugs?		

		Yes	No
15.	Have you ever neglected your family or missed work because of your use of drugs?		
16.	Have you ever been in trouble at work because of drug abuse?		
17.	Have you ever lost a job because of drug abuse?		
18.	Have you gotten into fights when under the influence of drugs?		
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20.	Have you ever been arrested for driving while under the influence of drugs?		
21.	Have you engaged in illegal activities in order to obtain drug?		
22.	Have you ever been arrested for possession of illegal drugs?		
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?		
25.	Have you ever gone to anyone for help for a drug problem?		
26.	Have you ever been in a hospital for medical problems related to your drug use?		
27.	Have you ever been involved in a treatment program specifically related to drug use?		
28.	Have you been treated as an outpatient for problems related to drug abuse?		

For Office Use Only: Code: _____

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Financial Policy

Thank you for choosing me your health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. If you are uncertain of the cost for a specific service, you are encouraged to inquire about this. Please know that it is your responsibility to contact your insurance company and to know the benefits that you have under your policy.

Fees:

Payment /Co-pay is due at The Time of Service.

- **With Health Insurance**
  - Diagnostic Assessment (up to three sessions) - $250
  - Individual Sessions - $110 (16-37 min); $145 (38-52 min); $200 (53-60 min)
  - DBT Group Sessions - $80 (75-90 min)
  - HPAP Session - $80
  - Family Therapy (With or Without Client Present) - $200 (53-60 min)

Without Health Insurance – MEDICARE and/or MEDICAID is not accepted

- **Cash Fee:**
  - Diagnostic Assessment (up to three sessions) - $200
  - Individual & Family/Couples Sessions - $170
  - DBT Group Sessions - $75
  - No Show Appointment & Late Cancellation Fee - $170
  - No Show Fee for DBT Group - $75
  - HPAP Meeting/Missed Session - $45
  - Court Prep Fee - $350/hour *($700 pre-payment required)*
  - Court Testimony Fee - $500/hour *($1000 pre-payment required)*

Payments:

- Cash, Checks, Visa, Mastercard or Discover Card are accepted
- Payment is due at the time of service
- For personal checks that are written and returned there will a $40 charge added to your bill. If a check is returned twice, a check will no longer be accepted

I, the undersigned client, hereby knowingly and with full understanding state that I am covered under insurance and agree to pay the agreed amount at the time of each visit for services received by Tandra T. Baker, Tapestry of Wellness, LLC, LPC-MH, LAC, QMHP. I understand that this amount is a good faith estimate of the client obligation but is not necessarily the amount owed by me. I further understand that this amount will be applied to any amounts owed for service rendered by Tandra T. Baker, Tapestry of Wellness, LLC, LPC-MH, QMHP, LAC, and that it is not total or final payment on my bill. After insurance processes my claim, and my portion is clearly defined, I will be billed for the difference of what my insurance plan processes as my portion, less the above referenced amounts paid at the time of service. If insurance does not cover services I agree that I am fully responsible for payment.

I have read, completely understand and agree to the above policy and the fees set for the counseling sessions.

Patient Signature: _____ Date:_____

Printed Name: _____

Therapist Signature: _____ Date: _____
Tandra T. Baker, LPC-MH, LAC, QMHP

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Card Payment Agreement

Name: _____ **Date:** _____

Credit Card Type	
Credit Card Number	
Expiration Date	
3 or 4 digit Security Code	
Name on Card	
Zip Code	

I agree that my card will be charged after each scheduled session and/or No Show/Late Cancellation.
Cash Fee Other: _____
Deductible Amount: _____ Co-Pay: _____

- **Intake: _____**
- **Individual Session: _____**
- **Group Session: _____**
- **No Show/Less than 24 hour Notice of Cancellation: Individual $170: DBT Group $75: HPAP Meeting Full Fee. THERE ARE NO EXCEPTIONS**

I agree to allow ***Tandra T Baker, Tapestry of Wellness, LLC, LPC-MH, LAC, QMHP*** to charge the card listed above for the purpose of payment. I agree that if my card expires I will supply my updated card information. I also identify that my card will be charged for all charges unless ***Tandra T Baker, Tapestry of Wellness, LLC, LPC-MH, LAC, QMHP*** is notified in writing to stop making charges to this credit card and an alternative form of payment is established. I agree to all the above terms and conditions.

Signed: _____ Date: _____

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NAME: _____ **DATE:** _____

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you *think you might have felt*. Please answer honestly. **All questions refer to the last week. If you felt different ways at different times in the week, give a rating for how things were for you on average. Please be sure to answer each question.**

	In the course of last week...	not at all	a little	rather	much	very strong
1	It was hard for me to concentrate	**0**	**1**	**2**	**3**	**4**
2	I felt helpless	**0**	**1**	**2**	**3**	**4**
3	I was absent-minded and unable to remember what I was actually doing	**0**	**1**	**2**	**3**	**4**
4	I felt disgust	**0**	**1**	**2**	**3**	**4**
5	I thought of hurting myself	**0**	**1**	**2**	**3**	**4**
6	I didn't trust other people	**0**	**1**	**2**	**3**	**4**
7	I didn't believe in my right to live	**0**	**1**	**2**	**3**	**4**
8	I was lonely	**0**	**1**	**2**	**3**	**4**
9	I experienced stressful inner tension	**0**	**1**	**2**	**3**	**4**
10	I had images that I was very much afraid of	**0**	**1**	**2**	**3**	**4**
11	I hated myself	**0**	**1**	**2**	**3**	**4**
12	I wanted to punish myself	**0**	**1**	**2**	**3**	**4**
13	I suffered from shame	**0**	**1**	**2**	**3**	**4**
14	My mood rapidly cycled in terms of anxiety, anger, and depression	**0**	**1**	**2**	**3**	**4**
15	I suffered from voices and noises from inside or outside my head	**0**	**1**	**2**	**3**	**4**
16	Criticism had a devastating effect on me	**0**	**1**	**2**	**3**	**4**
17	I felt vulnerable	**0**	**1**	**2**	**3**	**4**
18	The idea of death had a certain fascination for me	**0**	**1**	**2**	**3**	**4**
19	Everything seemed senseless to me	**0**	**1**	**2**	**3**	**4**
20	I was afraid of losing control	**0**	**1**	**2**	**3**	**4**
21	I felt disgusted by myself	**0**	**1**	**2**	**3**	**4**
22	I felt as if I was far away from myself	**0**	**1**	**2**	**3**	**4**
23	I felt worthless	**0**	**1**	**2**	**3**	**4**

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Now we would like to know in addition the quality of your **overall** personal state in the course of the last week. 0% means **absolutely down**, 100% means **excellent**. Please check the per- centage which comes closest.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
(very bad) ◄										► (excellent)

BSL - Supplement: Items for Assessing Behavior

	During the last week.....	Not at all	once	2-3 times	4-6 times	Daily or more often
1	I hurt myself by cutting, burning, strangling, headbanging etc.	**0**	**1**	**2**	**3**	**4**
2	I told other people that I was going to kill myself	**0**	**1**	**2**	**3**	**4**
3	I tried to commit suicide	**0**	**1**	**2**	**3**	**4**
4	I had episodes of binge eating	**0**	**1**	**2**	**3**	**4**
5	I induced vomiting	**0**	**1**	**2**	**3**	**4**
6	I displayed high-risk behavior by knowingly driving too fast, running around on the roofs of high buildings, balanc- ing on bridges, etc.	**0**	**1**	**2**	**3**	**4**
7	I got drunk	**0**	**1**	**2**	**3**	**4**
8	I took drugs	**0**	**1**	**2**	**3**	**4**
9	I took medication that had not been prescribed or if had been prescribed, I took more than the prescribed dose	**0**	**1**	**2**	**3**	**4**
10	I had outbreaks of uncontrolled anger or physically at- tacked others	**0**	**1**	**2**	**3**	**4**
11	I had uncontrollable sexual encounters of which I was later ashamed or which made me angry.	**0**	**1**	**2**	**3**	**4**

Please double-check for missing answers

WE THANK YOU VERY MUCH FOR YOUR PARTICIPATION! PLEASE RETURN THE QUESTIONNAIRE TO YOUR THERAPIST