The Relating Well Center, LLC
413 Johnson Street, Suite 210 • Jenkintown, PA 19046

CLIENT 2

Name: _____ Date: _____

Visit ❑ 1 - 2 ❑ 3 – 5 ❑ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	**Not at All**	**A Little**	**Somewhat**	**A Lot**
1. Nervousness or shakiness	❑	❑	❑	❑
2. Feeling sad or blue	❑	❑	❑	❑
3. Feeling hopeless about the future	❑	❑	❑	❑
4. Feeling everything is an effort	❑	❑	❑	❑
5. Feeling no interest in things	❑	❑	❑	❑
6. Your heart pounding or racing	❑	❑	❑	❑
7. Trouble sleeping	❑	❑	❑	❑
8. Feeling fearful or afraid	❑	❑	❑	❑
9. Difficulty at home	❑	❑	❑	❑
10. Difficulty socially	❑	❑	❑	❑
11. Difficulty at work or school	❑	❑	❑	❑

How much do you agree with the following?	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
12. I feel good about myself	❑	❑	❑	❑
13. I can deal with my problems	❑	❑	❑	❑
14. I am able to accomplish the things I want	❑	❑	❑	❑
15. I have friends or family that I can count on for help	❑	❑	❑	❑

16. In the past week, approximately how any drinks of alcohol did you have? ☐☐ drinks

17. In general, would you say your health is:
❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor
18. Please indicate if you have a serious or chronic medical condition:
❑ Asthma ❑ Diabetes ❑ Heart Disease ❑ Back Pain/Other Chronic Pain ❑ Other
19. In the past 6 months, how many times did you visit a medical doctor?
❑ None ❑ 1 ❑ 2-3 ❑ 4-5 ❑ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? ☐☐ days (answer only if employed)
21. In the past month, how many days were you able to work, but had to cut back on how much you got done because of your physical or mental health? ☐☐ days (answer only if employed)
22. In the past month, have you ever felt you ought to cut down on your drinking or drug use? ❑ Yes ❑ No
23. In the past month, have you ever felt annoyed by people criticizing your drinking or drug use? ❑ Yes ❑ No
24. In the past month, have you felt bad or guilty about your drinking or drug use? ❑ Yes ❑ No

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I, _____, hereby give permission to The Relating Well Center, LLC, to disclose and/or obtain information from **insurance provider**:

_____
_____
_____

Type of information to be disclosed/obtained:
__x__ My entire record
The purpose for such disclosure is:
__x___ Continuity of care
__x___ Payment purposes such as authorization of care and claims processing
_____ Other: _____

I, _____, hereby give permission to The Relating Well Center, LLC, to disclose and/or obtain information from the **doctor/ medical practice** named below:

Name of doctor and/or practice: _____

_____

Phone: _____ Address: _____

_____

Type of information to be disclosed/obtained:
____ My entire record
_x___ Relevant to health status including but not limited to medical conditions, medication, diagnosis, treatment progress and outcome
____ Other: _____

The purpose for such disclosure is:
__x___ Continuity of care
_____ Payment purposes such as authorization of care and claims processing
_____ Other: _____

I may revoke these consents at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire one year after I have terminated treatment at The Relating Well Center, LLC. I understand that I am under no obligation to authorize release of information.

_____
Signature of client Date

_____
Signature of parent, guardian, or authorized representative (when required) Date

_____
Signature of therapist Date