Alchemy Counseling
2412 W. Greenway Rd., Suite A2
Phoenix, AZ 85023
(602) 842-4388

Name: _____ Today's Date: _____
(First) (MI) (Last/Surname)

Address: _____ Home Phone: _____
(Street) (City) (Zip)

Cell: _____ Work: _____ Other Phone: _____
Is it OK to leave a message at any of these numbers? Y___ N___ If yes, which ones? _____
Emergency Contact (Name and Number): _____
Birthplace: _____ Social Security Number: _____
Email: _____ Date of Birth: _____ Age: _____
Gender: ___Male ___Female Ethnicity: _____ Religion/Spirituality: _____

Occupation: _____ Education (Years): ____ Employer: _____

Relationship Status (Circle one): Married/Partnered/Engaged/Dating/Single/Divorced/Widowed
Date of Marriage/Relationship(s) Starting: _____ Date of Divorce/Relationship(s) Ending: _____
Children

Name of Child	Date of Birth	Age	Living with You (Yes or No)	Grade	Name of School

How did you learn about our services? _____

What brings you to therapy:_____
_____
_____
_____

Please circle a number that indicates the urgency of your concern:
1 2 3 4 5 6 7 8 9 10
Not urgent at all Extremely urgent

Treatment and Medical History
Are you currently receiving or have you ever previously received services from a counselor/mental health professional? Y___ N___ If yes, how did it help you? _____

Have you ever been hospitalized for emotional and/or drug/alcohol treatment? Y___ N___ If yes, please give approximate dates and briefly describe the circumstances: _____
_____

Are you currently taking or have you ever taken any psychiatric medications: Y___ N___ If yes, please list--Current: _____ Past: _____

Do you or have you ever had a psychiatrist? Y___ N___ If yes, please give name: _____

Please list all other current medications and reasons for taking them: _____
_____

Do you have any family history of the following conditions? (Check all that apply):
___Suicide ___Depression ___Anxiety ___Bipolar ___Borderline Personality ___Schizophrenia
___Substance Abuse ___Phobias ___Obsessive Compulsive
___Sex Addiction ___Codependency ___Others:_____

Name of Primary Care/Family Doctor: _____
Last Doctor's Visit (Approximate Date): _____

Do you have health insurance? Y___ N___ If yes, which company? _____
Do you have out-of-network mental/behavioral health benefits? Y___ N___ Not sure ___

AUTHORIZATION FOR DIRECT PAYMENT - RELEASE OF RECORDS

I hereby authorize insurance payments directly to Scott Hooyman, LCSW. I hereby authorize the release and exchange of pertinent psychological, psychiatric, educational, and/or medical records for insurance purposes/case management purposes only.

_____
Signature of Insured or Responsible Party (Parent if Minor) Date

Behavioral Health Questionnaire

For the following questions, please circle a number best describes how you have been feeling for the past two weeks:

1. How distressed have you been?
   1 2 3 4 5 6 7 8 9 10
   Not distressed at all Extremely distressed

2. How satisfied have you been with your life?
   1 2 3 4 5 6 7 8 9 10
   Not satisfied at all Very satisfied
3. How energetic and motivated have you been feeling?
   1 2 3 4 5 6 7 8 9 10
   Not motivated/no energy Very energetic and motivated

In the past few weeks how much have you been distressed by:

4. Feeling fearful, scared?
   1 2 3 4 5 6 7 8 9 10
   Not distressed at all Extremely distressed

5. Alcohol/drug use interfering with you functioning at home/work/school?
   1 2 3 4 5 6 7 8 9 10
   Not distressed at all Extremely distressed

6. Thoughts of wanting to harm someone?
   1 2 3 4 5 6 7 8 9 10
   Not distressed at all Extremely distressed

7. Not liking yourself?
   1 2 3 4 5 6 7 8 9 10
   Not distressed at all Extremely distressed

8. Difficulty concentrating?
   1 2 3 4 5 6 7 8 9 10
   Not distressed at all Extremely distressed

9. Alcohol/drug use affecting your physical health?
   1 2 3 4 5 6 7 8 9 10
   Not distressed at all Extremely distressed

10. Thoughts of ending your life?
    1 2 3 4 5 6 7 8 9 10
    Not distressed at all Extremely distressed

11. Feeling sad most of the time?
1 2 3 4 5 6 7 8 9 10
Not distressed at all Extremely distressed

12. Feeling hopeless about the future?
1 2 3 4 5 6 7 8 9 10
Not distressed at all Extremely distressed

13. Powerful, intense mood swings (highs, lows, and/or anger)?
1 2 3 4 5 6 7 8 9 10
Not distressed at all Extremely distressed

14. Alcohol/drug use interfering with your relationships with family and/or friends?
1 2 3 4 5 6 7 8 9 10
Not distressed at all Extremely distressed

15. Feeling nervous?
1 2 3 4 5 6 7 8 9 10
Not distressed at all Extremely distressed

16. Heart pounding or racing?
1 2 3 4 5 6 7 8 9 10
Not distressed at all Extremely distressed

How have you been getting along in the following areas of your life over the past two weeks? (Leave blank if item does not apply.)

17. Work/school (For example, performance and attendance)
1 2 3 4 5 6 7 8 9 10
Terribly Fair Very well

18. Intimate relationships (For example, support, communication, closeness)
1 2 3 4 5 6 7 8 9 10
Terribly Fair Very well

19. Non-family social relationships/friends (For example, communication, closeness, level of activity)
1 2 3 4 5 6 7 8 9 10
Terribly Fair Very well

20. Life enjoyment (For example, recreation, life appreciation, leisure activities)
1 2 3 4 5 6 7 8 9 10
Terribly Fair Very well

<u>Behavioral Health History</u>

21. Did you ever experience physical, sexual, or emotional abuse when you were a child (Under 18 years of age)? Y___ N___
22. Have you ever experienced sexual/emotional/physical abuse as an adult (18 years or older)? Y___ N___
23. When you drink alcohol, do you drink more than three per occasion? Y___ N___ If yes, how often? _____
24. Have you ever had problems with illicit drugs or prescription medications? Y___ N___

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INFORMED CONSENT FOR TREATMENT

Please check each box after reviewing to acknowledge you have read it.

____(Initial) I have chosen to receive psychotherapy services. I understand that my choice has been voluntary and that I may terminate therapy at any time. I understand that psychotherapy is a collaborative effort between myself and my therapist. I understand that I have the right to be informed of the various steps and activities involved in receiving services. I will attempt to work with my therapist to develop and follow a plan of treatment. I also understand that I have the right to humane care and protection from harm, abuse, or neglect. I understand that I have the right to make an informed decision whether to accept or refuse treatment.

____(Initial) I understand that confidentiality of all records or information collected about me, and all information discussed in consultation and/or therapy sessions will be held in accordance with state and federal laws (42 CFT Prt 2) and cannot be released or disclosed without my written consent unless otherwise provided for in state and federal regulations. I understand that state and local laws require that my therapist report all cases of physical or sexual abuse of minors or the elderly. I understand that state and local laws require that my therapist report all cases in which there exists a clear danger to self or others.

____(Initial) I understand that I may be asked to complete a confidential SATISFACTION SURVEY or complete an OUTCOME MEASURES INVENTORY to facilitate my therapist maintaining a high level of quality care.

____(Initial) I understand that my portion of therapeutic expenses (insurance co-pay or deductible) is due at the conclusion of each session, and that I am responsible for payments not made by my insurance (within the limits of my insurance contract). I understand that I will be charged a fee of $30.00 for any check returned for [NSF] non sufficient funds. I also understand that I will be responsible for my portion of balances and fees (collection fee of 50% of balance) for balances that have not been paid in 90 days and turned over to a collection agency, and subject to reporting to credit bureau. I also agree to give accurate and current billing information (i.e.., insurance and billing address) and understand that incorrect information may result in my account being turned over immediately to a collection agency.

____(Initial) I understand that Alchemy Counseling os Scottsdale requires the minimum of a 24 hour notice if I will be unable to attend my appointment. I understand that if I no show for a scheduled appointment or fail to give minimum of a 24 hour notice, I will be charged full fee for that session (unless limited by my insurance).

____(Initial) I understand that in the case of a “If this is a life threatening or other emergency”(as instructed on Mr. Hooyman’s voice mail), I will dial 911.”

____(Initial) I have read and understand the above.

_____ _____
Patient's Signature Date

2412 W. Greenway Rd., Suite A2
Phoenix, AZ 85023
(602) 842-4388

PRIVACY INFORMATION

My practice is fully compliant with HIPAA regulations to protect the confidentiality of your information. As a practitioner I am the designated "Privacy Officer" under the federal HIPAA regulations. You have a right to fully informed consent regarding my handling of your privileged information. Unless you sign a written release of information, I cannot and will not release your treatment information to a third party. However, there are exceptions outlined below:

1. I may be required to release your information if the withholding of this information could result in harm to either you or another person. An example would be if you made a statement to me indicating your intent to harm yourself or another person, or in cases of abuse or neglect of a child or vulnerable adult, like the elderly or disabled.

2. I may be required to release your information by court order or subpoena. An example would be if you were party to litigation and a judge decided this information was needed.

3. I may be required to release your information to emergency treatment personnel or to your emergency contact if you require immediate medical attention while in session.

4. I may release your information to another health care provider if you initiate contact with that provider. I may release your information with your verbal consent to facilitate a referral. In most cases, however, I will ask for a written release of information for this purpose.

5. I may release your information to a consultant or supervisor for the purpose of insurance reimbursement, and to provide you with optimal care.

6. I may release your information anonymously in brief consultation with professional colleagues to provide you with optimal care. An example might be my describing your situation, without identifying you by name, and asking a colleague for other resources to pass on to you.

I will generally request a written release of information from you whenever possible. Your rights include: access to your records upon request, my safeguarding your records at all times, and keeping accurate financial and clinical records.

I, _____, have read and understand the above information.
Print Name

_____ _____
Signature Date

Scott Hooyman, MSW, LCSW
Alchemy Counseling
2412 W. Greenway Rd., Ste A2
Phoenix, AZ 85023
(602) 842-4388

PRACTICE POLICIES

Welcome

The following information is to help you become acquainted with my practice.

Please review the information and complete the attached forms.

Also, feel free to ask any questions you have during our session. The primary indicator for successful psychotherapy is the relationship between therapist and client. The first session will give us an opportunity to get acquainted.

I look forward to working with you.

Insurance

You are responsible for all charges billed for any unpaid or denied claims. The only exceptions are when I have made other agreements with your insurance company in a contract. You are also responsible for all co-payments, deductibles, any cancellation charges (which generally cannot be billed to the insurance company) and telephone consultations. I do not bill for phone calls unless they exceed 5 minutes in length.

Your consent allows me to share any clinical data necessary to process insurance claims. This can include diagnosis, and depending on the review process, content of our sessions. Please ask any questions you have regarding your insurance company's procedures.

Billing

As a contracted provider: I will collect a co-payment and file claims. The insurance company will pay the difference to me.

As an out-of-network provider: I will collect the full fee at the time of service and provide you with the necessary documentation so that you will be able to file claims for subsequent sessions. Reimbursement for my fees will be sent directly to you from the insurance company.

For private pay (No insurance, in or out of network): I will collect the full fee at the time of service.

Fees

Unless I have a contract with your insurance company, my fees are listed below:

Initial Assessment	$160
Individual Session	$140
Administrative Requests	$50
No Show/No Call Fee	$60
Cancellation with notice of 24 hours or more	No Charge

IF YOU NEED TO CANCEL OR RESCHEDULE, PLEASE CALL ME AT (602) 842-4388, WHICH IS LISTED ON MY BUSINESS CARD, AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT TIME TO AVOID ANY CHARGES.

Payment of fees: Cash, check, credit and debit cards. Payment is due in full at the time of service.

Communication

Please use (602) 842-4388 for all communication with me. This is my answering service and confidential voice mail. I return all calls by the next day of my work week, which is Monday through Friday.

Please indicate any telephone numbers you wish me to use and be sure to specify those you do NOT want me to use. Please include clear instructions where I can and cannot leave you a message. This is to preserve your privacy.

Urgent Situations and Crises

When you are in an urgent situation or crisis, please call 911 or one of the numbers below:

EMPACT/Suicide Hotline (480) 784-1500
Countywide Crisis Line (602) 222-9444
Banner Helpline (602) 254-4357

You may also go to the nearest emergency room if these numbers or a phone are not available, and you are in need of assistance.

Credentials

LCSW – Licensed Clinical Social Worker by the State of Arizona Board of Behavioral Health
MSW – Master of Social Work from Arizona State University
BA – Bachelor of Arts in Psychology and Spanish from Rutgers University
REBT – Certificate in Rational Emotive Behavior Therapy from the Albert Ellis Institute
EMDR – Eye Movement Desensitization and Reprocessing training from the EMDR Institute

A copy of my resume or curriculum vitae is also available upon request.

Collaboration

My expertise is in psychotherapy. There are times when other professionals can and should be involved in the healing process. I will refer you to other colleagues as needed if I believe that their input and expertise will be of benefit to you. I am not licensed to prescribe medications but work with physicians who can be of help in this area. I am also happy to consult with your personal physician or other specialist if you wish.

Family and other collateral involvement can also be important to your well being. I am open to working with your family or significant others at any point that you and I agree this would be useful.

I am committed to bringing the best knowledge and expertise to this relationship and am always willing to work with you and other professionals to assist you in achieving your goals.

I look forward to working with you.

By signing below, I acknowledge that I have read, understood, and received a copy of Alchemy Counseling's/Scott Hooyman's Practice Policies:

_____ _____

Signature of Client Date Signed

Scott Hooyman, MSW, LCSW
Alchemy Counseling, PLLC
2412 W. Greenway Rd., Phoenix AZ 85023
602-842-4388

TELETHERAPY/TELEPRACTICE INFORMED CONSENT

Scott Hooyman, MSW, LCSW/Alchemy Counseling PLLC provides mental health therapy and counseling services. Scott Hooyman, MSW, LCSW/Alchemy Counseling PLLC also offers Teletherapy or "telepractice" according to Arizona state laws. Telepractice is the provision of mental health therapy and counseling services through electronic technology, such as interactive audio, video, or other technologies that facilitate interaction between my counselor and me when we are not physically present in the same room at the same time.
____ I acknowledge my understanding of the above (please initial).

Social media is not used to communicate with me. Scott Hooyman, MSW, LCSW will not accept friend requests or contact requests through any social media platform (Facebook, Instagram, Twitter, LinkedIn, etc.), although clients can follow/like the Alchemy Counseling Facebook Page. If I need to contact Scott Hooyman, MSW, LCSW/Alchemy Counseling PLLC, I will not use social media. I understand that connecting through social media could compromise my confidentiality and privacy, while blurring the boundaries of the counselor-client relationship.
____ I acknowledge my understanding of the above (please initial).

Limitations and potential risks of teletherapy include, but are not limited to confidentiality risks of electronic communication, potential for technology failure or disruption, client identification and non-video communication, cultural and/or language differences that may affect delivery of services, possible denial of insurance benefits, and the possible need for face-to-face services. I understand the potential risks of sudden and unpredictable disruption of the platform used for a teletherapy session, and that an alternative means of electronic or other communication may be used in the event of a disruption. I also understand the importance of a confidential setting and of being aware of all authorized or unauthorized users including family members and fellow employees, who have access to any technology I may use in the counseling process.
____ I acknowledge my understanding of the above (please initial).

Emergency Procedures: If your therapist is unavailable when there is a technology failure or disruption of your telehealth session and you are in crisis, please call 911 or the County Wide Crisis line at (602) 222-9444.
____ I acknowledge my understanding of the above (please initial).

When video technology is not available for telehealth session and I choose to complete my session by phone, my therapist may ask questions to verify my identity (e.g., date of birth or home address).
____I acknowledge my understanding of the above (please initial).

Confidentiality: I understand Scott Hooyman, MSW, LCSW/Alchemy Counseling PLLC is required to protect the confidentiality of my records and information.
____ I acknowledge my understanding of the above (please initial).

Encryption: I understand Scott Hooyman, MSW, LCSW/Alchemy Counseling PLLC encrypts according to industry standards, compliant with HIPAA requirements.
____ I acknowledge my understanding of the above (please initial).

Client (or Minor's) Name (Print):_____

Client (or Guardian) Signature:_____Date:_____

TELEHEALTH NO-SHOW/LATE CANCELLATION POLICY

Alchemy Counseling requires clients to give a minimum of 24 hours notice to cancel or change an appointment. This notice allows us time to contact clients on our wait list.

There is a fee for late cancellation of an appointment as well as for failure to attend a scheduled appointment. The fees are listed below.

Please note that his policy is the same for telehealth sessions and in-office sessions.

Charges are as follow:

No Show/Late Cancellation Fee	$60
Cancellation at least 24 hours notice	$0

If you need to confirm, cancel or reschedule, please call our office at (602) 842-4388 at least 24 hours prior to your appointment in order to avoid any charges.

By signing below, I acknowledge that I have read, understood, and received a copy of Alchemy Counseling's No Show/Late Cancellation Policy:

_____ _____

Signature of Client Date Signed

Alchemy Counseling, PLLC

2412 W Greenway Rd Suite A2 Phoenix, Arizona 85023
602-842-4388 fax: 888-972-4886

Print Client Name: _____

Credit Card Authorization Option

Name on Card: _____

Credit Card #: _____

Credit Type: □ VISA □ MC □ AmEx Expiration Date: _____ / _____ CVV#: _____

Street Address of Card Holder: _____

City, State, Zip Code: _____, _____, _____

Phone Number of Card Holder: _____

I authorize Scott Hooyman and Alchemy Counseling, PLLC to charge my credit card for services provided by Scott Hooyman. I authorize this information to be kept on file for future use.

Signature of Card Holder: _____ Date: _____

Alchemy Counseling, PLLC
Scott Hooyman, MSW, LCSW
2412 W Greenway Rd, Ste A2 Phoenix, Arizona 85023 Phone: 602-842-4388

CONSENT FOR SPECIFIC COMMUNICATION WITH PRIMARY CARE PHYSICIAN OR SPECIALIST:

Consent to Use and Disclose your Health Information. I, the undersigned, understand that Alchemy Counseling works hard to protect the privacy and preserve the confidentiality of my protected health information. I have already signed the consent form allowing the use and disclosure of Private Health Information for treatment, payment, and other health-care functions. As an added level of patient protection and clarity, I specifically consent to the use and disclosure of attendance, diagnosis, and treatment to and from Alchemy Counseling for treatment purposes:

_____ _____

Name of Primary Care Physician or Specialist *Phone Number*

I have been informed that I have the right to ask Alchemy Counseling to not use or disclose some of the patient's protected health information. I will have to inform Alchemy Counseling these limits **in writing**. After signing the consent, I have the right to revoke it **in writing**. Alchemy Counseling may have already used or shared some of the patient's information according to the agreement as it was before it was revoked.

Print Client Name: _____

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Description of Personal Rep. Authority**

Alchemy Counseling, PLLC
Scott Hooyman, MSW, LCSW
2412 W Greenway Rd, Ste A2 Phoenix, Arizona 85023 Phone: 602-842-4388

CONSENT FOR COMMUNICATION WITH FAMILY / SPOUSE / PARTNER / etc. :

Sometimes therapy or counseling requires the therapist to communicate with family members. If other people are involved, please review the following. I authorize Alchemy Counseling, PLLC/Scott Hooyman, LCSW to disclose all treatment information to the persons listed below. I may refuse to sign this authorization form. I understand that Alchemy Counseling, PLLC/Scott Hooyman, LCSW will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. I understand I may withdraw my consent at any time by notifying Alchemy Counseling, PLLC/Scott Hooyman, LCSW in writing.

Please list the names and relationships of individuals here (family members, spouse, significant other, etc.):

Full Name	Relationship to me
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I authorize Alchemy Counseling, PLLC to disclose all treatment information to the persons listed above.

Print Client Name: _____

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Description of Personal Rep. Authority**

Scott Hooyman, MSW, LCSW
Alchemy Counseling
2412 W. Greenway Rd. Suite A1
Phoenix, AZ 85023
(602) 561-8793

INFORMED CONSENT FOR TREATMENT OF A MINOR

Please check each box after reviewing to acknowledge you have read each item.

□ I, _____ hereby grant Scott Hooyman, LCSW/Alchemy Counseling permission to provide outpatient behavioral services to my child, _____.

□ I understand that any information given to Scott Hooyman, LCSW/Alchemy Counseling will not be shared with anyone without written permission, **except where required by law (for example: danger to self, danger to others, or suspected child abuse).**

□ I have been informed of my rights as a patient of Scott Hooyman, LCSW/Alchemy Counseling.

□ I understand that I may withdraw my consent at any time by notifying Scott Hooyman, LCSW/Alchemy Counseling in writing.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Parent/Guardian's Signature Date

THE BURNS DEPRESSION CHECKLIST

Name: _____ **Date:** _____

Instructions: The following is a list of symptoms that people sometimes have. Put a check in the space to the right that best describes how much that symptom or problem has bothered you **during the past week**.

	0 - Never	1 - Sometimes	2 - Moderately	3 - A lot
Have you been feeling sad or down in the dumps?				
Does the future look hopeless?				
Do you feel worthless or think of yourself as a failure?				
Do you feel inadequate or inferior to others?				
Do you get self-critical and blame yourself for everything?				
Do you have trouble making up your mind about things?				
7.Have you been feeling resentful and angry a good deal of the time?				
Have you lost interest in your career, your hobbies, your family, or your friends?				
Do you feel overwhelmed and have to push yourself hard to do things?				
Do you think you're looking old or unattractive?				
Have you lost your appetite, or do you overeat or binge compulsively?				
Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?				
Have you lost your interest in sex?				
Do you worry a great deal about your health?				
Do you have thoughts that life is not worth living or think that you might be better off dead?				

Add up your total score for the 15 symptoms and record it here: _____

After you have completed th test, add up your total score. It will be between 0 (if you answered "not at all" for each of the 15 categories) and 45 (if ou answered "a lot" for each one). Use the key to interpret your score.

Total Score	Degree of Depression
0-4	Minimal or no depression
5-10	Borderline depression
11-20	Mild depression
21-30	Moderate depression
31-45	Severe depression

AAQ-II

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	2	3	4	5	6	7
never true	very seldom true	seldom true	sometimes true	frequently true	almost always true	always true

1.	My painful experiences and memories make it difficult for me to live a life that I would value.	1	2	3	4	5	6	7
2.	I'm afraid of my feelings.	1	2	3	4	5	6	7
3.	I worry about not being able to control my worries and feelings.	1	2	3	4	5	6	7
4.	My painful memories prevent me from having a fulfilling life.	1	2	3	4	5	6	7
5.	Emotions cause problems in my life.	1	2	3	4	5	6	7
6.	It seems like most people are handling their lives better than I am.	1	2	3	4	5	6	7
7.	Worries get in the way of my success.	1	2	3	4	5	6	7

This is a one-factor measure of psychological inflexibility, or experiential avoidance. Score the scale by summing the seven items. Higher scores equal greater levels of psychological inflexibility.

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (in press). Preliminary psychometric properties of the Acceptance and Action Questionnaire – II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy*.

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

36-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
Understanding and communicating						
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.3	Analysing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting around						
D2.1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.5	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

In the past 30 days, how much difficulty did you have in:						
Self-care						
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting along with people						
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities						
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.3	Getting all the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.

Because of your health condition, in the past 30 days, how much difficulty did you have in:						
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.7	Getting all the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Participation in society						
In the past 30 days:						
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.2	How much of a problem did you have because of barriers or hindrances in the world around you?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.4	How much time did you spend on your health condition, or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ____

This completes the questionnaire. Thank you.