SARATOGA CENTER FOR THE FAMILY
Building stronger families for stronger communities

Client Information Sheet – Adult

Client's Legal Name: ______________________ Date of Birth __________ Age _____

Client's Preferred Name: ______________________ Gender Identity ______________

Preferred Pronouns: ______________________ County of Residence ______________

Home Address: ____

Email Address: ____

Phone Number(s) ____

May we leave messages at any/all of the above numbers? ☐ No ☐ Yes

Currently Employed ☐ No ☐ Yes If Yes, Occupation ______________________

Marital Status: ☐ Married ☐ Divorced ☐ Remarried ☐ Never Married ☐ Other

Emergency Contact (Name & Number) ______________________________

Who referred you or how did you hear about Saratoga Center for the Family?

☐ Social Services ☐ Court ☐ Primary Care Dr. ☐ Saratoga County Mental Health ☐ Other:

Would you like to discuss additional services with a Victim Advocate? ☐ No ☐ Yes

In general, is your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Briefly describe your reason for seeking services:

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Insurance/Payment information

Client Legal Name: ______________________________

Client Date of Birth: ______________________________

Primary Care Physician: ______________________________ Phone: ______________________________

Does the client have health insurance? ☐ Yes ☐ No
If yes, complete below. If no, inquire about our Financial Assistance Program.

Insurance Company Name ______________________________

Insurance Member ID Number ______________________________

Group Number ______________________________

Name of Policy Holder ______________________________ Relationship ______________________________

Policy Holder's Date of Birth: ______________________________

Policy Holder's Place of Employment ______________________________

I authorize release of any medical or other information to my insurance company as necessary to obtain payment incompliance with the Health Insurance Privacy and Portability Act (1996). I also authorize payment of benefits directly to Saratoga Center for the Family. Additionally, I understand that I am responsible for any fees not paid by the insurance company. This includes fees associated with deductibles, co-insurance, co-payments and out of network charges.

Signature: ______________________________ Date ______________________________

Printed Name: ______________________________

Relationship to Client: ______________________________

Please notify us if your insurance changes in any way. It is your responsibility to inform Saratoga Center for the Family if your insurance terminates or changes. You will be responsible for all charges incurred due to a lapse or change in insurance coverage.

Symptoms Assessment

Please help us provide the best possible care by answering these questions. Please mark which best fits your experience/feelings within the past month.

		Not at all	A little/ Sometimes	Often
1	Nervousness or shakiness	☐	☐	☐
2	Lack of interest in things you previously enjoyed	☐	☐	☐
3	Tires easily, has little energy	☐	☐	☐
4	Feeling everything is an effort	☐	☐	☐
5	Heart pounding or racing	☐	☐	☐
6	Feeling fearful/afraid	☐	☐	☐
7	Feeling sad/unhappy	☐	☐	☐
8	Feeling irritable/angry	☐	☐	☐
9	Feeling of hopelessness	☐	☐	☐
10	Trouble concentrating	☐	☐	☐
11	Increased anxiety	☐	☐	☐
12	Difficulty socially	☐	☐	☐
13	Difficulty at home	☐	☐	☐
14	Difficulty at work or school	☐	☐	☐
15	Having trouble sleeping	☐	☐	☐

Satisfaction with Life Scale

Below are five statements that you may agree or disagree with. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding each item. Please be honest in your responding.

1 - Strongly Disagree
2 - Disagree
3 - Slightly Disagree
4 - Neither Agree nor Disagree
5 - Slightly Agree
6 - Agree
7 - Strongly Agree

_______ • In most ways, my life is close to my ideal.
_______ • The conditions of my life are excellent
_______ • I am satisfied with my life.
_______ • So far, I have gotten the important things I want in life
_______ • If I could live my life over, I would change almost nothing.

☐ **Total**

Scoring:	
31-35	Extremely Satisfied
26-30	Satisfied
21-25	Slightly Satisfied
20	Neutral
15-19	Slightly Dissatisfied
10-14	Dissatisfied
5-9	Extremely Dissatisfied

*The Satisfaction with Life Scale (SWL) Instrument Author: Pavot, W., & Diener, E. Measurement Instrument Database for the Social Sciences. Retrieved from www.midss.ie.

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

Name: ______________________ **Age:** ______ **Today's Date:** ______________

If this questionnaire is being completed by an informant, what is your relationship with the individual? ______________________.

In a typical week, how much time do you spend with the individual? ______________________ *Hours/week*

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

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

Score:

TRS

Name: ____________________ Age: ______ Today's Date: __________

Trauma Recovery Scale – Adult

Part I

☐ Yes or ☐ No

I have been exposed to a traumatic event in which *both* of the following were present:

- **a.** Experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others AND
- **b.** My response involved intense fear, helplessness, or horror

- If yes is answered, please complete parts II and III
- If no is answered, please complete part III (omit part II)

Part II

	Type of Traumatic Event	Number of Times	Dates/Ages
1	Childhood Sexual Abuse		
2	Rape		
3	Other Adult Sexual Assault/Abuse		
4	Natural Disaster		
5	Industrial Disaster		
6	Motor Vehicle Accident		
7	Combat Trauma		
8	Witnessing Traumatic Event		
9	Childhood Physical Abuse		
10	Adult Physical Abuse		
11	Victim of Other Violent Crime		
12	Captivity		
13	Torture		
14	Domestic Violence		
15	Sexual Harassment		
16	Threat of Physical Violence		
17	Accidental Physical Injury		
18	Humiliation		
19	Property Loss		
20	Death of a Loved One		
21	Other		
22	Other		
23	Other		
24	Other		
25	Other		

Comments:

Trauma Recovery Scale – Adult

Name:

Part III

Place a mark on the line that best represents your experiences during the past week.

1 I make it through the day without distressing recollections of past events

0%--100%

2 I sleep free from nightmares

0%--100%

3 I am able to stay in control when I think of difficult memories

0%--100%

4 I do the things I used to avoid (eg., daily activities, social activities, thoughts of events and people connected with past events)

0%--100%

5a I am safe

0%--100%

5b I feel safe

0%--100%

6 I have supportive relationships in my life

0%--100%

7 I find that I can now safely feel a full range of emotions

0%--100%

8 I can allow things to happen in my surroundings without needing to control them

0%--100%

9 I am able to concentrate on thoughts of my choice

0%--100%

10 I have a sense of hope about the future

0%--100%

Mean Score

Scoring instructions: record the score for where the hash mark falls on the line (0-100) in the box beside the item (average 5a with 5b to get score for 5). Sum scores and divide by 10.

Interpretation: 100-95 (full recovery/subclinical); 86-94 (significant recovery/mild symptoms); 74 (minimal recovery/severe); below 35 (probable traumatic regression)