



Patient Information

Today's Date: _____ Referred by: _____
 May We thank the person that referred you? _____

Patient's Name (Last, First, Middle) _____ Age _____ DOB _____

Home Address: Street _____ City _____ State _____ Zip Code _____

Mobile Phone _____ Email Address _____

Home Phone _____ Social Security Number _____ Marital Status _____

Patient's Employer _____ Occupation _____ How Long Employed? _____

Employer's Address _____ Phone Number _____

Spouse (or responsible party) _____ Social Security Number _____

Full Name of Children (in Birth date order):
 Name _____ Age _____

Others Living in Home _____ Relationship _____

Personal Physician _____ Address _____ Phone _____ Date of Last Exam _____

Current Therapist _____ Address _____ Phone _____

List All Medications Currently Taken _____

Have you been hospitalized in the last 5 years? If so, for what reason? _____

Have you had previous psychological or psychiatric treatment? Where and when? _____

Has any family member been seen previously by our office? If yes, when? _____

Insurance Carrier _____ Policy Holder _____ ID number _____ Group number _____

Insurance Authorization and Assignment (Please Read and Sign):
 I hereby authorize Southlake Counseling and Consulting and Southlake Center for Self Discovery to furnish information to insurance carriers listed above concerning my illness and treatments. I hereby assign to the physician/clinician all payments for medical services rendered to me. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

 Signature of Responsible Party _____ Date _____



PATIENT RIGHTS AND RESONSIBILITIES

Welcome to our Office

CONFIDENTIALITY

Privacy and confidentiality are of the utmost importance to the clinical relationship. Information given by the client remains private and confidential. The therapist will not share information with any person without your written permission, except as required by law or in a situation deemed potentially life threatening. I grant permission to the therapist to communicate with my emergency contact person if a situation is deemed potentially life threatening.

FINANCIAL

Insurance information needs to be current and accurate. You are expected to pay all deductibles and co-payment amounts at the time of each visit. Clients are responsible for the payment of all applicable fees at the time of each visit. If you are the parent or guardian of a minor, all costs not covered by your insurance company will be your responsibility. **The office does not become involved with division of accounts between divorced parents.**

APPOINTMENTS

Appointments are scheduled as a forty-five minute therapeutic hour. In the event that you must cancel an appointment, please call (704) 896-7776 at least 24 hours, preferably 48 hours in advance. Failure to give 24 hour notice will result in your being billed in full for that session. Insurance companies will not reimburse for missed appointments.

MANAGED CARE CLIENTS

Most managed care plans require pre-approval for mental health services. Noncompliance could lead to denial of benefits (payment for services). If you have entered therapy with this office under a managed care plan, please verify prior approval for services. Under some managed care plans, the therapist is required to provide clinical information to a case manger after the initial session if additional sessions are needed. If you have any questions about this procedure, please speak to the therapist.

Signature

Date



In Case of Emergency

The Southlake Center for Self Discovery and Southlake Counseling and Consulting are not medical facilities. Therefore, we only admit participants that are physically safe. For this reason, we ask that you see a physician for blood work (Biochemical Profile and CBC) and that you consent to the following policy. During treatment, some patients have suicidal, self-harm or homicidal thoughts. These generally pass within hours or days if discussed in sessions. You may call the Center at any time during working hours and leave a message for your primary therapist who will make every effort to call you back before the end of the day. If you have an emergency after hours (5:30 pm- 9:30 am) or on the weekend, you may leave a message with Kimberly Krueger at 704-896-7776.

Please read the following contract, which is required of all individuals being treated on an outpatient basis at The Southlake Center for Self Discovery and Southlake Counseling and Consulting:

1. I promise to talk with my individual therapist if I should have any thoughts of harming myself or someone else. I understand that for some individuals, these thoughts may be a natural part of the therapy process and are likely to pass if I talk about them.
2. I understand that the ultimate responsibility for my health and therapy is my own. Therefore, I agree to give my therapist 48 hours to respond to my call. In the interim, I may phone a hotline for support or go to an emergency room if unable to keep myself safe.

I have read and understand the emergency policies and promise to abide by them.

Patient Signature	Date	Witness	Date
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Parent/ Guardian Signature	Date	Witness	Date
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Insurance and Financial Policies

709 Southeast Drive Suite 20, Davidson, NC 28036
704-896-7776 phone 704-896-0992 fax

Health insurance is a contract between you, your employer and your health insurance company. Each policy has different rules regarding which services are allowed, deductible amounts, how you are charged, where lab work is sent, etc. You are responsible for knowing the terms of your health contract benefits. We need all of the information on the attached demographics sheet as well as a copy of your insurance card(s). Be sure to give us your primary AND secondary cards if applicable. If the time frame for submission of a claim lapses due to incorrect information, you are responsible for those fees.

Prior approval is required for most mental health treatment. You are responsible for getting the initial authorization number. If you have it, and have not already called it in to us, please provide it to the receptionist. If not, we will ask that you use our phone to get that number PRIOR to being seen. Additionally, some policies require that your Primary Care Physician refer you to us. In those cases, you must be certain that he/she knows to send us such referral. We must have such referral in hand before we can proceed. **YOUR FAILURE TO OBTAIN THE PROPER REFERRAL OR INITIAL AUTHORIZATION WILL MAKE YOU FULLY RESPONSIBLE FOR OUR FEES.** You may be limited by your policy in the number of mental health visits per year allowed or you may have a dollar limit ("cap").

At the time of service, deductible, co- payments and/or your percentage of fees are payable. Any balance due after your insurance company pays or denies your claim is payable BY YOU when billed.

If we have to use an outside agency to collect the balance on your account or obtain current address, insurance information, etc., and administrative fee will be billed to your account.

1. Telephone calls to clinicians may be subject to a \$10 minimum charge.
2. Pharmacy call-ins may be subject to a \$10 charge, if authorized by your psychiatrist.
3. Processing time/paperwork with your insurance to obtain non-formulary medication authorizations is subject up to a \$20 charge.
4. Form letters, reports, etc. are subject to an administrative charge.
5. Missed appointments not cancelled 24 hours in advance will be charged to you AT FULL FEE even if you did not receive a reminder call.
6. Payment is due at the time of service, unpaid fees/co-payments will be assessed a \$3.00 surcharge.
7. Any involvement in court procedures, depositions, or testimonies are billed at \$250.00 an hour.

Please remember YOU, not your Doctor, are the policyholder. If your insurance fails to pay on a timely basis, (within 90 days), we will send you a Statement of Account notifying you that your claim is unpaid, at which time you/your employer must assist in pursuing your benefits.

Your signature below indicates that you fully approve and understand the above.

Signature _____ date _____



ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Main Office: 709-20 Northeast Drive
Davidson, NC 28036
(704) 896-7776

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my health care providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information (PHI). I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my health care provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that *Southlake Counseling and Consulting* and *The Southlake Center for Self Discovery* restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, and I understand that *Southlake Counseling and Consulting* and *The Southlake Center for Self Discovery* are not required to agree to my requested restrictions. If *Southlake Counseling and Consulting* and *The Southlake Center for Self Discovery* do agree, then *Southlake Counseling and Consulting* and *The Southlake Center for Self Discovery* are bound to abide by such restrictions.

Patient Name _____ Date _____

Signature of Responsible Party _____

Relationship to Patient _____

Dependent family members also covered by this acknowledgement: _____

For Office Use Only

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

The patient refused to sign Emergency situation

Communication barriers Other: _____



Notice of Privacy Practices
Under the Health Information Portability & Accountability Act
H.I.P.A.A.

The effective date of this Notice of Privacy Practices is August 15, 2003.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

As part of our services, we maintain personal information about you and your health. State and federal law protects such information by limiting its uses and disclosures. "Protected health information" (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present, or future physical or mental health or condition, the provision of health care services, or the past, present, or future payment for the provision of health care. The confidentiality of alcohol and drug abuse patient records is also specifically subject to additional restrictions under other state and federal law. We are required to comply with these additional restrictions.

Your Rights Regarding Your PHI: The following are your rights regarding PHI that we maintain about you:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in certain limited circumstances, to inspect and copy your PHI that we maintain. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request a copy of the required accounting of disclosures that we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you in a certain way or at a certain location. We will accommodate reasonable requests and will not ask why you are making the request.
- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice.
- **Right of Complaint.** You have the right to file a complaint in writing with us or with the Secretary of Health and Human Services if you believe we have violated your privacy rights. *We will not retaliate against you for filing a complaint.*

Our Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations:

Treatment: We may use your PHI for the purpose of providing you with health care treatment. To coordinate and manage your care, we may disclose your PHI to others of your current providers. We may also disclose your PHI to other health care providers who become involved in your care.

Payment: We may use your PHI in connection with billing statements we send you and our system for tracking charges and credits to your account. In addition, but with your authorization, we may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability, as well as to submit claims for payment and medical necessity and utilization reviews.

Health Care Operations: We may use and disclose your PHI for the health care operations of our program in support of the functions of treatment and payment. Such disclosures would be to a Qualified Organization only or to a Business Associate/ QSO (Qualified Service Organization) to provide services to the program and its patients for data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect.

(Continue on Next Page)



Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object:

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. For example, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Audit and Evaluation: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations performing utilization and quality control. If we disclose PHI to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your PHI.

Medical Emergencies: We may use or disclose your PHI in a medical emergency situation to medical personnel only.

Child Abuse or Neglect: We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Research: We may disclose your PHI for use in a research project that an Institutional review board has determined to be of sufficient importance to outweigh the privacy intrusion, to be impractical without PHI, to have specified safeguards against further disclosure in reports or otherwise, and, among other provisions, to require destruction or de-identification of your PHI.

Criminal Activity on Program Premises/Against Program Personnel: We may disclose your PHI to law enforcement officials if you have committed a crime on program premises or against program personnel or you have made a threat to commit such crimes. Such disclosure is limited to circumstances of the incident, including name, address, status as a patient, and last known whereabouts.

Qualified Service Organization: We may disclose your PHI to a Qualified Service Organization to provide certain services to the program and its patients, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy. If a QSO has more than will be utilized, otherwise only a Qualified Service Organization Agreement will be used. In the case the services is from a health care provider performing services to treat you, a Business Associate Agreement will not be utilized because you will have a direct patient-provider relationship.

Court Order: We may disclose your PHI if a court of competent jurisdiction issues an appropriate order.

Uses and Disclosures of PHI With Your Written Authorization:

We will make other uses and disclosures of your PHI only with your written authorization. You may revoke this authorization in writing at any time, unless we have taken a substantial action in reliance on the authorization such as providing you with health care services for which we must submit subsequent claim(s) for payment.



Answer Sheet

David M. Garner, PhD

Fill in your name and the date. Follow the instructions in the EDI-3 Item Booklet and enter your ratings on this sheet.

Name _____ Date _____ / _____ / _____

A = ALWAYS U = USUALLY O = OFTEN S = SOMETIMES R = RARELY N = NEVER

1.	A U O S R N	19.	A U O S R N	37.	A U O S R N	55.	A U O S R N	73.	A U O S R N
2.	A U O S R N	20.	A U O S R N	38.	A U O S R N	56.	A U O S R N	74.	A U O S R N
3.	A U O S R N	21.	A U O S R N	39.	A U O S R N	57.	A U O S R N	75.	A U O S R N
4.	A U O S R N	22.	A U O S R N	40.	A U O S R N	58.	A U O S R N	76.	A U O S R N
5.	A U O S R N	23.	A U O S R N	41.	A U O S R N	59.	A U O S R N	77.	A U O S R N
6.	A U O S R N	24.	A U O S R N	42.	A U O S R N	60.	A U O S R N	78.	A U O S R N
7.	A U O S R N	25.	A U O S R N	43.	A U O S R N	61.	A U O S R N	79.	A U O S R N
8.	A U O S R N	26.	A U O S R N	44.	A U O S R N	62.	A U O S R N	80.	A U O S R N
9.	A U O S R N	27.	A U O S R N	45.	A U O S R N	63.	A U O S R N	81.	A U O S R N
10.	A U O S R N	28.	A U O S R N	46.	A U O S R N	64.	A U O S R N	82.	A U O S R N
11.	A U O S R N	29.	A U O S R N	47.	A U O S R N	65.	A U O S R N	83.	A U O S R N
12.	A U O S R N	30.	A U O S R N	48.	A U O S R N	66.	A U O S R N	84.	A U O S R N
13.	A U O S R N	31.	A U O S R N	49.	A U O S R N	67.	A U O S R N	85.	A U O S R N
14.	A U O S R N	32.	A U O S R N	50.	A U O S R N	68.	A U O S R N	86.	A U O S R N
15.	A U O S R N	33.	A U O S R N	51.	A U O S R N	69.	A U O S R N	87.	A U O S R N
16.	A U O S R N	34.	A U O S R N	52.	A U O S R N	70.	A U O S R N	88.	A U O S R N
17.	A U O S R N	35.	A U O S R N	53.	A U O S R N	71.	A U O S R N	89.	A U O S R N
18.	A U O S R N	36.	A U O S R N	54.	A U O S R N	72.	A U O S R N	90.	A U O S R N
								91.	A U O S R N

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Item Booklet

David M. Garner, PhD

DIRECTIONS

Enter your name, the date, your age, gender, marital status, and occupation. Complete the questions on the rest of this page. Then, turn to the inside of this booklet and carefully follow the instructions.

Name _____ Date _____/_____/_____

*Age _____ Gender _____ Marital Status _____ Occupation _____

- A. *Current weight: _____ pounds
- B. *Height: _____ feet _____ inches
- C. Highest past weight (excluding pregnancy): _____ pounds
 How long ago did you first reach this weight? _____ months
 How long did you weigh this weight? _____ months
- D. *Lowest weight as an adult (or lowest weight as an adolescent if not yet age 18): _____ pounds
 How long ago did you first reach this weight? _____ months
 How long did you weigh this weight? _____ months
- E. What weight have you been at for the longest period of time? _____ pounds
 At what age did you first reach this weight? _____ years old
- F. If your weight has changed a lot over the years, is there a weight that you keep coming back to when you are not dieting? _____ Yes _____ No
 If yes, what is this weight? _____ pounds
 At what age did you first reach this weight? _____ years old
- G. What is the most weight you have ever lost? _____ pounds
 Did you lose this weight on purpose? _____ Yes _____ No
 What weight did you lose to? _____ pounds
 At what age did you reach this weight? _____ years old
- H. What do you think your weight would be if you did not consciously try to control your weight?
 _____ pounds
- I. How much would you like to weigh? _____ pounds
- J. Age at which weight problems began (if any): _____ years old
- K. Father's occupation: _____
- L. Mother's occupation: _____

INSTRUCTIONS

First, write your name and the date on the EDI-3 Answer Sheet. Your ratings on the items below should be circled on the Answer Sheet. The items ask about your attitudes, feelings, and behaviors. Some of the items relate to food or eating; other items ask about your feelings about yourself.

For each item, decide if the item is true about you **ALWAYS (A)**, **USUALLY (U)**, **OFTEN (O)**, **SOMETIMES (S)**, **RARELY (R)**, or **NEVER (N)**. Circle the letter that corresponds to your rating on the Answer Sheet. For example, if your rating for an item is **OFTEN**, you would circle the "O" for that item on the Answer Sheet.

Respond to *all* of the items, making sure that you circle the letter for the rating that is true about you. **DO NOT ERASE!** If you need to change an answer, mark an "X" through the incorrect letter, and then circle the correct one.

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.

(continued)

27. I feel inadequate.
28. I have gone on eating binges where I felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.
38. I think about bingeing (overeating).
39. I feel happy that I am not a child anymore.
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards.
43. My parents have expected excellence of me.
44. I worry that my feelings will get out of control.
45. I think my hips are too big.
46. I eat moderately in front of others and stuff myself when they're gone.
47. I feel bloated after eating a normal meal.
48. I feel that people are happiest when they are children.
49. If I gain a pound, I worry that I will keep gaining.
50. I feel that I am a worthwhile person.
51. When I am upset, I don't know if I am sad, frightened, or angry.
52. I feel that I must do things perfectly or not do them at all.
53. I have the thought of trying to vomit in order to lose weight.
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).
55. I think that my thighs are just the right size.
56. I feel empty inside (emotionally).
57. I can talk about personal thoughts or feelings.
58. The best years of your life are when you become an adult.
59. I think my buttocks are too large.
60. I have feelings I can't quite identify.

(continued)

61. I eat or drink in secrecy.
62. I think that my hips are just the right size.
63. I have extremely high goals.
64. When I am upset, I worry that I will start eating.
65. People I really like end up disappointing me.
66. I am ashamed of my human weaknesses.
67. Other people would say that I am emotionally unstable.
68. I would like to be in total control of my bodily urges.
69. I feel relaxed in most group situations.
70. I say things impulsively that I regret having said.
71. I go out of my way to experience pleasure.
72. I have to be careful of my tendency to abuse drugs.
73. I am outgoing with most people.
74. I feel trapped in relationships.
75. Self-denial makes me feel stronger spiritually.
76. People understand my real problems.
77. I can't get strange thoughts out of my head.
78. Eating for pleasure is a sign of moral weakness.
79. I am prone to outbursts of anger or rage.
80. I feel that people give me the credit I deserve.
81. I have to be careful of my tendency to abuse alcohol.
82. I believe that relaxing is simply a waste of time.
83. Others would say that I get irritated easily.
84. I feel like I am losing out everywhere.
85. I experience marked mood shifts.
86. I am embarrassed by my bodily urges.
87. I would rather spend time by myself than with others.
88. Suffering makes you a better person.
89. I know that people love me.
90. I feel like I must hurt myself or others.
91. I feel that I really know who I am.

Additional copies available from:

PAR Psychological Assessment Resources, Inc.
16204 N. Florida Avenue • Lutz, FL 33549 • 1.800.331.8378 • www.parinc.com

NAME _____

DATE _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY <small>did not bother me much</small>	MODERATELY <small>was very unpleasant (but I could stand)</small>	SEVERELY <small>could barely stand</small>
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

BECK DEPRESSION INVENTORY

Source: Aaron T. Beck

Read over the statements grouped with each letter, A through U. Pick out the statement within each group that best describes the way you feel today, that is, right at this moment. Circle the number next to the statement that you have chosen in each group. If two or more statements in a group describe the way you feel equally well, circle each one. Be sure to read over all of the statements in each group before you decide on one.

A.) Sadness

- 0 I do not feel sad.
- 1 I feel blue or sad.
- 2a I am blue or sad all the time and I can't snap out of it.
- 2b I am so sad or unhappy that it is quite painful.
- 3 I am so sad or unhappy that I can't stand it.

B.) Pessimism

- 0 I am not particularly pessimistic or discouraged about the future.
- 1 I feel discouraged about the future.
- 2a I feel I have nothing to look forward to.
- 2b I feel that I won't ever get over my troubles.
- 3 I feel that the future is hopeless and that things cannot improve.

C.) Sense of failure

- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2a I feel I have accomplished very little that is worthwhile or that means anything.
- 2b As I look back on my life all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person (parent, husband, wife).

D.) Dissatisfaction

- 0 I am not particularly dissatisfied.
- 1a I feel bored most of the time.
- 1b I don't enjoy things the way I used to.
- 2 I don't get satisfaction out of anything anymore.
- 3 I am dissatisfied with everything.

E.) Guilt

- 0 I don't feel particularly guilty.
- 1 I feel bad or unworthy a good part of the time.
- 2a I feel quite guilty.
- 2b I feel bad or unworthy practically all the time now.
- 3 I feel as though I am very bad or worthless.

F.) Expectation or punishment

- 0 I don't feel I am being punished.
- 1 I have a feeling that something bad may happen to me.
- 2 I feel I am being punished or will be punished.
- 3a I feel I deserve to be punished.
- 3b I want to be punished.

Self-dislike

- 0 I don't feel disappointed in myself.
- 1a I am disappointed in myself.
- 1b I don't like myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

H.) Self-accusations

- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself for my faults.
- 3 I blame myself for everything bad that happens.

I.) Suicidal ideas

- 0 I don't have any thoughts of harming myself.
- 1 I have thoughts of harming myself but I would not carry them out.
- 2a I feel I would be better off dead.
- 2b I feel my family would be better off if I were dead.
- 3a I have definite plans about committing suicide.
- 3b I would kill myself if I could.

J.) Crying

- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now. I can't stop it.
- 3 I used to be able to cry but now I can't cry at all even though I want to

K.) Irritability

- 0 I am no more irritated now than I ever am.
- 1 I get annoyed or irritated more easily than I used to.
- 2 I feel irritated all the time
- 3 I don't get irritated at all at the things that used to irritate me.

L.) Social withdrawal

- 0 I have not lost interest in other people.
- 1 I am less interested in other people now than I used to be.
- 2 I have lost most of my interest in other people.
- 3 I have lost all my interest in other people and don't care about them at all.

M.) Indecisiveness

- 0 I make decisions about as well as ever.
- 1 I try to put off making decisions.
- 2 I have great difficulty in making decisions.
- 3 I can't make decisions at all anymore

N.) Body image change

- 0 I don't feel I look any worse than I used to.
- 1 I am worried that I am looking old or unattractive.
- 2 I feel that there are permanent changes in my appearance and they make me look unattractive.
- 3 I feel that I am ugly or repulsive-looking.

O.) Work retardation

- 0 I can work about as well as before.
- 1a It takes extra effort to get started at doing .
- 1b I don't work as well as I used to.
- 2 I have to push myself very hard to do anything.
- 3 I can't do any work at all.

P.) Insomnia

- 0 I can sleep as well as usual.
- 1 I wake up more tired in the morning than I used to.
- 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- 3 I wake up early every day and can't get more than 5 hours sleep.

Q.) Fatigability

- 0 I don't get any more tired than usual.
- 1 I get tired more easily than I used to.
- 2 I get tired from doing anything.
- 3 I get too tired to do anything.

R.) Anorexia

- 0 My appetite is no worse than usual.
- 1 My appetite is not as good as it used to be.
- 2 My appetite is much worse now.
- 3 I have no appetite at all anymore.

S.) Weight loss

- 0 I haven't lost much weight, if any, lately.
- 1 I have lost more than 5 pounds.
- 2 I have lost more than 10 pounds.
- 3 I have lost more than 15 pounds.

T.) Somatic preoccupation

- 0 I am no more concerned about my health than usual.
- 1 I am concerned about aches and pains or upset stomach or constipation.
- 2 I am so concerned with how I feel or what I feel that it's hard to think of much else.
- 3 I am completely absorbed in what I feel.

U.) Loss of libido

- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.



David M. Garner, PhD

DIRECTIONS

Enter your name, the date, your age, gender, marital status, and occupation. Complete the questions in this booklet as accurately as you can.

Name _____ Date ____/____/____

*Age _____ Gender _____ Marital Status _____ Occupation _____

A. DIETING

*Have you *ever* restricted your food intake due to concerns about your body size or weight?
_____ Yes _____ No

How old were you the *very first time* that you began to seriously restrict your food intake due to concerns about your body size or weight? _____ years old

B. EXERCISE

On average, over the *last 3 months*, how often have you exercised (including going on walks, riding a bicycle, etc.)? _____ If you exercise more than once a day, please count the *total number of times* that you exercise in a typical week. _____ times a week

On average, how long do you exercise each time? _____ minutes

*What percentage of your exercise is aimed at controlling your weight?

_____ 0% _____ less than 25% _____ 25%-50% _____ more than 75% _____ 100%

C. BINGE EATING

Please remember in answering the following questions that an eating binge *only* refers to eating an amount of food that others of your age and gender regard as *unusually large*. It does *not* include times when you may have eaten a normal quantity of food that you would have preferred not to have eaten.

*Have you *ever* had an episode of eating an amount of food that others would regard as *unusually large*?
_____ Yes _____ No

If no, please skip to Question D.

How old were you when you *first* had an eating binge? _____ years old

How old were you when you began binge eating on a *regular* basis? _____ years old

*During the *last 3 months*, how often have you typically had an eating binge?

- _____ I have not binged in the last 3 months.
_____ Monthly I usually binge _____ times(s) a month.
_____ Weekly I usually binge _____ time(s) a week.
_____ Daily I usually binge _____ times(s) a day.

*At the *worst* of times, what was your average number of binges per week? _____ binges per week
How long ago was that? _____ months ago _____ at its worst right now

If you have not binged in the last 3 months, please skip to Question D.

*Do you feel out of control when you binge?

- _____ Never _____ Rarely _____ Sometimes _____ Often _____ Usually _____ Always

Do you feel that you can stop once a binge has started?

- _____ Never _____ Rarely _____ Sometimes _____ Often _____ Usually _____ Always

Do you feel that you can prevent a binge from starting in the first place?

- _____ Never _____ Rarely _____ Sometimes _____ Often _____ Usually _____ Always

Do you feel that you can control your *urges* to eat large quantities of food?

- _____ Never _____ Rarely _____ Sometimes _____ Often _____ Usually _____ Always

Do you feel distressed by your bingeing?

- _____ Never _____ Rarely _____ Sometimes _____ Often _____ Usually _____ Always

Do you find bingeing pleasurable?

- _____ Never _____ Rarely _____ Sometimes _____ Often _____ Usually _____ Always

D. PURGING

*Have you *ever* tried to vomit after eating in order to get rid of the food eaten? _____ Yes _____ No
If **no**, please skip to Question E.

How old were you when you induced vomiting for the first time? _____ years old

*During the *last 3 months*, how often have you typically induced vomiting?

- _____ I have not vomited in the last 3 months.
_____ Monthly I usually vomit _____ time(s) a month.
_____ Weekly I usually vomit _____ time(s) a week.
_____ Daily I usually vomit _____ time(s) a day.

*At the *worst* of times, what was your average number of vomiting episodes per week?
_____ vomiting episodes per week

How long ago was that? _____ months

E. LAXATIVES

*Have you *ever* used laxatives to control your weight or "get rid of food?" _____ Yes _____ No

If **no**, please skip to Question F.

How old were you when you *first* took laxatives for weight control? _____ years old

How old were you when you began taking laxatives for weight control on a *regular* basis? _____ years old

*During the *last 3 months*, how often have you taken laxatives for weight control?

_____ I have not taken laxatives in the last 3 months.

_____ Monthly I usually take laxatives _____ time(s) a month.

_____ Weekly I usually take laxatives _____ time(s) a week.

_____ Daily I usually take laxatives _____ time(s) a day.

How many laxatives do you usually take each time? _____ laxatives

What kind of laxatives do you take? _____

*At the *worst* of times, what was the average number of laxatives that you were taking per week?

_____ laxatives per week

How long ago was that? _____ months

F. DIET PILLS

*Have you *ever* taken diet pills? _____ Yes _____ No

If **no**, please skip to Question G.

*During the *last 3 months*, how often have you typically taken diet pills?

_____ I have not taken diet pills in the last 3 months.

_____ Monthly I usually take diet pills _____ time(s) a month.

_____ Weekly I usually take diet pills _____ time(s) a week.

_____ Daily I usually take diet pills _____ time(s) a day.

*At the *worst* of times, what was the average number of diet pills that you were taking per week?

_____ diet pills per week

How long ago was that? _____ months

G. DIURETICS

*Have you *ever* taken diuretics (water pills) to control your weight? _____ Yes _____ No

If **no**, please skip to Question H.

*During the *last 3 months*, how often have you typically taken diuretics?

_____ I have not taken diuretics in the last 3 months.

_____ Monthly I usually take diuretics _____ time(s) a month.

_____ Weekly I usually take diuretics _____ time(s) a week.

_____ Daily I usually take diuretics _____ time(s) a day.

*At the *worst* of times, what was the average number of diuretics that you were taking per week?

_____ diuretics per week

How long ago was that? _____ months

H. MENSTRUAL HISTORY (For females only)

*Have you ever had a menstrual period? _____ Yes _____ No

If **no**, please skip to Question I.

How old were you when you first starting menstruating? _____ years old

*Do you have menstrual periods now? (Check one)

_____ Yes, regularly every month.

_____ Yes, but I skip a month once in a while.

_____ Yes, but not very often (for example, once in 6 months).

_____ No, I have not had a period in at least 6 months.

_____ No, I am postmenopausal, have had a hysterectomy, or am pregnant.

_____ *How long has it been since your last period? _____ months

*Have you ever had a period of time when you did not menstruate for 3 months or more (excluding pregnancy)? _____ Yes _____ No

If yes, how old were you when you *first* missed your period for 3 months or more? _____ years old

For how many months did you miss your period? _____ months

How much did you weigh when you stopped menstruating? _____ pounds

Are you currently taking birth control pills? _____ Yes _____ No

If yes, how old were you when you first started using the pill? _____ years old

I. CURRENT MEDICATION

Are you currently taking any medication prescribed by a physician? _____ Yes _____ No

If yes, please list the medications you are taking.

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